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ABSTRACT

EMPOWERMENT TRAINING: THE IMPACT ON TRADITIONAL CASE OUTCOME MEASURES IN VOCATIONAL REHABILITATION.

By

Judy K. Ferris

The state-federal vocational rehabilitation system is charged with the responsibility of providing services aimed at achieving the vocational goals of America's working-age population of people with disabilities. Consumer involvement in service delivery and satisfaction with services are among the benchmarks used to determine continued funding of this system. Research in fields other than vocational rehabilitation, suggests that empowerment-training (ET) increases consumer involvement and satisfaction with services. However, ET has not been empirically studied in the field of vocational rehabilitation. This study used a correlational field design and subject matching procedures to study the impact of ET on tangible and intangible outcomes for 22 consumers of Michigan Jobs Commission, Rehabilitation Services system. Although not statistically significant, subjects who received ET were more likely to gain

employment, less prone to premature drop out and reported gains in self-esteem and decision-making skills related to receiving ET

DEDICATION

This dissertation is dedicated to my children, Shastitie, Tianna and Kaylee. The love and respect that we hold for one another has an energy of its own that transcends the demands of school, work and social obligations. I offer this public statement as a small token of my affection.

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Chapter 1

Introduction

Work plays an important economic, psychological and social role in people's lives. Many people with disabilities want to work, but have faced barriers that exclude them from participation in the work force. In an effort to eliminate barriers to work, the state and federal governments have worked to provide vocational rehabilitation services to people with disabilities. Laws have been passed to eliminate discrimination in hiring and to provide open access for competitive employment (e.g., Americans With Disabilities Act of 1990, Employment Opportunities for Disabled Americans Act of 1986, Job Training Reform Amendments of 1992, Rehabilitation Act Amendments of 1992). In spite of legislation and state-federal rehabilitation efforts people with disabilities continue to be over represented among the unemployed. One possible explanation for unemployment among people with disabilities is that people with disabilities lack empowerment. Empowerment is the sense that one can act to produce positive change. Empowerment is critical for effective planning and the implementation of strategies directed at obtaining the role of worker. This study will examine the impact of providing

empowerment training to consumers of state-federal vocational rehabilitation services.

Work is an important life activity that has the capacity to provide personal and social meaning. People want to work for many reasons, such as: individual success and satisfaction, expression of achievement strivings, to earn a living or to further ambitions and self-assertions. However, embedded in the notion of work, is the idea that all people live in a community and are expected to contribute valued goods, supplies and services (Richardson, 1993). Work is a substantial activity that connects the individual to the community. The work in which one engages is often used as a basis for future social engagement, relational acceptability, raising or maintaining self-esteem, and as the keystone of personal and social comparison. In America, an individual's societal value seems largely determined by the status, prestige or economic gain of his or her work. By extension, people who do not work occupy the lower rungs of society. One important factor that defines the culture of disability is the reality of pervasive and chronic unemployment.

The meaning implied in the word disability varies across legal definitions, social experiences, legislative

specifics and international agreements. For the purposes of this paper, I consider disability to mean any condition that results in limitations such that the individual is unable to perform his or her customary work. The probability of becoming disabled between the ages of 20 and 60 is one in five for males and one in seven for females (Akabas, Gates & Galvin, 1992). Approximately 43 million people in the US have a disability and the number is increasing (Newacheck, Bedetti, & Halfron, 1986; GAO, 1993; Wilson & Drury, 1984; Zola, 1988). About two-thirds of working age people with a disability (14-18 million people) are unemployed (GAO, 1993; Newacheck, Bedetti, & Halfron, 1986; Wilson & Drury, 1984; Zola, 1988). Of those who are unemployed, 80% want to work (Akabas, Gates, & Galvin; 1992; Harris, 1998; Harris, 1986; Rochlin, 1987).

The cost of unemployment among those with a disability can be measured in more or less tangible ways. For instance, in social-economic terms the cost of disability includes examples such as Social Security Administration payments to people with a disability totaling 38.3 billion dollars in 1989 (DeJong & Batavia, 1990) and workers compensation expenses that consume approximately 3% of U.S. employers' total payroll (Shrey & Olsheski, 1992). Less

tangible, but very real, are the psychosocial costs such as loss of personal self-worth and feelings of hopelessness. In Harris's 1986 cross-sectional surveys of 1,000 non-institutionalized *disabled* people, only 43% identified themselves as disabled. The act of identifying one's self as disabled may be equated with dependency, decreased opportunity and, being unemployable (Akabas, Gates, & Galvin; 1992; Rochlin, 1987). Respondents who held a job were more likely to reject the 'disabled' label (Harris, 1987). In the last two decades grass root efforts (e.g., the Independent Living Movement) and legislation (e.g., The Americans With Disabilities Act and The Rehabilitation Act Amendments of 1998) have worked to facilitate employment for people with a disability. Attempts have been made to eliminate barriers that hinder employment opportunities and to encourage a sense of consumerism.

Barriers to employment opportunity, such as those resulting from inaccessibility or discrimination, have been theoretically eradicated through political-legislative measures. However, the removal of barriers through anti-discrimination legislation has not proven to be the panacea once anticipated. In spite of recent legislation, cases where personnel managers preferentially consider and hire

able-bodied people abound (Dateline NBC, September 9, 1997). It seems as though political legislation has provided a framework for achieving employment opportunity to people with disabilities. However, the legal framework alone is insufficient to alleviate the unemployment problem.

The state-federal vocational rehabilitation (VR) system, a governmental agency within the Department of Health and Human Services funded by tax payers, is charged with the responsibility of assisting unemployed or under employed people with a disability to get the necessary services to allow them to work. The 'bottom line' of VR is employment and VR consumers are the business of the nation (Rochlin, 1987). In any one year the state VR system provides services for 5 - 7% of the working age disabled population. The likelihood of not being successful in VR (not completing a plan or dropping out) is 30 to 45% (GAO, 1993, p.88-89). In spite of all that has been accomplished through legislation and policy implementation within state-federal vocational service agencies, people with disabilities may lack sufficient resources to utilize the benefits and protections provided to them.

One possible reason for unsuccessful vocational rehabilitation efforts is that many people with disabilities

may lack personal empowerment. Being empowered is different than having an internal locus of control. Individuals with an internal locus of control believe they are responsible for taking action and that they are in control of their own destiny (Reber, 1985). They carry exclusive blame or credit for their life situation. People who are empowered have a more relational orientation. They believe that they can act, and that the actions taken will positively impact the desired outcome. This includes trusting that systems can be successfully negotiated and that they can rely on allies for assistance. People who lack empowerment tend to hold a set of beliefs that discourages them from approaching a task, taking risks (even when the odds for success are quite good) or expecting positive outcomes. They may believe that their situation is hopeless, that the system will not respond to their needs, that no one will assist them or that the outcome doesn't matter. Empowerment seems to be a necessary condition for active involvement in planning, seeking and obtaining employment.

Problem Statement

> Only through involvement in a counseling relationship can the vocational planning process become a psychologically relevant experience to the rehabilitation client. Such involvement should improve the precision of goals and

strengthen client commitment to their achievement (Fuhriman & Pappas, 1987).

The importance of consumer involvement is increasingly being recognized. Evidence of the value placed on consumer involvement can be seen in counselor training programs (DeJong, 1983; Nosek, 1987; Vash, 1992) and in legislated consumer involvement mandates. Specific language pertaining to involvement can be found in the Amendments to the Rehabilitation Act of 1973. The mandates began in 1992 (i.e., section 102: 6Cb1Ai, 6CBi, & 6CBx) and are present in the 1998 Amendments. Perhaps the most convincing evidence is the use of consumer satisfaction and vocational outcomes as benchmarks for continued funding of state VR services. Clinical observations made by vocational counselors and site administrators suggested that when consumers were involved with the planning of their vocational rehabilitation program they tended to be more vested in achieving their goals and were more satisfied with vocational counseling services (personal communications Partnerships for Choice Steering Committee, 7/20/94). This and socio-political pressures such as mandated involvement led the practice setting, Michigan Jobs Commission - Rehabilitation Services (MCJ/RS), to implement internal policies aimed at increasing and

assuring consumer involvement. For example, consumers are provided an orientation session that explains the consumer's role and responsibility as one that involves collaborative planning and decision-making. Consumers are selectively invited to participate on committees that make recommendations for service delivery protocols. Further, consumers can request that an outside advocate attend planning sessions, and there is a renewed commitment to on-going revision of the individual written rehabilitation plan.

It was expected that policy changes would increase both consumer involvement and the number of persons being successfully rehabilitated. After all, it had been established that consumers expect to be involved (Murphy & Solomone, 1983). Current public opinion holds the individual responsible for being involved, and MJC/RS believed it had set up a system that encouraged high consumer involvement. However, in spite of recent policy changes, informally VR counselors noted no difference in overall consumer involvement, and agency data did not appear significantly different (personal communication Carole Sheppard August 12, 1994). It seemed that the implemented changes were not sufficient to increase consumer

involvement. The question became what was blocking consumers from becoming involved?

It can be argued that past and present social programs have failed, or will fail, not because people lack involvement opportunity, but because they lack empowerment to become involved. To be involved one must possess sufficient opportunity, competence and will. In the case of MJC/RS, opportunity had been provided and Solomone (1983) had answered the question of consumer will, or desire to be involved, in the affirmative. Therefore, the question of consumer competence to be involved took front stage.

Consumer competence is embedded in the notion of empowerment. In order to be involved one must first be empowered. (Bolton & Brookings, 1996; Swift & Levin, 1987). Empowerment is a multifaceted construct consisting of a subjective and objective component. Empowerment in the subjective domain consists of a sense of control over one's life (Bolton & Brookings, 1996; Rappaport, 1985; Swift & Levin, 1987). Thoughts and feelings of self worth, power, possessing satisfactory ability and motivation are fundamental elements of empowerment. Empowerment in the objective domain refers to influencing attitudes, practices and resource distribution (Cornell Empowerment Group, 1994;

Segal, Silverman, & Temkin, 1995). Examples of objective empowerment include, persuading employers to focus on ways the person with a disability can be an asset, removing work disincentives in public financial maintenance programs and allocating more resources to enforcement of existing legislation. Empowerment is personal, social, political, and economic participation made possible by believing that one's actions can make a difference.

All people have the potential to be empowered. It is not a scarce commodity (Rappaport, 1985, p.17). However, empowerment cannot be bestowed upon those with lesser power. It must develop and be initiated by those who seek self control, expanded choices, independence or interdependence, increased authority, self determination and recognition (Gruber & Trickett, 1987; Pinderhughes, 1983; Rappaport, 1985; Simon, 1990; Szymanski, 1994; Vash, 1991; Yeich & Levine, 1992). Empowerment occurs through the following processes: 1) Increasing self-efficacy (Bandura, 1982; Shapiro, 1984; Mathis & Richan, 1986). 2. Reducing Self-Blame (Hirayama & Hirayama, 1985). 3. Assuming personal responsibility for change (Bock, 1980; Gutierrez, 1990). 4. Developing group consciousness (Sarri & du Rivage, 1985). The process of empowerment moves from invited participation

to involvement and finally to actually making one's own life decisions. Invited participation occurs when another, who has more power in decision-making, such as the VR counselor elicits the opinion or preference of the less powerful client. Power is generated, and more equally distributed, through the process of empowerment (Biegel & Naperste, 1982; Dodd & Gutuerrez, 1990; Kieffer, 1984; Pinderhughes, 1993). Since professionals do have more power (i.e., status, legitimacy, and access to control), client empowerment is inherently relational. Client empowerment sacrifices 'power over' in favor of the alternative, 'power with'. 'Power with' necessitates that the counselor and client are committed to client involvement (Labonte, 1994). The counselor must be willing to give up some decisional control. The client must be willing to accept personal and public responsibility for actions and life plans. The goal of empowerment is to produce an individual who is comfortable making his or her own decisions and plans.

Empowerment training fosters social skills, client decision-making, and peer support. It has been used to ready clients for active involvement in the rehabilitation process (Anthony & Farkas, 1989; Berman-Rossi & Cohen, 1988; Cohen, 1989; Davila, 1992; Fanslow 1982; Mowbray, 1990;

Richie, 1975; Susser, Goldfinger, & White, 1990). Empowerment training equips people with skills; information and enduring *I can* beliefs that mobilize motivation, cognitive resources, and actions necessary to exercise control (Bandura, 1989; Rappaport, Reischl, & Zimmerman, 1992; Tobias, 1995).

Purpose of this Study

The purpose of this study is to determine the impact empowerment training has on case closure outcome (i.e., retention in MJC/RS counseling, getting a job) and satisfaction with empowerment training. Clients who are served by state vocational agencies have a disability that impedes employment. Yet, they want to work. We, as taxpayers, have a vested economic and social interest in funding programs that increase the likelihood that a person with a disability will move from the status of subsidy recipient to public contributor. Therefore, it is critical that state VR systems learn which factors lead to the achievement of successful vocational outcomes.

Satisfaction with services, one of the benchmarks for continued funding of state VR programs, does not directly predict employment outcomes. However, it may contribute to the retention of consumers. If consumers are satisfied with

the services they are receiving and the manner in which services are being rendered it is likely that they will continue working with counselors at the MJC/RS to obtain employment. Clinical wisdom, consumer voices and political powers all tell us clients should be involved. Therefore, satisfaction with services may be dependent on providing consumers with the tools they need to increase their involvement. Consumers enter vocational rehabilitation with a host of life circumstances and experiences (e.g., limited practice making decisions, limited exposure to the world of work, previous experience with discrimination or oppression, and low assertiveness) that may render them unprepared for the demands of active involvement.

The concept of empowerment may be an effective way to establish a relationship between involvement and outcome. That is, as empowerment increases, involvement increases and thus, the likelihood of successful rehabilitation (i.e., employment, case cost and velocity) increases. Empowerment training has been most often offered to clients who seem indecisive, unassertive or lacking in life experience. Within MJC/RS, these are the consumers who are least involved, less satisfied with services and most dependent on governmental assistance and who are perceived as most at

risk for service discontinuation prior to successful rehabilitation.

Empowerment training is a widely used intervention. However, the impact of empowerment training initiatives is seldom studied. When it is studied, it is rarely reported in tangible outcome measures and no long-term follow up is done (Checkoway & Van Til, 1987; Fanslow, 1982; Krauss, 1983; Rappaport, Reischl & Zimmerman, 1992; Segal, Silverman, & Temkin, 1993; Ware, Desjarlais, AvRuskin, Breslau, Good, & Goldfinger, 1992). More specifically, researchers have only recently begun to systematically study empowerment in the VR domain. Therefore, there is limited data to support the impact of empowerment on vocational outcomes. In these political times, where competition for dwindling financial resources is fierce, where we aspire for involvement and consumer satisfaction, where accountability is measured in both economic and human terms, it is critical that case service dollars be utilized in a way that maximizes effectiveness. This research studied the impact of the Michigan Association of Centers for Independent Living, Partnerships for Choice project (PFC), an empowerment training program funded and utilized by MJC/RS, to determine the impact of empowerment training on

satisfaction with service and successful vocational rehabilitation. This study took place over a 3 year period and provides data at 3-6 months post empowerment training (i.e., end of fiscal year 1996) and at one and two years post empowerment training (i.e., end of fiscal years 1997 and 1998).

This study is relevant to counseling psychology in three ways. First, it applies the construct of empowerment to a specific problem in a way that allows for tangible outcome measures. In addition, because the empowerment training used in this study emphasized self-efficacy and decision-making skills, information on specific components of empowerment may be illuminated. Second, the investigation of the hypothesized relationship between empowerment and involvement may bring us one step closer to understanding involvement. Third, psychology as a field aspires to relieve social injustice. Systematic evaluation of the impact of empowerment training may relieve people with a disability and tax payers by providing information that may contribute to decisions regarding intervention funding based on tangible outcome data.

Definition of Terms

Involvement - The act of being an earnest participant in the development and implementation of goals and objectives related to vocational development. Involvement denotes taking ownership, control and appropriate responsibility for success in vocational rehabilitation.

Empowerment - An attitude that consists of thoughts, feelings and belief in the right of self-determinism, such that motivation to act is produced. Additionally, the notion that when people work together they can impact the structure of society. In this study empowerment denotes both emotional and cognitive elements while self-efficacy refers solely to cognitive factors.

Correlational Field Design - A research design that is carried out in the natural setting and that focuses on exploring how variables of interest move together. In this study the natural setting is the MJC/RS office with regularly employed counselors and the local center for independent living with regularly employed staff. Exploration of how variables are related includes, but is not limited to, the relationship between participating in empowerment training and case closure status.

Thematic Analyses - This is a strategy for systematically exploring open-ended responses such that they can be grouped into categories based on the intended meaning of the response. Categorization based on theme can facilitate investigation of ranking or salience of the broad content within responses.

MJC/RS - The Michigan Jobs Commission, Rehabilitation Services is a vocational rehabilitation program legislated and authorized by state-federal government, administered by The Department of Health and Human Services utilizing appropriated tax payer money. As a public agency, the charge given to MJC/RS is to facilitate the employment and independent living of Michigan's residents who have a disability through goal directed service delivery.

Consumer - A person with a disability who is being assisted by an agency. In this study the agency is MJC/RS.

Empowerment Training Program - A program developed to do one or more of the following: increase feelings of self-confidence, expand choices, promote actions aimed at self-determinism, motivate, and create social, political or economic change. In this study the empowerment training program was directed toward producing self confidence through increased personal awareness, expanding choices

through exposure to a peer group and program materials, and increase skill in decision making through practiced plan development and availability of an advocate.

Research Questions

This study explored questions in the following two areas: 1) Does empowerment training impact VR consumers' vocational outcomes (short-term, long-term)? 2) Are VR consumers who participate in empowerment training satisfied with the empowerment training program? The first question is critical for consumers and society, in that both hold expectations that employment is the primary goal of state VR services. Any intervention that facilitates the likelihood of obtaining this goal while increasing consumer involvement is worthy of investigation. To look for answers to this question it was important to investigate quantifiable, tangible measures such as the MJC/RS consumers' case status (e.g., dropped out, ready for work, successfully and unsuccessfully rehabilitated). Retention seemed important to this question because it may contribute to the probability of successful rehabilitation. It seemed useful to explore the impact of empowerment training over an extended period (i.e., 2-3 years) to determine the robustness of empowerment training as an intervention. In

answering the second question, intangible measures such as feelings of empowerment and overall satisfaction with the empowerment training experience were qualitatively analyzed.

Due to the exploratory nature of this research, subject characteristics were tracked. This information was critical in determining for whom and under what circumstance empowerment training had an impact. In addition a post-hoc analysis of correlations among all MJC/RS variables was performed. It was expected that this added information would contribute to determining the direction of future research.

It is hypothesized that VR consumers who receive empowerment training will: 1. Experience employment outcomes at a rate that is higher than expected based on actuarial data and at a rate higher than the control group (consumers who do not receive empowerment training). 2. Drop out less than is expected when compared to base rate data and less frequently than control subjects do. 3. Experience case costs equal to that of control subjects. 4. Have a pattern of successful rehabilitation at one and two year follow up points that is superior to the pattern found for control subjects. 5. Report feeling that empowerment training increased their sense of competence related to vocational

rehabilitation involvement. And, 6. Report feeling overall satisfaction with the empowerment training program.

Chapter 2

Literature Review

The goal of this chapter is to provide an overview of relevant theory and research literature. An attempt will be made to clarify the underlying logic supporting the present study's purpose, questions and hypotheses. This chapter will begin with a general overview of work in people's lives. Special attention will be given to employment issues of people with disabilities. Then a general description of the state VR system will be presented. This will be followed by sections describing research related to consumer involvement, which is one of the legislative mandates, and satisfaction, which is one of the benchmarks for continued public sector VR program funding. Finally, relevant literature on empowerment, with an emphasis on self-efficacy will be discussed. This chapter will close with a summary of conclusions and hypotheses.

Work

Work is activity performed to produce goods or services for others (Rothman, 1987). Since the beginning of humanity people have engaged in work. Entrance into and exit from the work force are social markers, cultural rights of passage. In America, one's entrance into the workforce

symbolizes transition to, or attainment of adulthood. When a person fails to obtain the worker role, he or she is perceived as developmentally inadequate or deficient. Exit from the work force marks retirement. Retirement is socially celebrated and is a time to acknowledge that one has contributed an acceptable amount of service. Clearly, work is a highly prized social value.

Besides monetary gain, work can be linked to psychological factors such as: personal identity, self worth, life satisfaction, and a sense of personal accomplishment. In addition to psychological factors, the act of working (or not working) has sociological and psychosocial implications. Work promotes society's future existence, feeds families, and provides purpose, power and connections (Richardson, 1993; Szymanski & Parker, 1996).

Accounts of history inform us that people with disabilities were largely excluded from the world of work (Hohenshil & Humes, 1979; Rubin & Roessler, 1987). For hundreds of years disability was often viewed as 'punishment for sin'. Shame and fear of negative community reactions contributed to the isolation and maltreatment of people with disabilities by their families and other social institutions. Prosperity and optimism in 19th century

America provided a more receptive environment for people who were perceived as not accountable for their misfortunes, specifically those disabled as a result of serving the American military interest (for a more thorough review refer to Chapter 1 in Rubin & Roessler, 1987). Thus the world of work became more open to, and accepting of, people with disabilities. Changes in the labor market over the last century have led to workers needing more knowledge and interaction skills versus physical prowess (Szymanski & Parker, 1996; Wegmann, Chapman & Johnson, 1989). Therefore, jobs require more education and afford more autonomy than ever before.

In a labor market that demands more education it is clear that people must obtain higher degrees of training to compete. One explanation for failure to obtain competitive levels of training is uncertainty related to career or educational choice (Brown & Brooks, 1990). In a study of 125 college students at 3 midwestern universities, Tseng (1992) compared students with different types of disabilities and found that regardless of disability type, older students had significantly more career indecision than younger students did. In other words, confusion related to choice of college major was predicted by age not disability

type. There are many possible reasons for why age is related to indecision. For example, older students may feel constrained or restricted by age. They may fear that they have lost or never learned fundamental skills to perform in highly competitive or technical fields of study. Regardless of the reason that age is related to indecision, it seems important that disability type was not a factor. Griggs (1993) expanded Tseng's work by comparing students with physical disabilities to students without disabilities. Differences in career indecision were not related to having a disability. Instead, age, being divorced and father's education (entered as a cluster) predicted career indecision. Enright (1994) examined the relationship between disability status, career indecision, and beliefs related to the world of work among 119 college students (59 with disabilities and 60 without disabilities). She found a significant correlation between self-doubt and career indecision. In addition a small interaction was found between self doubt and disability status in relation to students' perceptions of their vocational situation. McCarthy (1986) studied 353 people with disabilities ages 20-30. All had acquired their disability before the age of 14 and had graduated from high school. In this study 52%

were employed and almost two-thirds had received some post-secondary training. Most importantly, McCarthy found that educational achievement was the best predictor of vocational achievement. DeLoach (1989) examined the employment outcomes of 501 University of Illinois alumni with disabilities. She found that 417 were employed.

Although the research focusing on disability as it impacts college students is important, generally, people with disabilities tend to have obtained less education than people without disabilities and are more likely to face work related challenges (Szymanski, Ryan, Merz, Tervoni, & Johnston-Rodriguez, 1996). Those who are ill prepared to meet the new challenges of higher standards in the labor market (many of whom will be people with disabilities) will compete for a smaller number of lower paying, less secure jobs. Unfortunately people in these less secure, lower paying jobs often find themselves at or below poverty level with limited or no health care benefits and certainty that they can and will be replaced should market forces suddenly shift.

Approximately 13.5% of the US population experience disabilities that interfere with work activity (Storek & Thompson-Hoffman, 1991). In the 1990-1991 Survey of Income

and Program Participation 11% Whites, 13.3% Blacks and 11.1% Hispanics reported a work-related disability (O'Neil, 1993). Most people with disabilities want to work. However, a large proportion (67%) suffers chronic unemployment (GAO, 1996; Harris, 1986, Taylor, 1994). Employment is an important predictor of poverty. In a study by Taylor (1994), people with a disability occupied income brackets less than $25,000 per year at a rate of 59%, while their non-disabled counterparts were in this bracket at a rate of only 37%. Considering the importance of work to society and its members, it is not surprising that early state-federal program initiatives were aimed at helping veterans form selected disability groups with employment as a goal. Later VR programs extended services to citizens with all types of disabilities (Wright, 1980).

State VR

Twentieth century tragedies related to industrial accidents and war, coupled with a growing humanitarian philosophy led to the establishment of public sector vocational rehabilitation (VR) programs that were administered and supported by a state-federal match agreement. In 1920 a 1 million-dollar state-federal appropriation was available for VR efforts. However,

programs were considered experimental. The program goal was to assist civilians and veterans who were physically disabled enter the work force. Because public monies funded VR services, only those people who were most likely to find a job were provided assistance. It was assumed that families, charities and hospitals would care for the rest. Public awareness campaigns of the 1940's along with scientific/medical breakthroughs of the 1950s and 1960s lead to accelerated expansion of VR services. The Eisenhower, Kennedy and Johnson presidencies are sometimes referred to as the Golden Era in rehabilitation. During this period, eligibility requirements were broadened, medical rehabilitation and educational opportunities were increased, financial maintenance programs were established or enhanced, and research and training grants were funded. The impetus for change or expansion of VR services was sometimes the result of public outcry. Grassroots efforts, begun by the Independent Living Movement of the 1970's, served to expand the goal of public VR services to include emphasis on serving the more severely disabled and facilitating living in an environment with maximum freedom of choice.

The legal authority for the state-federal VR program resides in the Rehabilitation Act of 1973 and its subsequent

amendments. The law is interpreted and administered by the Office of Special Education and Rehabilitation Services of the US Department of Education through the Rehabilitation Services Administration (RSA). States submit a plan to RSA for approval, which sets forth matters of program operation. This plan becomes the standard by which the state's VR performance is measured (Parker, 1987). Increased accountability (e.g., documentation of adherence to plan as registered and tracking outcome data) and funding, have greatly expanded the scope of rehabilitation services.

Legislative imperatives and the resulting changes in rehabilitation practice reflected congress's strong commitment to providing services that were consumer driven and that facilitated the inclusion of people with disabilities into all aspects of society. Mandates of the 1970s included: serving the severely disabled, promoting consumer involvement, stressing program evaluation, providing support for research and advancing the civil rights of people with disabilities (Mandeville & Brabham, 1987; Rubin & Roessler, 1987, p.45). Of special interest to this study are involvement and program evaluation mandates.

Consumer involvement was addressed at the state and federal levels by adding people with disabilities to policy boards and councils. Involvement at the individual level was promoted by mandating joint involvement of the consumer and counselor throughout the rehabilitation process (CRC Code of Ethics (R2.8), 1996; Randolph, 1975). The spirit of individual consumer involvement implies that the counselor will share decision-making power with the consumer when determining program eligibility, vocational planning and necessary service procurements. To share decision-making power the counselor must respect the consumer's life style choices, values and attributions of performance capacities.

Program evaluation mandates stressed the development of standards by which the impact of rehabilitation services could be assessed. State rehabilitation programs were expected to disclose: the percentage of a target population being served, the effectiveness in terms of timeliness and adequacy of services being provided, the outcome of services with regard to suitability of client placement and employment retention, and client satisfaction with rehabilitation services (Rubin & Roessler, 1987, p.49). The following components of rehabilitation legislation that

originated in the 1970s remain central in legislation of the 1990s and are foundational in the proposed study:

1. Individuals, regardless of disability severity, are assumed to be capable of working in some capacity.

2. People with a disability must be provided the opportunity to obtain employment in an integrated work setting.

3. Individuals must be active participants in their rehabilitation planning, including making decisions and, or informed choices regarding their vocational goals and objectives.

4. Persons with disabilities can choose to include natural supports in their planning (e.g., family member, friend, and advocate).

5. Qualified service providers assist the individual in achieving his/her goals.

6. Measures of program success or other accountability measures must not inhibit the accomplishment of individual goals and objectives

7. Financial assistance is provided to states for expanding and improving independent living services.

8. Financial assistance is provided to states for improving the working relationship among and between programs and agencies receiving federal or non-federal assistance.

In spite of broadened eligibility and services available from state VR programs, employment of people with disabilities remains a salient issue in the disability

community and the primary goal of state-federal funded vocational rehabilitation programs.

The 1993 report from the Governmental Accounting Office (GAO) provided the following description of VR consumers and program services. The system serves approximately 995,000 consumers per year. VR consumers, as a group, tend to be older, less educated and have lower family incomes than the general working population. Musculoskeletal, cardiovascular and mental illnesses are respectively the three most common reported types of disability. The majority of consumers receive diagnostic/evaluation and counseling services. Other services include, but are not limited to restoration, transportation, job placement, referral, income maintenance, and various forms of training. Consumers are considered rehabilitated if they engage in an occupation commensurate with their abilities for a period of 120 days after the provision of VR services. Non-rehabilitated status means that a consumer received some services but was not rehabilitated and dropout refers to consumers who leave the VR system prior to the development of a service plan. The average consumer receives 3.5 services. Sixty-two percent of all cases are closed successfully rehabilitated and these consumers earn approximately $12,800 per year. The average

cost of services for successfully rehabilitated cases was $1,225. Thirty percent of all cases were closed non-rehabilitated and the typical consumer reported annual earnings of about $10,280. Average cost of services for each non-rehabilitated case was $998. Eight percent of consumers drop out and report average annual income of $11,050. The average cost of services for consumers who dropped out was $133.

The 30% of consumers who make up the non-rehabilitated group are of special interest to this study. Vocational counselors in the MJC/RS system provided feedback suggesting that this group seemed to experience more difficulty with involvement because they perceived their vocational situation as hopeless or were unsure about their role in the world of work (personal communication 9-21-94, Partnerships For Choice Steering Committee). In other words they lacked the empowerment necessary to be involved in preparing for and implementing a vocational plan of action.

Involvement

Involvement is an everyday term used to denote the act or fact of participating. Perhaps because the term is so widely used, it is often not defined in research. Research has measured involvement in 2 ways. First it has counted

actions that imply participation. Second, it has collected self-reports of the frequency and intensity of thoughts and feelings presumed to indicate involvement (e.g., salience, time spent considering a decision). The second method is most often used in counseling literature.

In a landmark study done by Murphy & Solomone (1983) of perceptions of control and the counseling relationship, client-counselor pairings were qualitatively studied utilizing tape-recorded interviews with 7 counselors and 12 clients. Six of the 7 counselors were state rehabilitation counselors, thus strengthening this article's relevance to this study. These authors did not report on client or counselor race, ethnicity, or educational level. However, they did have an apparent mix of disability type and severity. Interviews were semi-structured and open-ended. Clients were asked to describe their rehabilitation experience. Of special interest is client expectation regarding control of services. Findings indicated that clients either verbalized or intimated an expectation that they would be the primary decision-maker. Consumers seemed to expect very specific vocational services and anticipated that the expert guidance they were offered could be accepted or rejected. Counselors, however, concentrated early in the

counseling process on influencing change in the consumer's initial expectations of services. Implications drawn from this study suggest that although the consumer of VR services values the advice of a counselor (who is perceived as a credible expert) he or she wants to be in control of final service related decisions.

Farley, Bolton and Parkerson (1992) conducted a study designed to increase participants' involvement in vocational planning. Seventy-five subjects in the public VR system were provided group vocational choice training and one-to-one discussions designed to facilitate the participant's knowledge of self. Findings indicated that participants who received the experimental intervention gained more confidence in decision-making, became more aware of personal attributes that impact vocational choice and had more gains in scores on the Career Decision Scale than subjects who did not receive the intervention.

Al-Darmaki & Kivlighan (1993) utilized a correlational field design to study 25 counseling dyads at a mid-western university-counseling center. Instruments used in the study included the Working Alliance Inventory (WAI) and the Revised Psychotherapy Expectancy Inventory. Findings suggest that when the client and counselor agree on the

expected level of client involvement the counselor perceives more of a bond in the working alliance. A self-fulfilling prophecy may occur. Clients who expect an egalitarian relationship are more likely to collaborate with their counselors. When the counselor perceives the client as a collaborator, they are likely to elicit or encourage client involvement.

Nurco, Shaffer, Hanlon, Kinlock, Duszynski, & Stephenson (1988) conducted a quasi-experimental field study, utilizing 897 subjects from 25 addiction treatment centers across the US. They manipulated client-counselor match on expectations of involvement by assigning clients to counselors. Slightly more males were included in the sample than were females. White males showed the strongest tendency toward early involvement in treatment seeking and males were slightly more educated than females. No counselor characteristics were reported. Treatment outcomes were measured at 6-month follow up. Outcome measures were general quality of life issues and changes in the most important non-drug related problem, along with treatment compliance. Results indicated that Black clients felt significant client-counselor discordance with regard to confidence in treatment. A significant positive correlation

between client's perception of treatment modality appropriateness and positive outcome (i.e., abstaining from substance use) was found in Hispanic males. With Black females there was a low, but significant correlation between appropriateness of services and positive outcomes. The authors concluded that for some minority groups, getting the expected type of treatment and client's 'I can beliefs' coupled with counselor confidence, made a difference in treatment outcomes. The authors' attention to special populations raises the question, 'Is the disability population similar to other minority populations?' A thorough reading of disability history indicates that persons with disabilities have experienced much of the same history as other US minority groups. For example, most people with a disability have experienced negative stereotyping, oppression, social and institutional discrimination. They have long been thought of as unattractive, asexual, a burden, contagious, and undesirable. They have been warehoused and hidden.

Friedlander & Kaul (1983), found that clients who were made aware of their counselor's expectations for their active participation made more self references rather than other references in counseling sessions. Clients tended to

take more responsibility for the direction of the dialogue in the session. In short, clients focused on issues they believed most salient given their current state of counseling readiness. Client directed sessions might serve to optimize positive change while protecting the client from surpassing frustration tolerance thresholds. In high alliance dyads (client and counselor agreed on tasks, goals and perceived a mutual bond) the client was more involved with communication (frequency and depth of messages) than the counselor.

In a study of power and involvement, by Reandeau & Wampold (1991), the 2 highest and 2 lowest scoring dyads on the Working Alliance Inventory (WAI) of 14 were studied. It must be noted that the lowest 2 dyads were not low by standards of the Working Alliance Inventory (WAI) traditional cutoff measure. Subjects were predominantly White and age range was limited. Educational level of counselors was broad and no other counselor characteristics were reported. All sessions were audio taped and transcribed. The Penman Classification Scheme was used over a 9-month period to organize the data. Inter-rater reliability was .70-83. After the third session both the client and counselor completed the WAI. Results indicated

that there was an overall pattern of high power for the counselor and low power for the client. More interesting was that in high alliance dyads the client's proportion of high involvement communications was greater than that of the counselor's. The converse was true in low alliance cases. Additionally, involvement may be an important predictor of treatment outcome.

Szymanski & Parker (1996) discussed an earlier study done by Westbrook, Buck & Wynne (1994) that supported the importance of involvement. They found that the median correlation of consumer self-rated abilities with abilities measured by diagnostic instruments (i.e., Differential Aptitude Tests) was .5. This suggests that when consumers are directly involved in assessment of interests and aptitudes, the expense of testing may be avoided.

Although the construct of involvement needs further clarification, research suggests that clients who want involvement and expect it may realize better outcomes. It seems important to minimize inconsistencies in client-counselor expectations regarding determining the locus of the problem and who will do what in the relationship (Clairborn, Ward & Strong, 1981; Murphy & Solomone, 1983; Newton & Caple, 1974; Tichnenor, Thomas & Kravetz, 1981).

Additionally, counselors seem to respond to client gestures or requests for involvement by collaborating more, and using more egalitarian communications. In turn there is a tendency for clients and counselors to agree more on tasks and goals. The client perceives a greater bond with the counselor and is therefore, more likely to continue receiving services. A practical response to this seems to be, 'Why not teach clients to be involved and train counselors to accept client involvement as a valuable asset in therapy?'

Satisfaction

Satisfaction implies pleasure or contentment. It is based in the affective domain and therefore has been rightly studied by survey methods, often Likert scales that tap self-reported feelings. Assumptions are sometimes made that when a client is satisfied with treatment, involvement has been achieved (personal communication Partnerships For Choice Steering Committee, 8-15-94). Satisfaction with services in the vocational rehabilitation setting is often determined by factors such as: disparity in expectations and reality, bond with counselor and training or employment outcome.

Heppner & Heesacker (1983) investigated the relationship between client expectations and satisfaction with counseling. The study was done in the first 8 weeks of the 1980 fall semester at a large mid-western university-counseling center. Seventy-two clients, 24 males and 48 females, were asked to help the counseling center by evaluating its services. Problem identification indicated that 76% of the clients had personal issues, 38% academic and 36% vocational. It was not unusual for clients to indicate more than 1 area of concern. Beginning counselors received proportionally more clients with academic and vocational issues. Instruments included: The Counselor Rating Form (CRF), Counselor Evaluation Inventory (CEI) and the Expectations about Counseling Questionnaire (EAC). All have satisfactory reported reliability and validity. Clients received and completed the EAC immediately following consent to participate. Two weeks prior to the end of the semester all clients were mailed the CRF and CEI. Findings indicated that the less disparity there was in clients' counseling expectations and reality, the more likely clients were satisfied with services and case outcomes. Additionally high levels of client involvement, when the counselor desired it, led to greater client satisfaction.

Many people with a disability experience personal and social factors that limit their ability to participate in the rehabilitation process as an active player (e.g., self-efficacy, self-esteem, and/or self-awareness). Because the trend in counseling (both rehabilitation and psychology) has moved away from expert toward a consumer model, clients who are unprepared for active involvement may experience a greater disparity in what they expect versus what they receive. As a result they are likely to be dissatisfied (Dukro, Beal & George, 1979).

When people participate in activities that provide choices they tend to have increased performance that is consistent over time and greater satisfaction with program services (Mitchell, 1988; Oakes & Lipton, 1990). Although some researchers have found satisfaction correlated with case outcome, it is possible for a client to be satisfied without a positive case outcome. Those who realize positive to very positive outcomes are probably very satisfied and those who experience little disparity in expectations and reality are likely to be satisfied. Specifically, a VR client may expect to be unemployable, not be rehabilitated, and yet be satisfied with vocational service delivery. Although consumer satisfaction seems important, satisfaction

does not necessarily equate with tangible case outcome measures (e.g., becoming employed).

Empowerment

The language of empowerment pervades the rhetoric of politicians, management consultants and administrators. In 1986 the American Psychological Association sponsored a mini-convention where it discussed the need to target specific groups for empowerment. Physically and emotionally disabled people were one recognized high need group. Empowerment has been alive in rehabilitation literature for more than 30 years. For example, in the 1960's the concept of co-management, where the professional counselor and the client work as equal partners was presented (Bolton & Brookings, 1996). Evidence of the increasing emphasis being placed on empowerment is the number of articles published on the topic. In a review of empowerment literature Gutierrez, Parsons & Cox (1998, p.224-5) found 45 articles published in Social Work journals from 1976-1991. A recent Psyclit search (12-23-97) found 1,217 articles based on the keyword empowerment. Among those, 44 were specific to people with disabilities and 11 were specific to vocational rehabilitation. In the recent Psyclit search, just as in

the earlier search of Social Work journals, studies that included tangible outcome measures were rare.

Mental health practitioners agree that empowerment is a highly valued construct. However, owing to the lack of outcome studies with tangible measures, its efficacy is often difficult to articulate to funding sources, program managers and outside observers. Program evaluation, or outcome studies serve the important role of clarifying which interventions work, linking the program to the literature, explicating principles of practice and providing influential support for access to new or continued funding (Parsons, Jorgenson & Hernandez, 1994; Smith, 1992)

Theory Based Literature.

Definitions and descriptions of empowerment vary across mental health disciplines and within the field of rehabilitation. Sue & Sue (1990) and Vash (1991) have presented the broadest definitions of empowerment. Sue proposed that empowerment *is allowing people to reach their potential by removing obstacles that lie in their path* and Vash believed that *anything that is motivating is empowering*. VR's mandate for independent living and individualized vocational rehabilitation constitutes the intent of empowering people with disabilities (Holmes,

1993). Vash (1992) made the point that embracing the concept of empowerment was essentially, ''. . . an admission of counselors (that they) had been monopolizing the power attached to the helping role, a recognition that it undermined our clients while it made us feel good and a resolution to stop it.'' She warned that counselors can not give clients power, the best they can do is to remove obstacles to client power and facilitate the emergence of client power that is often hidden even to clients themselves.

Holmes (1993) provided a thorough definitional review of empowerment in rehabilitation literature. One definition that seems precise and clear was put forward by Swift & Levine (1987). They described empowerment as a developmental process that increases people's control over their lives. These authors believed that empowerment consisted of 1) A state of mind that is characterized by realistic 'I can' beliefs, 2) Modification of the power distribution and 3) Is both a process and a goal. An individual may lack empowerment in one domain while being empowered in another. People with disabilities often experience empowerment deficits in one or more of the following environments: individual, social, economic and political.

Swift & Levine (1987) noted that if people believe they already have enough control in their lives, or that it is appropriate for others to make decisions for them, they are unlikely to press for change. Therefore, awareness related to empowerment is the first step of empowering people. To move from a disempowered state to an empowered state demands access to resources (dollars, education, and social support). Furthermore, competently using resources is critical. Systems must be open to change in the distribution of resources. In practice, differential valuation is commonly ascribed on the basis of race, ethnicity, sex, religion, age, physical or emotional impairment, gender preference, etc.

Stubbins (1991) purported that VR's normal practice of looking for the deficits of the disability, labeling and use of medical terminology perpetuates consumer powerlessness. He purported that definitions of empowerment from outside VR may challenge the system beyond its capability to change. VR practice that represents authentic empowerment entail the client and counselor working together as equals for a common goal that is emancipating. This working relationship will include the counselor facilitating clients discovering power from within themselves. Empowerment is a way of thinking

about people in terms of quality counseling and facilitation aimed at freeing people from implicit and explicit forms of social control.

A model of empowerment was proposed by Zimmerman and colleagues (Zimmerman, 1990; Zimmerman, Israel. Schulz & Checkoway, 1992; Zimmerman, & Rappaport, 1988; Zimmerman & Warchaunsky, 1998). They believed that empowerment consisted of intrapersonal, interactional and behavioral components. The intrapersonal component views empowerment at the psychological level and encompasses constructs such as: perceived control, self-efficacy, motivation to exert control and competency perceptions, as well as beliefs about one's ability to influence social systems. The interactional component included knowledge about resources and problem solving skills. The behavior component referred to actions taken to influence others. An argument can be made to focus on the intrapersonal components of empowerment because it can be argued that empowerment is ultimately a personological construct reflecting the degree to which the values and attitudes associated with empowerment have been incorporated into the person's worldview. Zimmerman & Rappaport (1988) reviewed studies that suggested a sense of community, social isolation, worthlessness, civic duty,

concern for the common good and sense of connectedness to others are all aspects of empowerment.

Recently researchers in rehabilitation and disability spokespeople have begun to tweak out essential elements that make up the construct of empowerment. People with disabilities who have been active in the Disability Movement (Dart, 1992; Hahn, 1992; Ward, 1988) believe that empowerment involves the notion that disability is a normal characteristic, disability may provide insights that lead to positive self-identity, and people with disabilities need to trust themselves to acquire a sense of political purpose. Holmes (1993) discussed the components of empowerment as power, control, collaboration and self-discovery. Szymanski (1994) described the features of empowerment as self-control, expanded choices, independence or interdependence, authority and self-determination. Zimmerman (1998) conceptualized empowerment as control, awareness and participation.

Jenkinson (1993) purported that decision-making, a by-product of empowerment, breaks down when, 1) Options are not clear; 2) The decision maker lacks awareness of his or her values and preferences. Without personal awareness the decision maker is particularly vulnerable to the influence

of others; 3) The decision maker does not feel in control of available options; and 4) The decision making process reduces motivation for decision making, resulting in a less than adequate decision. Choice is a fundamental aspect of empowerment. The consumer should have control over values, decisions and choices, rather than the service provider choosing which options are available and which decisions are to be made.

Empowerment in theory based literature seems to be highly valued as a tool for facilitating consumer-directed services. In other words, when consumers are empowered to fit services to their individual needs and counselors or professionals facilitate the process of providing consumer-directed services, the best possible outcomes will be realized. Within a contextual system that does not allow unlimited empowerment resource constraints may serve to limit consumer-directed service delivery. When this is the case the empowered consumer may view the participation in the service delivery system as counter to their personal interests and choose to discontinue services. It appears that in some cases empowerment can lead to discontinuation of services. This relationship is not addressed in current literature.

Outcome & Process Based Literature

Like theory based literature, outcome and process based literature does not address what happens when a system does not service the needs of an empowered consumer. However, this body of literature does provide important information related to the perceived benefit of empowerment-training, program retention and a variety of tangible outcomes resulting from empowerment-training.

Brown & Ringma (1989) investigated the impact of providing empowerment training and transfer of control in service delivery to consumers. This study followed 4 consumers who moved from an institutional setting to a community living arrangement that included participation in an integrated work setting. Researchers discovered that the extent to which consumers were able to direct their own care and develop their preferred lifestyle was dependent on staff willingness to respond to consumer direction. Consumers noted difficulties when they perceived staff as authoritarian. Staff reported difficulty when they perceived the consumers as not providing sufficient direction or refused to do what they were capable of doing. Results indicated that consumer empowerment is not independent of relationships with those who provide services

or care. This study supported many of the theoretical elements of empowerment. Collaboration and self-determination seemed to be of special importance.

Schiarappa & Rogers (1991) devised the first study to produce a measure of empowerment at Boston University's Center for Psychiatric Rehabilitation. Guided by Zimmerman's theoretical model of empowerment, they utilized multiple instruments to measure a variety of concepts under the empowerment umbrella. Responses from 100 psychiatric patients who were members of 2 self-help programs were analyzed. The resulting empowerment scale had an internal consistency reliability of .85 and it correlated positively with activism and educational achievement. The construction of this instrument provides a way to measure empowerment. Because intrapersonal empowerment is hypothesized to be an internalized orientation, consisting of values and attitudes that can be acquired, self-report methods (i.e., direct inquiry) provide data with equal validity.

Recently Bolton and Brookings (1998) developed a self-report instrument that was aimed at producing a comprehensive measure of empowerment. This 64-item instrument included the following 4 subscales: Personal Competence, Group-Orientation, Self-Determination and

Positive Identity as a Person with a Disability. Instrument development utilized a pool of 156 subjects with disabilities who had been referred to an agency for an assessment or who were college students registered for assistive services at a Midwestern university. Internal consistency reliability for subscales ranged from .8-.89. This instrument is representative of the increased interest in clarifying psychometrically the concept of empowerment. However, due to the self-report nature of the instrument threats to validity, such as biased, responding remains an issue.

The majority of empowerment studies that report tangible outcomes have been focused on people who experience mental illness as their most salient disability characteristic. Mental illness is the third most common reason given by people for unemployment (GAO, 1993). Rosenfield (1992) studied people with severe mental illness who were becoming deinstitutionalized. Findings indicated that providing economic resources and utilizing an empowerment model of service delivery significantly related to overall quality of life.

Connelly, Keele, Kleinbeck, Schneider & Cobb (1993) ethnographically chronicled the lives of severely mentally

ill clients who were involved in a client-run drop-in center. Client's perceived that empowerment meant they participated more in the community, their choices were increased, they provided support for each other and they negotiated on a more equal basis with staff. Similar results were found in studies done by Baker and Brightman (1984) and Hixson, Stoft and White (1992).

Coursey, Keller & Farrell (1996) studied a stratified random sample of 12 psychosocial rehabilitation centers that served clients with serious mental illness in the state of Maryland. Among their findings they discovered that clients who felt empowered spent less time in hospitals, expected a shorter stay in therapy, and knew more about their problems.

In an effort to establish validity and reliability for an emerging empowerment instrument, Segal, Silverman, & Temkin (1995) collected baseline and 6 month data on 248 mentally ill people who were participating in self-help agencies. Findings indicated that organizational and extra-organizational empowerment is contingent on involvement in the work role. Personal empowerment is more related to general independent social activity than to work involvement. Self-efficacy and self-confidence seem to bridge the various components of empowerment.

Empowerment training has been systematically investigated as an intervention strategy for patients with diabetes (Anderson, Funnell, Butler, Arnold, Fitzgerald & Feste, 1995). These authors examined the outcomes of a 6-week, 1 session per week, patient empowerment program. They found that the group who received empowerment training showed gains in self-efficacy and developed a healthier attitude toward living with their disease.

Balcazar, Mathews, Franscisco, Fawcett & Seekins (1994), looked at the effect of empowerment training at 4 advocacy agencies. The number of members participating in the study ranged from 6-16 at each site. Education and experience varied. Participants were proportionally more female and approximately three-fourths had a disability or cared for a person with a disability. Researchers collected data from regular meeting agendas (issue identification), number of actions taken (e.g., phone calls, letters, program or public event participation), and observed or reported changes (i.e., curb cut, remodeling, fund raising, etc.). Results indicated that organizations, like people, select a level of involvement that meets their own needs. Overall, advocacy empowerment did positively impact actions taken and outcomes achieved.

Parsons (1994) utilized qualitative interview techniques to evaluate 5 empowerment-based programs. In the final analysis she found that empowerment processes affected the participant's perceptions of self, knowledge or skills and action planning. Client self-ratings and staff ratings of clients indicated that clients experienced increased self-awareness, self-acceptance, belief in self and feeling that he or she had rights. Empowerment focused programs or interventions suggested improved knowledge or skill in the areas of assertiveness, setting limits on giving, problem solving, critical thinking and accessing resources. Action planning increased with regard to giving back to the community and taking control in other domains. Parson's work provides strong evidence supporting the positive impact of empowerment.

Accumulating evidence suggests that change, both personal and social, rely on methods of empowerment (Bandura, 1988a; Bolton & Brookings, 1998; Rappaport, Swift & Hess, 1984; Ratcliff, 1984; Silbert, 1984; Zimmerman, 1998). Empowerment denotes equipping people with skills, information and enduring 'I can' beliefs and connotes a sense of high positive self-efficacy.

Self Efficacy

Self-efficacy, a key component of empowerment, is concerned with people's belief in their ability to successfully undertake a task and the idea that the consequences of trying will be worth the effort. Self-efficacy judgments affect choice of activity and personal environment. People tend to avoid activities and situations that they believe exceed their coping capabilities; but, they readily undertake activity and select environments they believe they can handle (Bandura, 1989; Hackett, 1986).

Anxiety and stress reactions are low when people perceive tasks to be within their self-efficacy range (Brown & Lent, 1992). Self-doubts regarding task performance capabilities produce increased subjective distress and physiological arousal. For example, people who believe they can control their troubling thoughts will do so and persevere in their efforts. Those who judge themselves highly efficacious find it easier to avoid intrusive negative thoughts.

Self-efficacy consists of 4 essential elements: 1. The individual is aware of the actions needed to produce the desired outcome. 2. The person believes they are capable and expects to succeed. 3. The individual believes that the

outcome is within their control. And 4. The outcome is sufficiently desired to motivate the person to act (Mitchell, Brodwin & Benolt, 1990). Efficacy can be enhanced in 4 major ways (Bandura, 1986). The most effective way is through mastery experiences. Performance successes build efficacy; failures undermine it. Modeling 'coping strategies' and presenting achievements for comparative self-appraisal can strengthen efficacy. Social persuasion has also been shown to strengthen people's beliefs that they possess certain capabilities. Positive social appraisals have the greatest impact when challenges are structured in graduated steps that are likely to bring success. Finally, changing physiological states that are read as signs of strength and personal vulnerability can alter self-beliefs of efficacy.

Ozer & Bandura, (1990) studied responses of 43 women, age 18-55, from the San Francisco Bay area who were enrolled in a community offered self defense program. Thirty-eight percent had been previously physically assaulted and 27% had sexual intercourse forced on them in a previous relationship (note that the subjects did not necessarily equate this with rape). Subjects participated in 5, four and one-half hour, empowerment sessions over a 5-week period. Findings

suggested that before participation in the program behaviors were a function of cognitive control (i.e., ability to stop or focus on thoughts), self-efficacy and negative thoughts. After the empowerment program, behavior was a function of perceived coping self-efficacy, through its influence on risk discernment and personal vulnerability appraisal. At follow up, perceived coping and self-efficacy regulated both participation and avoidance behavior mediated by personal vulnerability appraisal and risk appraisal. In short, 'I can' beliefs were the basis of active involvement.

In a study done by Seilheimer & Doyal (1996) the empowerment element of self-efficacy in relation to housing satisfaction was explored. Subjects were a group of 125 randomly selected recovering mentally ill consumers who were moving into a community supported living arrangement. Findings indicated that consumers prefer the least restrictive environment and consumers in the least restrictive environment show increased levels of self-efficacy.

In a review of the literature (Brown & Lent, 1992) concluded that self-efficacy beliefs are: 1. Predictive of career entry indexes (e.g., perceived options, academic achievement and career indecision) 2. Related to work

adjustment outcomes and coping with job loss 3. Predictive of performance 4. A valid construct based on convergent support 5. Often helpful in explaining sex-typed occupational considerations. In addition, employment interview experiences and employment offers depend on factors such as, confidence, self efficacy expectations and coping strategies (Kanfer & Hulin, 1985).

CONCLUSION

Work is, and always has been, one of life's important activities that serve to determine an individual's personal and socio-political worth. People with disabilities experience from chronic unemployment and under employment. The public VR system is charged with the task of assisting people with disabilities become more independent. Increased independence does not necessarily involve employment. However, VR is, more often than not, associated with vocational pursuits.

Consumer involvement and satisfaction have become the benchmarks that help to determine continued funding of state-federal VR programs. Because empowerment seems to be the cornerstone of involvement it has become the preferred philosophy of VR service. Empowerment refers to facilitating the active participation (involvement) of the

VR consumer in all aspects of evaluation, planning and implementation of an Individualized Written Rehabilitation Plan. Consumers are expected to direct their services and are free to accept or reject the expert advice of their counselor.

The 1993 GAO report indicated that approximately 30% of consumer cases are closed 'not rehabilitated' and an additional 8% of consumers dropout of the program prior to the development of an Individualized Written Rehabilitation Plan. Communications with MJC/RS central office (Carole Sheppard, 7-10-94) suggested that Michigan's state-federal VR system was not significantly different in this respect from the picture presented in the GAO report. She noted that observations made by MJC/RS personnel indicated that some consumers might lack the intrapersonal empowerment necessary to be involved in the treatment process.

Empowerment training has not formally been studied in the arena of state-federal VR programs. A study addressing the impact of empowerment in the VR setting would serve to fill the gap in rationale between empowerment as a philosophical model and empowerment as a practice model of service delivery. This study attempted to determine if empowerment training impacts the outcome of VR services.

Qualitative data were used to determine consumers' satisfaction with the empowerment intervention and quantitative data measured treatment outcomes in terms of successful vocational rehabilitation, case cost and types of services provided.

Hypotheses

The specific hypotheses of this study are that VR consumers who receive empowerment training will:

1. Obtain employment at a rate that is higher than the group that does not receive empowerment training. Specifically, subjects who receive empowerment training will have employment outcomes that exceed expected values based on actuarial data, while subjects who do not receive empowerment training will have employment outcomes that are equal to the expected value using actuarial data.
2. Prematurely (i.e., prior to vocational plan development) drop out or discontinue MJC/RS services at a lower rate than subjects who do not receive empowerment training based on actuarial data. While, subjects who do not receive empowerment training will prematurely discontinue services at a rate that is equal to the expected value using actuarial data.

3. Case costs of both groups (empowerment training and control) will be equal and will not significantly differ from the expected case cost based on actuarial data.
4. Display a pattern of successful rehabilitation (i.e., employed for 120 days) that is superior to those who do not receive empowerment training at 1 and 2 year follow up.
5. Report an increased sense of control and self-confidence as a result of empowerment training.
6. Report feeling satisfied with the content and quality of the empowerment training program.

Chapter 3

Methodology

The original project from which this study draws its data is titled Partnerships For Choice (PFC) and was administered by the Michigan Association of Centers for Independent Living (MACIL). Jean Golden, President of the Center for Handicapper Affairs (a MACIL member CIL), initiated this project in response to MJC/RS's call for Innovation and Expansion (I&E) grant proposals. The goal of the project was to demonstrate that 'consumer choice' (i.e., increased involvement and satisfaction with services) can be achieved through formation of an effective partnership among the consumer, VR counselor and IL advocate. This project holds that the partnership represents an evolutionary change within VR service delivery. This type of change is in stark contrast to other demonstration projects that utilized a voucher system to increase consumer control and satisfaction with services. The PFC project was funded (approximately $60,000) over a 2 year period through MJC/RS I&E money.

This chapter will provide an overview of the general methodology and specific procedures used in this study. First, the reader will be provided with a description of the PFC project. This section will include subsections on

project development, curriculum development and project implementation. Second, selection and characteristics of subjects will be discussed. In addition to a description of subjects, this section will provide a brief summary of information related to MJC/RS counselors, MJC/RS sites, CIL sites and CIL Independent Living (IL) skill specialists who conducted the empowerment training(ET) sessions. Next, material used in the study, specifically the ET curriculum and instrumentation, is presented. The next section discusses the procedures and data collection used in this study. Design factors are then presented. This chapter ends with a section describing the data analysis and hypotheses.

PFC Project

Project Development

The Partnerships For Choice (PFC) project emerged from the foundational work and grant submission of Jean Golden, Executive Director of the Lansing area CIL. Ms. Golden and others believed that consumers could benefit from having more choices and autonomy in decision-making as it pertained to vocational development within the context of the MJC/RS system. At the time of initial conceptualization of the PFC project, MJC/RS had available funds earmarked for Innovation and Expansion Grant (I&E) projects. A portion of I&E money

was allocated to another project that utilized a 'voucher' system for the purpose of expanding consumer choices and providing increased autonomy. Voucher systems inherently increase consumer control because the consumer in essence has permission to spend an allotted amount of money on the services he or she believes are most important. However, voucher systems have a tendency to minimize consumer support resources by diminishing the role that VR counselors play in assisting the consumer through provision of information and referral, and by reducing consumers' perceived access to the VR counselors fund of knowledge (e.g., career choice, labor market demands). The original grant proposal for the PFC project put forward the idea that consumer choice, involvement and autonomy could be strengthened within a partnership model. The partnership consisted of the MJC/RS consumer, MJC/RS counselor and a CIL-IL staff member. The partners would collaborate to provide services that optimized the chances of the consumer being successful at obtaining his or her goals. The consumer was recognized for his or her strengths such as self-knowledge. The MJC/RS counselor was recognized for VR and labor market expertise, and the CIL-IL partner was recognized for strengths related

to advocacy, modeling and ability to assist in the process of teaching consumers empowering strategies.

The first step in the project was to bring together a Steering Committee with member representatives from CILs, MJC/RS and consumers (refer to Appendix A). The Steering Committee's purpose was to guide the development of research, curriculum content and empowerment training procedures, and to produce an inter-agency atmosphere of collaboration. In my role as Project Coordinator, I attended all meetings of the Steering Committee assuming the general role of employee and specific role of technical facilitator.

The first three working sessions of the steering committee focused on discussions of fundamental concepts (i.e., empowerment, involvement, partnership), clarifying individual's roles as board members and developing a 'task list' with target dates for completion. Discussions related to defining important concepts were at times arduous, leading to no consensus. For example, the steering committee struggled when it came to defining involvement. Consistent with what seems to have happened in professional research, the group 'gave up' trying to define involvement because the task seemed an ineffective use of their

resources. At other times the steering committee seemed to easily join in consensus. They agreed that empowerment is predominantly an intrapsychic phenomenon that is altered by interactions with one's environment. For example, if the environment encourages reasoned risk and punitive consequences for failure are minimal, intrapsychic empowerment is increased. The steering committee agreed that the partnership or collaborative environment enhanced intrapsychic empowerment for committee members and they hoped that this enhancement would generalize to all PFC partnerships.

The steering committee clearly conceptualized the partnership on two levels. At a systems level MJC/RS, CILs and consumers were partners and their purpose was to establish and maintain contact with one another (i.e., collaborate on projects and brainstorm policy decisions). At an individual level the MJC/RS counselor, a consumer and the CIL-IL person are a partnership. The purpose of this partnership is to maximize the consumer's choices and facilitate the obtainment of the consumer's goals.

Steering committee members selected themselves into one or more of the following three working groups: research, partnership building and document-advisor/editor. The role

of the research group members was to develop a research plan, create operational definitions and formulate reasonable methods to collect data that would answer the global question 'Does PFC increase consumer involvement and satisfaction?' Although most 'detail' type issues were decided upon in smaller working groups some were deemed appropriate for full discussion among the whole steering committee. One such issue, brought to full committee by the research group, was related to timing of empowerment training. The steering committee had to decide whether to offer the empowerment training at status 2 (when the consumer is deemed eligible for services) or wait until status 10 (when the consumer is ready to develop an individualized written rehabilitation plan). Both options had advantages and supporters. The committee decided to offer empowerment training at status 10. Members believed this would, 1) provide empowerment training in a time frame that intersected with MJC/RS expectations of consumers (i.e., practice planning just before formalizing the IWRP) and 2) minimize disruption to consumers in empowerment training groups by reducing the likelihood that consumers would drop out (i.e., drop out rate is lower as the case progresses). Other concerns of the research group that were

discussed in full committee included: subject selection procedures, confidentiality and sharing of information between the CIL and MJC/RS, and how to limit the use and accessibility of pertinent data.

The first task of the partnership-building working group was to improve the relationships between MJC/RS counselors and CIL staff members. Steering committee members identified some of the historical reasons that relations between the two organizations have not always been positive. In an effort to build the type of positive relationships necessary for collaborative partnerships, this working group put together a series of meetings for MJC/RS counselors and CIL staff members. Five such partnership meetings were conducted over a 3-month period. Attendance ranged from 4 to 16 people. The audience included MJC/RS managers and counselors, CIL Directors and staff members. The meeting agenda included the following items: What do you do over there at MRS? What do you do over there at the CIL? What is my vision of a partnership? What are potential barriers to building this type of partnership? How can we make this partnership a reality? The purpose of these questions and the subsequent dialogue was to 1) dispel myths or stereotypes 2) verbally share a common desire to do a

'good' job and serve the consumer and, 3) begin or enhance collaborative relationships. The partnership-building working group summarized each meeting and provided input into several internal memorandums.

The document-advisor/editor working group reviewed all documents and reports. However, their principal charge was to facilitate the development of curriculum material (i.e., empowerment training modules 1 and 2). This working group researched existing empowerment based programming and solicited selected groups for material contributions. They were instrumental in obtaining consumer feedback through curriculum piloting with focus groups. The document-advisor/editor working group was also responsible for assuring that the empowerment training manuals were user friendly (e.g., reading level, visual organization).

Curriculum Development.

Consumers were recruited to participate in empowerment related focus groups either through personal invitation or by responding to a public informational leaflet. The purpose of these focus groups was to solicit consumers' input related to the concepts of empowerment and involvement. Consumers also were asked to share their beliefs or ideas related to how they, as consumers, would like to learn about

empowerment. Invitations to participate were provided to individuals currently receiving MJC/RS or CIL services by MJC/RS counselors or CIL staff members. Participation incentives were not provided to consumers, nor were disincentives associated with not accepting the invitation to be part of the focus group. Likewise, the individual who learned of the opportunity to participate in a focus group by reading a leaflet in the waiting room or in the bulletin board area of a MJC/RS or CIL office and who volunteered to participate received no incentives or disincentives. Three consumer focus groups were conducted with group attendance ranging from 5 - 9 consumers. In summary, consumer focus groups revealed that consumers perceive lack of personal empowerment and authoritarian environments as interacting to block the vocational and personal success of people with disabilities. Consumers expressed a need for greater empowerment through increased self-knowledge (e.g., what do I want from working, what are my talents, how do I achieve and maintain self-confidence).

Concurrently, 3 focus groups were conducted that included 6-10 CIL and MJC/RS staff. The purpose of these groups was to determine if lack of empowerment was seen as a barrier to successful vocational rehabilitation and if so,

what could be done to increase consumer empowerment? Lack of empowerment was unanimously seen as a barrier to successful vocational rehabilitation. CIL and MJC/RS focus group attendees tended to believe that empowerment would increase if consumers 1) knew more about themselves and the world of work, 2) developed or enhanced decision-making skills and 3) could effectively use advocates (including self-advocacy). Based on information gathered through these focus groups the outline for the empowerment training curriculum was established.

In response to a letter requesting assistance in developing the empowerment training curricula 5 CILs and 1 MJC/RS office contributed materials that were currently being used or that they believed were potentially relevant. Submitted materials were sorted and categorized into the following types: 136 inspiration pieces (e.g., quotes, short stories, poems), 28 pieces related to promoting positive self image, 2 lesson plans with 4 exercises related to 'how to interview', 2 informational guides related to consumer's 'rights and responsibilities', 2 listings of agency resources, 1 list of auxiliary resources, and 1 lesson plan related to sexuality. These contributions along with those listed in Appendix C were used in the development of the

empowerment training text. The document-advisor/editor working group and the PFC Project Coordinator selected specific contributions for inclusion based on consumer feedback, face validity, subjective sense of 'best fit', ease of reading or text consistency.

To address issues of readability, the first and subsequent drafts of the empowerment training text were analyzed using the Flesch-Kincaid spelling and grammar tool on the Microsoft Word computer software package. Sections of the final draft ranged in reading level from 6.2 - 7.8. The overall reading level was 7.4. Six staff (3 CIL and 3 MJC/RS) provided feedback related to readability. Four staff believed the reading level was appropriate for the consumers they served. One thought that the reading level was too high and another thought it was too low. Specific comments included, ''The reading level is so low that it is potentially demeaning.'' and ''Most of the people I work with read at about third grade. This will lose them.''

Five different CILs across the state of Michigan hosted 31 consumers (3-9 per site) who participated in feedback sessions related to the empowerment text. At these sessions the PFC project coordinator elicited consumers' assistance in helping make changes that would make the sections easier

to read, understand or complete. Consumers actively provided feedback that resulted in 46 word changes, 8 sentence changes and 2 alterations in graphic material. Two consumers suggested that the reading level was 'a bit low' but that the material was interesting. One consumer left the feedback session without explanation. Overall, consumers reported that the drafted segments were readable (and understandable) at the level they were written. After the revisions suggested by the consumers were finished the training text went to press.

Project Implementation.

Although MJC/RS, CILs and the PFC Steering Committee had been working collaboratively for a period of months and the empowerment training curriculum was drafted, formal agreements to implement the PFC project had not yet been secured and details of the project had not been widely disseminated. A meeting was called to inform all interested parties (approximately 70 people attended) about the PFC project. Meeting attendees were provided with information related to the project's conceptualization, development and details of implementation procedures. MJC/RS office managers were asked to poll their staff about willingness to participate in the project. MJC/RS offices that were

closest to CIL sites became formally committed PFC participating site offices. Within each MJC/RS site counselors with a 'general' caseload were asked to volunteer participation.

CIL personnel were selected to carry out the training. When the demands of the PFC training project did not fit neatly into a position already developed at each CIL, a CIL staff member was hired or an existing staff member was trained and their job description modified for the duration of the project. MJC/RS counselors and IL trainers participated in 1 or more PFC orientation sessions to facilitate communication related to expectations, procedures and goals.

According to Shavelson (1988, p.692) in order to discover differences of .45 standard deviations between groups at a .8 power level it would be necessary to have 62 participants (31 ET and 31 C). All consumers who had not completed an Individualized Written Rehabilitation Plan on the caseloads of participating MJC/RS counselors were asked to complete the Consumer Survey. One important function of the survey was to establish a potential consumer pool. There were 96 consumer surveys distributed, of which 77 were

completed and returned. Sixty-one respondents indicated interest in receiving empowerment training.

Within the time period between establishing a participant pool and training start-up the number of potential subjects was reduced to 43. The decrease was due to the following problems: 13 participants had completed an Individualized Written Rehabilitation Plan, 4 had dropped out of the MJC/RS service system and 2 had become employed. Clearly the number of potential subjects was not optimal for satisfactory levels of statistical power. However, the decision was made to proceed with a small sample size rather than to recruit additional subjects for a couple reasons. First, the time it would take to recruit more subjects may create 'wait' time for existing subjects that would hinder or negatively impact the degree of naturalness they experienced in their rehabilitation process. Second, maturation or current events such as intake process may not be consistent for subjects in early versus later selection.

Characteristics of the participants in the potential subject pool were then explored to provide information necessary to initiate a subject matching procedure. Eleven pairs of participants matched on a one-to-one basis across the following characteristics: age grouping, gender,

race/ethnicity, marital status, years of education, primary disability type, severity of disability, length of time case had been open (age of case) and income level grouping at the time of entering the MJC/RS system. Random selection to the ET group was made within each matched pair. These 22 consumers became the subjects on which this study evaluates the impact of empowerment training.

Fifty other consumers participated in the empowerment training program. These consumers as a group were not significantly different than the 22 consumers who are the subjects in this study. Specifically, they demonstrated an interest in participating, were in MJC/RS status 10 (development of an individualized written rehabilitation plan), had a similar range in age and education as the subjects and tended to respond to the consumer survey with a similar pattern of responses. A notable difference is that these consumers were selected by the MJC/RS counselor to participate. The additional 50 empowerment training participants were essential for the purpose of providing the subjects with a group experience. Empowerment training group membership at the participating sites ranged from 3 to 11 participants.

Participating IL trainers were provided with participants' names and contact information. They set up the first Empowerment Training meeting and when necessary assisted with arranging transportation and accommodations. At the first training session IL Trainers secured releases of information, consent to participate (refer to Appendix D) and facilitated the completion of the Pre-Empowerment Training Questionnaire. IL Trainers were permitted flexibility in scheduling the training sessions and determining the presentation format as each consumer group had a unique set of preferences and needs. Training time was set at 20 hours total with 2 collaborative meetings that included the partnership (MJC/RS counselor, IL Trainer and consumer). Throughout the training period self-evaluation data were collected and a copy of each form was sent to the PFC Project Coordinator. Self-evaluation data included 4 items (yes/no) relating to the consumer's sense of behavioral competence within that session (e.g., asked for help when needed, was on time) and 2 open-ended questions (i.e., what was learned and what it means to the respondent). Trainers used consumers' self-evaluation data to assess any on-going participant issues. At the last

session IL Trainers facilitated the completion of the Post-Empowerment Training Evaluation.

At 6 weeks post-completion of the empowerment training program, the PFC Project Coordinator made contacts by telephone or face to face with ET participants. Participants were asked to talk about their experience as an ET participant (15-30 minutes). Nine ET participants provided follow-up data. Four follow-up interviews were done face to face and 5 were done by telephone. These follow-up contacts were used as a tool to check the validity of data collected in the Post Empowerment Training Questionnaire. The following questions were asked during this contact, *Describe your experience in the empowerment training program. What, if anything, did you gain from the experience? Were you satisfied with the training? Would you recommend the training to others?*

All other data collection procedures were archival in nature. Data were provided by MJC/RS, Central Office and is part of the accumulated records from 'normal and usual' day to day practice.

Subjects

Consumer Participants.

Consumer participants (N=22) were drawn from a potential pool of all consumers on the 'general' caseload of

participating MJC/RS counselors. Those in the ET group were randomly selected from consumers who indicated a desire to participate in empowerment training. Participants in the Control (C) group were chosen based on matching procedures (refer to Procedures section). Participation was solicited in a manner that made it clear one could refuse participation without fear of formal or informal reprisal (refer to Appendix F & D). Those participants, who desired empowerment training, but were not part of this study, were offered empowerment training at a later date.

The empowerment training (ET) participant group consisted of 5 males and 6 females, of whom 7 self identified as Caucasian, 2 self identified as African-American and 2 as Hispanic. Eight ET participants had 12 years of education, 2 had less (9 & 10 years) and 1 had 14 years. Five ET participants had never been married, 5 were either separated or divorced and 2 were married. The most common types of primary disability found in the ET group were Orthopedic, Mental/Emotional and Other (n=5, 3 & 3 respectively).

The control group (C) consisted of 5 males and 6 females, of whom 7 self identified as Caucasian, 2 as African-American and 2 as Hispanic. Eight C participants

had 12 years of education, 2 had less than 12 years (9 & 10 years) and 1 had 15 years. Five ET participants had never been married, 5 were either separated or divorced and 2 were married. The most common types of primary disability found in the C group were Orthopedic, Other and Mental/Emotional (n=, 4,4 & 3 respectively).

MJC/RS records identified all participants as having at least 1 secondary disability. ET and C groups were not significantly different with regard to severity of primary disability, length of time as a MJC/RS client, age, gender, marital status, education, ethnicity and income at the time of entry into the MJC/RS system. Participation in this study was strictly voluntary.

MJC/RS Counselors & MJC/RS Sites.

Eighteen counselors, 11 female and 7 male, 2 at each of 8 offices and 1 at each of 2 offices, volunteered to participate. Fifteen counselors self identified as Caucasian and 3 as African-American. Counselors ranged in age from 25-59 with a mode within the 39-45 category. Most counselors had been in their current position at MJC/RS for a period of 7-9 years. All counselors had obtained training at the master's degree level, with the exception of 1 who identified as a student in her last semester of a master's

program in rehabilitation counseling. The 10 participating MJC/RS offices are a portion of the total 35 Michigan offices and represent all regions of the state (Appendix E).

CIL Sites & CIL-IL Skill Specialists.

Centers for Independent Living are non-profit community-based agencies with substantial consumer involvement that provide services to people with disabilities in an effort to maximize their self-determination and minimize dependence (Frieden, 1983). IL Skill Specialists are CIL staff members who have extensive working background in community resources, services identification and procurement, knowledge of the principles and techniques of independent living skills training and peer counseling, and who are experienced with working with the VR system at the local level. IL Skills Specialists conducted the empowerment training for ET participants in this study. Trainers consisted of 12 IL Skills Specialists, 8 female and 4 male, 1 at each of 8 sites and 2 at the remaining 2 sites that participated in this study. Age ranged from 18-59 with a mode within the 32-38 category. Six IL trainers had obtained a bachelor's degree, 4 a master's degree and 2 reported having some training beyond high school. Eleven IL trainers reported being in their

position at their site for 3 years or less. Ten of Michigan's 11 CILs are represented in the sample (Appendix E).

Material & Instruments

The Partnerships For Choice Empowerment is a training curriculum (refer to Empowerment Training Material Development section) divided into 2 major modules. The first module is organized around empowerment through self-awareness and increasing self-efficacy. Within each section there is a written explanation of the identified construct, life examples and exercises for applying the concept to the consumer's personal world.

Module 1, Empowerment, contained the following sections: Introduction to the Partnership, Self-Esteem, Risk Taking and Personal Decision-Making, Personal Explorations, The Meaning of Work and Employment Plan of Action. The first section, Introduction to the Partnership, was designed to orient the consumer to the partnership concept and to answer basic questions. For example, Why am I here?, What are the roles and responsibilities of the partners? What will I gain from the partnership? This section also was used to set up a decision-making dialogue to establish when, where and how frequently the empowerment training group

would meet. The next section focused on self-esteem. It included: a definition of self-esteem, characteristics of high self-esteem, an exercise to rate self-esteem, information related to how self-esteem is impacted by others and self-talk, and ways to increase self-esteem. This section included My Declaration of Self Esteem, by Satir; an inspirational quote, by Combs; and a visual display of the contributions of social, emotional, physical and work self-image to self-esteem. The next section covered the issue of risk taking. This section included: information related to 'sizing up' a risk and making a decision whether or not to take a risk and information related to increasing risk taking ability in the domains of personal, partnership and work behaviors.

The next section focused on self-exploration and was received by consumer focus groups as the most useful section of empowerment training module 1. It included 5 exercises and 2 inspirational pieces (1 by Maltz and 1 by Schuller). This section covered the following content area: Who am I?, What will I become?, identifying personal strengths and weaknesses, and identifying personal abilities. The last two sections of module 1 were viewed as the second most helpful sections by consumers in focus groups, whereas

MJC/RS focus group participants saw them as the most important sections. These sections centered on the meaning of work and developing an employment plan of action. The section on the meaning of work included general information about the different meaning work has in people's lives; exploration into what work means for the reader, including his or her personal work values; an exercise designed to assess the individual's work interests; and information related to the connection between job satisfaction and retaining employment. The section on employment plan of action was designed to present information to ready the empowerment training group member for the activities that would be presented in module 2 (i.e., Consumer Choice and Informed Decision-making). Information presented in this section included: selecting a suitable occupation, checking out the labor market, getting ready for employment and establishing an alternative plan of action.

The second module is organized around issues relating to work in people's lives and planning for employment. Like module 1, module 2 presents definitions, examples and provides exercises for application (refer to Appendix B). Module 2, Consumer Choice and Informed Decision-Making, contained the following sections: Introduction: You as the

Consumer, Rules of Informed Choice Decisions, and Ways in Which People Make Consumer Decisions (Appendix B).

The first section is an introduction that begins with a brief statement to the consumer explaining what is to come in the following sections. This is followed by an exercise to facilitate the consumer's awareness of his or her pre-employment needs (e.g., goal, equipment, services, training). The next section focuses on types of consumers. This section includes a description of 3 types of consumers (need driven, outer directed and inner directed) followed by an exercise to self assess consumer type. A brief statement related to empowerment through responsible consumer decisions was then presented. The next section focused on rules of informed choice decisions. In this section the following topics are covered: motivation, information search, evaluating alternative choices, the purchase process and outcome of purchase. The next section discusses consumer approaches (i.e., limited and extended problem solving). Module 2 ends with a plan of action exercise that was designed to provide the consumer with a practice opportunity to make and carry out consumer decision-making.

Pertinent information was collected using surveys (refer to Appendix F); MJC/RS Referral, Orientation and

Intake Data (3.3300) and Closure Data (3.3250) forms; and self-report evaluation of progress and satisfaction with empowerment training (refer to Appendix G). In addition, MJC/RS computerized tracking of diverse of variables (i.e., case expenditures, procurements, client income, work activity and case status change) was utilized.

Consumer Survey.

This instrument (Appendix F) contains 69 items and was developed specifically for this study. The purpose of the survey was to explore differences in attitudes, expectations and beliefs related to empowerment and satisfaction. Information gained from the Consumer Survey facilitated matching on variables outside the scope of existing MJC/RS data (e.g., disability type, severity, years of education). Specifically, responses were used as a means of matching an individual ET participant with a control subject on attitudinal differences. Items 1-12 ask the consumer to indicate an appropriate category for demographic information and history with MJC/RS and CIL. It is possible that being a person of color or having a prior experience with either a CIL or MJC/RS may impact empowerment. Therefore, it seems necessary to check these variables when considering group differences.

Items 13-16 are YES/NO questions regarding perceptions of decision-making in the consumer's life. It is assumed that perceiving one has control is a precursor to actively assuming control. Therefore, perceptions of control translate into potential empowerment.

Items 17-69 were designed to reflect themes that emerged from the literature review on empowerment. These items utilize a Likert scale ranging from 1 (Strongly Disagree) to 7 (Strongly Agree). Items in this section were sorted using face validity into the following categories:

1. Global self-efficacy - For example: I know what my basic rights are as a citizen. I make sure that I am treated fairly. I deserve to be respected.
2. Work self-efficacy - For example: In the right situation I am capable of working. I am capable of successfully preparing myself to get a job. My counselor is certain that I have job potential. I am certain that I could keep a job if I had one.
3. Client-counselor relational expectations - For example: I understand my rights and responsibilities as a consumer of MRS services. I listen to others when they suggest services I might need. I should have a 'say' in who provides the services I need.

4. Satisfaction with MJC/RS services - For example: Overall, I am satisfied with the application process. My MRS counselor understood my problem fully. I know what I can expect from MRS.

The Consumer Survey was developed and utilized to facilitate the subject matching process. Results of preliminary instrument validation revealed an overall Cronbach's alpha of .81 for items 17-69.

Self-report Evaluation of Empowerment Training.

Participants were asked to complete a Pre-training Questionnaire (Appendix G) at the beginning of their first empowerment training session. The questionnaire consists of 9 open-ended items that were designed to elicit information related to the consumer's expectations of the training and individual needs or preferences. This questionnaire was designed specifically to collect data about consumers' evaluative feelings of the empowerment training. The questionnaire asked consumers to respond to 5 open-ended questions. These questions related to control, expectations, topics of interest and current self-concept. Three questions (2 closed and 1 open-ended) were asked to facilitate the work of CIL staff who presented the training material. These questions dealt with preferred time of

meeting, accommodation requests and preferred style of learning. Data from the Pre-training Questionnaire was used in the analysis of the subjective value of empowerment training from the consumer's perspective.

After each major section of the training modules, consumers were asked to complete an Empowerment Training Self-Evaluation (Appendix G). This form consisted of 5 closed end items designed to tap behavioral components of involvement. A sixth item on the self-evaluation asked the consumer to describe what was learned in that session and what it meant to him or her personally.

At the close of the last empowerment training session consumers were asked to complete the Post-training Questionnaire (Appendix G). This instrument contained 9 items. Two items were open-ended questions designed to tap thoughts and feelings related to the personal impact of training: 1. What areas do you feel more in control of after this training? and 2. How do you see yourself differently now that you have been through this training (If not, why not)? The word choice and construction of these two questions may appear to contribute to biased responses. However, the wording follows the natural language pattern indigenous to subjects. To say it another way, they are

questions that the subject would expect or predict. It was possible for subjects to report no increase in control and no change in how he or she viewed the self. However, this pattern did not occur and may in part be the result of these two questions. The questions prompt the respondent to look for the positive, to see the self as changing, as empowered. This prompt toward empowerment is fully consistent in the context of an empowerment training program. According to Sanday (1983), the use of natural language and interviewing that focuses on the indigenous perspective contribute to the clarity and precision of data. Because the construction of these two questions may elicit responses with bias that favors reporting a positive change, CIL-IL trainers encouraged ET participants to provide genuine feedback on all items. All other items were designed to elicit data related to feelings or thoughts about the training. Key questions included, How do you feel about the training?, Did you get what you expected out of this training? and Are you satisfied with the training you received? Data were used in the analysis of the subjective value of empowerment training from the consumer's perspective.

MJC/RS 3.3300 and 3.3250 Forms.

The MJC/RS counselor, using information collected during a client interview, fills in these forms. Information included on 3.3300 pertains to demographic characteristics: education, income sources and amounts, special medical issues including health coverage benefits and number of hours worked per week. Information on 3.3250 includes: reason for case closure, primary source of income including reliance on public assistance programs, number of hours worked and occupational code, weekly earnings from work, health coverage benefits, types of services provided by MJC/RS and source of outside service procurements and success or non-success of rehabilitation.

MJC/RS Computerized Tracking.

A computer system is set up that has the capacity to track and analyze case information at an individual, office, regional or state level. Data is entered at remote terminals located in each MJC/RS office and then sent to a central division that specializes in data management and statistical analyses. Types of data accessed for this study include: case statuses, disability codes, number of dependents, number of hours worked per week at intake, case cost, income at intake from all sources, number of hours

worked per week at close, income at close from all sources, and types of services provided.

Design

Although empowerment is a widely used concept in rehabilitation and psychological literature, attempts to measure the outcome of empowerment training are relatively absent. This study is part of an exploratory or discovery process and therefore, utilized a correlational field design. The defining feature of a correlational-field design is that the overarching goal is to describe relationships among variables from within a real-life setting using subjects who are drawn directly from the population of interest (Heppner, Kivlighan & Wampold, 1992, p.70-71). Gelso (1979) described correlational field design as befitting the pilot stages of on-going research. He purported correlational-field design was an appropriate method when investigation of inter-correlation is essential. The correlational field design will disallow the interpretation of cause-effect relationships. However, when no significant relationship is found between key variables, it is very helpful in disconfirming hypotheses.

Perhaps the most compelling reason for choosing the correlational field design was to maximize generalizability

through utilization of the natural environment where the actual treatment occurs. Although this design has the least potential for control of contaminating factors, thus is subject to spurious results, it produces findings that are most generalizable and relevant to practitioners (Gelso. 1985; Harmon, 1978; Heppner, Kivligan & Wampold, 1992). Issues of generalizability are crucial to counseling research and external validity is the strength and hallmark of correlational field design.

Consumers' satisfaction with the empowerment training program and subjective impressions of empowerment resulting from ET were analyzed following the qualitative, thematic approach outlined by Sanday (1983). This approach was used successfully by Machabanski (1986) and Bartee (1993) in research that sought to describe phenomena from the perspective of minority group members. This method uses a semiotic style (i.e., the study of patterned linguistic communication). The core of this approach lies in the search for indigenous perspective through the utilization of survey and interview responses. Interviewing some of the subjects serves to clarify how they use terminology, keywords and phrases. The first step in designing the qualitative part of this study was to examine the literature

relevant to empowerment. Through this examination it was determined that empowerment training should, 1. Improve how participants feel about themselves (intrapersonal empowerment) and 2. Increase 'I can' beliefs, especially related to decision-making skills. Therefore, *self-esteem* and *decision-making skills* were used as the preliminary sorting categories for responses to the Pre-empowerment Training Questionnaire and the Post-empowerment Training Evaluation.

The other area of interest, satisfaction with training, was measured by comparing responses on the Pre-empowerment Training Questionnaire (What do you expect/want from training?) with the Post-training Evaluation item (Did you get what you expected from training?). Satisfaction was also determined by the Post-training item *Are you satisfied with training?* Two independent judges, one a 25-year-old male who was employed full-time as a delivery person and the other a 34-year-old female who was employed part-time as a hair stylist, read all responses. Judges compiled frequency data (the number of times a critical concept appeared) and sorted each response based on perceptions of the respondent's intended meaning (e.g., supported or refuted empowerment/positive change). Heppner, Kivlighan & Wampold,

(1992) describe this method of qualitative analysis as useful at a theoretical or speculative level. This design attempts to describe a phenomenon (e.g., satisfaction) by focusing on the participants' beliefs about the phenomenon. Given the multidimensionality of empowerment and the importance of satisfaction with services this thematic design seems appropriate and useful.

Procedures and Data Collection

As discussed in the section on project implementation there were several steps in the early phase of research development. These steps included: bringing together a steering committee, developing an empowerment training curriculum, running focus groups to ensure that the project would meet the needs of consumers, hosting meetings to disseminate project information, securing site and consumer participation, and providing on-going professional support. MJC/RS offices that were located closest to CILs became PFC sites. MJC/RS counselors and IL Trainers participated in 1 or more PFC orientation sessions to facilitate communication related to expectations, procedures and goals.

Potential subjects were drawn from participating counselors current caseloads and were identified as wanting to participate based on responses to the Consumer Survey.

Subjects demographic and attitudinal characteristics were explored resulting in the creation of the 11 matched pairs, which are the basis of data in this study. Counselors selected additional consumers to participate in empowerment training. Therefore, each empowerment training group had a total membership of 3 to 11 VR consumers.

Pre and post training questionnaires, which was completed in the empowerment group setting, and semi-structured interviews, which were done by the PFC Project Coordinator, were used to collect data relevant to hypotheses 5 and 6 (i.e., perceived training benefits and satisfaction with training). Archival data, which is regularly collected by MJC/RS counselors and entered into the MJC/RS central computing system, was used to address hypotheses 1 through 4 (i.e., employment, drop out, case cost).

Data Analysis & Hypotheses

Zero-ordered correlations were used to determine the relationship between all variables of interest. This study is part of the discovery process therefore, a correlation matrix was developed to accommodate all variables. The initial goal was to first look at the 'big picture' with the hope that it would provide information that might guide

future analysis. The customary cut-offs were used to establish high (score $\geq$ .7), moderate (.69 $\geq$ score $\leq$ .5) and low (.49 $\geq$ score $\leq$ .3) correlation. This provided an exploratory tool, a way to understand the characteristics of the sample.

Hypotheses 1 - 4 were tested using a non-parametric two-way design procedure, the Chi-Square (χ^2) goodness-of-fit test. The chi-square statistic is often used in contexts other than an experiment, in the analysis of results obtained from field observations or survey research, and to establish the presence of correlation between two different sets of subject characteristics (Keppel & Saufley, Jr., 1980). The Chi-square procedure tests whether the observed frequency differs significantly from the expected frequency and is used with data that is in the form of counts. According to Shavelson (1988) assumptions and requirements for using this test include:

1. Each observation must fall in 1 and only 1 category.
2. The observations in the sample are independent of one another.
3. The expected frequency for each category is not less than 5 for $df \geq 2$ and not less than 10 for $df \geq 1$.

4. The observed value of χ^2 with 1 degree of freedom must be corrected for continuity in order to use the table of values of $\chi^2_{(critical)}$.

In order to use this test it was imperative that information was available to produce the expected frequencies. Expected frequencies were available through MJC/RS central office data summaries.

In addition to the Chi-square procedure, Cramer's V was used because there are two groups (i.e., ET and C) and three levels (i.e., successful, unsuccessful and drop-out) which leads to a matrix with unequal numbers of rows and columns. A decision tree provided in A Guide For Selecting Statistical Techniques For Analyzing Social Science Data (Andrews, Klem, Davidson, O'Malley & Rodgers, 1991) recommends use of Cramer's V when unequal numbers of rows and columns are present. Cramer's V is preferred to other measures of association based on Chi-square because it can obtain unity (1) even when the number of rows and columns are not equal (Blalock, 1979; Hays, 1981). An independent groups t-test was used to determine if there are differences in mean case cost between subjects who close successfully (i.e., obtain employment) and those who close unsuccessfully (i.e., drop out prior to developing a IWRP or close without

obtaining employment post IWRP development). The independent groups t-test is used typically to analyze the relationship between two variables when one of the dependent variables is quantitative and is measured on an interval scale, the independent variable is between subjects and the independent variable has 2 and only 2 values (Jaccard, 1983).

Pre and Post-training Empowerment Questionnaires responses were analyzed and categorized based on correspondence with questions asked and data that emerged from responses. Frequency and response descriptors (adjectives and adverb synonyms) were independently counted and sorted by two inter-raters. Pre-training categorization resulted in the following categories: *Expect to Learn, Want/Desired Outcomes* and *Self-view.* Post-training responses resulted in the following categories: *Material Learned, Training Benefits* and *Self-View.* Satisfaction with services was analyzed by comparing the respondent's answers to a Pre and Post training item and by examining frequencies of *satisfied* responses to a direct question on the Post-training Evaluation. Where there was disagreement, a third rater was used to facilitate the categorization of responses. It was possible for a participant to provide

more than one response to items that were open-ended. Therefore, each separate response to an item was categorized individually. Throughout the process conclusions were drawn from identified levels of meaning and constructs presented in responses. Interviews were conducted with respondents to confirm or disconfirm interpretations and conclusions.

Chapter 4

Results

The purpose of this study was to investigate research questions related to the impact of empowerment training on tangible and intangible outcome measures. Tangible outcome measures will be presented first. These measures include employment, case cost and dropout and are addressed in the following hypotheses.

Hypothesis 1: Participants in empowerment training will obtain employment at a rate that is different than the group that does not receive empowerment training. Specifically, subjects who receive empowerment training will have employment outcomes that exceed expected values based on actuarial data, while subjects who do not receive empowerment training will have employment outcomes that are equal to the expected value.

Hypothesis 2: Participants in empowerment training will prematurely drop out or discontinue MJC/RS services (i.e., prior to vocational plan development) at a rate that is different than subjects who do not receive empowerment

training. Specifically, subjects who receive empowerment training will prematurely discontinue services (i.e., drop out) at a lower frequency than what is expected based on actuarial data, while subjects who do not receive empowerment training will prematurely discontinue services at a rate that is equal to the expected value.

Hypothesis 3: Case costs of both groups (those receiving empowerment training and those not receiving empowerment training) will be equal. Specifically case costs for each group will be equal and will not differ from the case cost expected value based on actuarial data.

Hypothesis 4: Participants in empowerment training will display a pattern of successful rehabilitation at one and two year follow up points (i.e., employed for 120 days) that is superior to those subjects in the control group who do not receive empowerment training.

Next, data that relates to intangible outcome measures are presented. These measures include consumers' reports of psychological benefit from the empowerment training and

satisfaction with empowerment training. These measures are addressed in hypotheses 5 and 6.

Hypothesis 5: Empowerment training participants will report an increased sense of control and self-confidence as a result of empowerment training.

Hypothesis 6: Empowerment training participants will report feeling satisfied with the content and quality of the empowerment training program.

After presentation of data related to the specified hypotheses a correlation matrix will present relationships among all tangible outcome variables available through the State of Michigan's MJC/RS Central Office computerized data system. Significant relationships among these variables contribute to the descriptive picture of subjects as they move through the vocational rehabilitation process. This section is followed by exploration of subject characteristics and tracking of subjects throughout the life of this study (fiscal years 1996 to 1998).

Tangible Outcomes

Employment.

Whether or not empowerment training impacts employment outcome is of central concern. Table 1 provides case status

information at the end of Fiscal Year 1996. This date is between three and nine-months post-empowerment training, depending on the site of service delivery. Successful closure, status 26, is defined by MJC/RS as a case where it is determined that the client has been satisfactorily employed at least 120 days. Observations indicate the group that received empowerment training had more successful closures than expected (4 actual, 2.5 expected), while the group who did not receive empowerment training had less successful closures than expected (1 actual, 2.5 expected). Although Table 1 suggests a trend for the empowerment group to have more successful closures than expected at the end of Fiscal Year 1996, Pearson Chi-Square Test (1.692, 1df, p= .193) indicated no significant differences between the groups at the p=.1 level. However, it should be noted that this finding may have practical significance and at least one cell had less than the recommended number of observations to correctly apply this statistical procedure.

Table 2 provides information related to case closure (open/closed) combining data from Fiscal Year Ends 1996 to 1998. Note that the increase in number of cases from 22 in 1996 to 29 in 1998 was due to cases carrying over from one year to the next. For example, a case open in more than one

year of the study was counted by this particular statistical application twice, once for each year the case was open. Observed closure patterns in 1998 closely resemble those found in 1996. Specifically, those who received empowerment training had more than the expected number of closures (combined total of successful and unsuccessful cases) while those who did not receive empowerment training had fewer closures (ET group 10 actual, 8.3 expected; Control group 6 actual, 7.7 expected). Pearson Chi-Square Tests resulted in a value of 1.660, 1df, p=.198.

Table 1

Closure Status of Subjects at 1996 Fiscal Year End

Status		Group ET	Group C	Total
10 Eligibility and Plan Development	Count	1.0	1.0	2.0
	Expected Count	1.0	1.0	2.0
	% w/i status	50.0	50.0	100.0
	% w/i group	9.1	9.1	9.1
	% of total	4.5	4.5	4.5
16 Physical and Mental Restoration	Count	0.0	3.0	3.0
	Expected Count	1.5	1.5	3.0
	% w/i status	0.0	100.0	100.0
	% w/i group	0.0	27.3	13.6
	% of total	0.0	13.6	13.6
18 Training	Count	4.0	4.0	8.0
	Expected Count	4.0	4.0	8.0
	% w/i status	50.0	50.0	100.0
	% w/i group	36.4	36.4	36.4
	% of total	18.2	18.2	36.4
26 Closed Rehab (Successful)	Count	4.0	1.0	5.0
	Expected Count	2.5	2.5	5.0
	% w/i status	80.0	20.0	100.0
	% w/i group	36.4	9.1	22.7
	% of total	18.2	4.5	22.7
28 Closed Non-Rehab (Unsuccessful)	Count	2.0	1.0	3.0
	Expected Count	1.5	1.5	3.0
	% w/i status	66.7	33.3	100.0
	% w/i group	18.2	9.1	13.6
	% of total	9.1	4.5	13.6
30 Closed Non-Rehab (Dropped-out)	Count	0,0	1.0	1.0
	Expected Count	0.5	0.5	1.0
	% w/i status	0.0	100.0	100.0
	% w/i group	0.0	9.1	4.5
	% of total	0.0	4.5	4.5
Total	Count	11.0	11.0	22.0

Table 2

Cumulative Closed and Open Cases Fiscal Years 1996 to 1998

		Group		
		ET	C	Total
OPEN	count	5.0	8.0	13.0
	expected count	6.7	6.3	13.0
	% within closed	38.5	61.5	100.0
	% within group	33.3	57.1	44.8
	% of total	17.2	27.6	44.8
CLOSED	count	10.0	6.0	16.0
	expected count	8.3	7.7	16.0
	% within closed	62.5	37.5	100.0
	% within group	66.7	42.9	55.2
	% of toal	34.5	20.7	55.2
Total	count	15.0	14.0	29.0
	expected count	15.0	14.0	9.0
	% within closed	51.7	48.3	100.0
	% within group	100.0	100.0	100,0
	% of total	51.7	48.3	100.0

Drop-out.

As seen in Table 1 at the end of Fiscal Year 1996 no subject from the ET group had dropped out while 1 subject who did not receive empowerment training dropped out. It was expected that .5 from each group would drop out, or discontinue services prior to developing an Individualized Written Rehabilitation Plan. The same pattern of results were found at 1997 Fiscal Year End, bringing the total of dropouts for the group who did not receive empowerment training to 2 while dropout for those who received training

remained at 0. The pattern reversed during the 1998 Fiscal Year, which resulted in overall dropout counts of 2 subjects who did not receive empowerment training and 1 subject who did receive training.

Case Cost.

Table 3 presents descriptors related to cost of closed cases for subjects who received empowerment training and those who did not receive empowerment training. Combining all subjects through all years, there was no difference at the 95% confidence interval between those who close successfully or drop out ($F=.66$, $p=.433$). However, the average cost of successful closure in the ET group is approximately one-quarter of that for the C group (1538 and 6132 respectively). Furthermore, the average cost of unsuccessful closure or drop out in the C group is four times higher than the ET group (4391 and 714). Although both between group comparisons of cost are significant at the $p < .05$ level, it should be noted that there are 3 cases in the C group, fiscal year 1998, with unusually high costs.

Table 3

Cost of Closed Cases for Fiscal Year Ends 1996-1998

	Training Year 1996		Follow-up Years 1997		1998	
	ET	C	ET	C	ET	C
N	6	3	4	3	1	3
Mean	657	1406	2713	1400	0	10862
SD	663	1452	1805	1481	0	11705

Intangible Outcomes

Training Benefits.

Analyses of qualitative data derived from Fiscal Year 1996 Pre and Post-training Questionnaires are presented in Table 4. All ET subjects attributed an increase in either self-esteem or self-confidence to participation in empowerment training. Post-training ET participants were asked to answer the question, ''Do you see yourself differently now that you have been through the training? If yes, please explain. Although only 2 respondents wrote the word yes, all provided responses that indicated the perception of positive change. The following 5 statements represent randomly selected responses to the question related to self-perception of change.

1: ''I think of myself better now.''

Interviewer: ''Can you tell what you mean when you say better?''

1.1: ''Like I have more confidence. I can decide for myself what is right for me and people will listen or not. It doesn't really matter if they listen, I know what I am, a good person.''

2: ''I see that I can do it.''

Interviewer: ''What can you do?

2.1: ''I can put a plan together. Before I thought that no matter what I tried it wasn't going to work out for me. But now, I feel better. It's like the doubts are gone.''

3: ''More self confidence.''

4: ''Deserving''

Interviewer: ''Can you tell me what you mean when you say deserving?''

4.1: ''I mean I'm a good person, so I should be proud and others will want me (pause), like as a friend or to work for them, because I'm good and not because they feel sorry for me.''

5: ''My self-esteem is much higher.''

Nine of the 11 ET subjects reported an increase in their sense of control, while the remaining two subjects did not comment on this area. The following statements are 4 randomly selected responses to the question relating to sense of control.

1:''All areas.''

Interviewer: ''What do you mean by all areas?''

1.1: ''I mean everything from what job I apply for to what I spend my money on to who I have for friends.''

2: I feel more in control in deciding what jobs would be good for me because I know MJC/RS will help me make the right choice.''

3: ''Choosing a career after I see my options.''

4: ''My choices I make in life. My job opportunities that are out there.''

Interviewer: ''Can you say more about this?''

4.1: ''Yes, it's like if there is s job out there I can decide if it will be one that I should take. Maybe it's kind of what I want but not really, or maybe I can take it and it will be OK, or I can just say no, that job isn't something I can do. It's like that for a lot of things, like doctors, like family and other people.''

Other benefits appeared to be increased sense of self-efficacy related to vocational planning and an increased awareness of one's self-identity. The following 5 statements are representative of responses in these areas.

1: ''I learned how to find information that I need to plan things for myself.''

Interviewer: ''That seems important to you. Can you tell me what you mean when you say find information?''

1.1: ''Like before I had no idea that there was a computer system at the library that gave a forecast of the kinds of employees that would be needed, or I didn't know that I could get

estimates and trial periods on things like my scooter, even though I'm not the one really paying for it. I didn't know that I could ask people to be able to watch them work so that I would really know what they did on that kind of a job. There was just a lot of things I didn't know about how to get questions answered or even what questions to ask. I still don't know everything, but I know a lot more and there are people who can help me.''

2: '' I liked doing the plan of action. It was very helpful because I learned how to organize the steps.''

Interviewer: ''Organize the steps?''

2.1: ''In our group we did a practice plan. The plan was for at how to get a job that we wanted. It was really cool and it helped me figure out what I need to do first. I have done another one since then. It's getting pretty easy and I feel organized, like It's clear.''

3: ''I learned about ADA and we talked about what my rights are. I think people like me are discriminated against everyday. I have a plan now of what I can say and do when that happens to me again.''

4: ''I learned about who I am.''
Interviewer: ''What does the term who I am mean to you?''

4.1: ''It's everything about me. We did these sheets on values. I learned that I value adventure more than money. That seems crazy but it's just how I am.''

5: ''A lot of information about me.''

Interviewer: ''Was there some information that seemed most important, most helpful?''

5.1: ''The stuff like how I think and what's important to me. A lot of the stuff my mother has already talked with me about but it was better learning it this way. It was like I was finding it out for myself.''

Follow-up interviews with 9 of the 11 ET subjects were conducted at 1998 Fiscal Year End (2 ET subjects could not be reached). Interviews yielded information that supported findings from 1996. The following 6 statements represent responses to follow-up inquiry.

Interviewer: ''Now that time has passed, what are your feelings about the empowerment-training?''

1. *''The training was good. It took me awhile but I finally did find a job and I like it. I don't make as much money as I hoped, but I don't think I'll be doing this forever. I want to be a driver. The training helped me be more together, to figure stuff out.''*

2. *''It was good for me. I still think about some of the stuff, like how to plan and stick up for myself without crying and being depressed.''*

3. *''They need to do that in high school. There's all these kids who finish school and then have no idea what to do next. I think it helped me be more confident. I'm working and I want to go back to school.''*

4. *''It was really good. Are they doing another one?''*

5. *''I liked it and especially that we got to keep the book. I've showed some of my friends the book. They liked it too.''*

6. *''It was OK. The Action plan helped me. I learned a lot about planning and setting goals.''*

Table 4

1996 Pre and Post-training Questionnaires

Pre-training	Post-training
Expect to Learn Decision making skills Confidence Advocacy skills Where others are (related to disability adjustment and employment status)	Learned Decision making based on my values What my needs are and how to fill them How to ask 'good' questions About who I am
Want Increased self-esteem More choices Focus in life goals Ability to self-advocate	Training Benefits Increased confidence Increased decision-making skill Effective question asking
Self-view Confused/unsure of direction in life Insecure/negative self-image Somewhat positive self-image	Self-view Confident/secure Positive self-image On the 'right' road

Satisfaction.

Analysis of 1996 Post-training Questionnaires and interviews found that the ET group's average rating on a 5 point Likert scale (1=very dissatisfied and 5=very satisfied) for satisfaction with the contents of the

training program was 4.8. Satisfaction with the performance of ET trainers was 4.5 and satisfaction with MJC/RS counselor's participation in the empowerment training was 3.3. Analyses of follow up interviews done at 1996 and 1998 Fiscal Year Ends revealed satisfaction with the empowerment training program was attributed to the relevance of material content, perceptions of the ET trainer's knowledge and unconditional positive regard, and perceptions of MJC/RS counselor's openness to consumer's increased sense of self-control.

1. *''All of the topics were good and they seemed to go together.''*

2. *''The trainer wore an earring. That made me feel more comfortable, like here is someone who will understand me, not some suit. He was good and he knew a lot.''*

3. *''I needed it. It was what I hoped for, you know (pause) learning how to take control and make decisions. I expected it to be good but it was even better. This should be offered to everyone.''*

4. *''I'm glad I went to the training. Sometimes they make you jump through hoops, but this one was different. I learned a lot about myself and how to make a plan. I'm really surprised that my counselor was so in to this.''*

5. *''I'm completely satisfied. It was the best thing I've done in classes. It made me get up and do something. I have more motivation and control.''*

Correlation of All Possible MJC/RS Tangible Variables

The correlation matrix (Appendix H) was produced and examined for the following reasons. First, theory suggests that differences in empowerment levels of groups may lead to differences in the pattern of procured services. Second, the counselor's perceptions of a consumer's need may be impacted by participation in this study. Third, the relationship among variables may guide future research. Table 5 presents significant correlations found in the Correlation Matrix (Appendix H).

Tests for statistical significance were performed using SSPS/PC+. An *a-priori* cutoff of $|.7|$ with $p \leq .05$ determined significant high correlations. Table 5 presents the entire correlation matrix. Within the broad categories of intake, closure and services, there were four significant correlations.

Table 5

Significant Correlations of MJC/RS Tangible Variables

Sig.	Pearson Corr.	Variable Descriptors
P<.01	.95	income at intake/other services
P<.01	.92	hours worked per week at intake/ weekly earnings at intake
p<.05	.87	job referral/job placement
p<.05	.73	earnings from Social Security Disability Insurance at closure/ earnings from other sources at closure
p<.05	.70	number of dependents/other services

1. Intake - At the time of intake the more hours one worked per week, the more one earned (r=.92, $p < .01$). This relationship seems obvious, however it is notable because it reflects a trend for earners to experience an hourly wage employment situation rather than one with a salary which does not depend on hourly employment activity. Subjects with more income at the time of intake received more services that were categorized as other (r=.95, $p < .01$).
2. Closure - At case closure earnings from Social Security Disability Insurance (SSDI) was positively correlated

with earnings from other sources (r=.73, p <.05). Interestingly, people who relied more heavily on SSDI had lower SSDI benefits than those who received income from SSDI and other sources (e.g., child support, alimony, gifts or grants) did. This is likely a function of how SSDI benefits are calculated.

3. Services - Subjects with more income at the time of intake received more services that were categorized as other (r=.95, p < .01). And, subjects who received more services categorized as other had more dependents (r=.70, p < .05). Subjects who receive job referral were more likely to receive job placement (r=.87, *p* <.05). When subjects were formally connected with a potential employer they were more likely to become placed in a job.
4. Services - As the number of services documented as miscellaneous increased, the number of services documented as other decreased (-.8, p <.05). This relationship reveals that when counselors document a service as miscellaneous, they are less likely to record client services in the other category as well.

Subject Characteristics

Tables 6-8 present data related to case closure status, subject characteristics and services received for all closed

subjects from fiscal year end 1996 to fiscal year end 1998. As shown in Table 6, at 1996 fiscal year end (the first year of the project) 6 of 11 consumers in the ET group closed, while 5 remained open. Four ET subject cases were closed successfully having obtained employment and held the job for a period of 120 days. Two ET subjects closed unsuccessfully after having completed an Individualized Written Rehabilitation Plan. Closures demographics were as follows: 1 male, 5 female, 1 African-American, 5 White, 1 with 10 years of education, 4 with 12 years of education, 1 with 14 years of education, 1 married, 3 divorced, 2 never married, 4 with orthopedic impairments, 1 with a mental or emotional impairment, and 1 with a learning disability. Of those who closed, psychological services were provided such that 5 received counseling and 1 received adjustment services. Vocational services, excluding psychological, were provided in cases that closed such that: 3 received miscellaneous services, 1 received maintenance service, 2 received transportation services, 2 received job referral, 1 received job placement and 2 received other services. As can be seen in Table 6 the mean case cost for closed cases was $657 and the mean weekly earnings gain was approximately $73.

At 1996 fiscal year end (the first year of the project) 3 of 11 consumers in the C group closed, while 8 remained open. One C subject closed successfully having obtained employment and held the job for a period of 120 days. One closed prematurely or dropped out prior to developing an Individualized Written Rehabilitation Plan and 1 closed unsuccessfully after IWRP development. Closures demographics were as follows: 2 male, 1 female, 1 African-American, 2 White, each had 12 years of education, none had ever married, 2 with a mental or emotional impairment, and 1 with a Traumatic Brain Injury. Of those who closed, psychological services were provided such that 2 received counseling and 1 received adjustment services. Vocational services, excluding psychological, were provided in cases that closed such that: 2 received miscellaneous services, 1 received maintenance service, 1 received transportation services, 2 received job referral, 2 received job placement. As can be seen in Table 6 the mean case cost for closed cases was $1406 and the mean weekly earnings gain was approximately -$22.

Table 6

Case Status, Subject Characteristics and Services Received at 1996 Fiscal Year End.

	1996 Fiscal Year End							
	EMPOWERMENT TRAINING				CONTROL			
CASE STATUS	Open	Closed Success	Closed UnSuccess	Drop	Open	Closed Success	Closed UnSuccess	Drop
N	5	4	2	0	8	1	1	1
CHARACTERISTICS								
Race/Ethnicity								
African-American		1				1		
Caucasian		3	2				1	1
Hispanic								
Gender								
female		3	2				1	
male		1				1		1
Education								
less than 12 years			1					
12 years		3	1					
12.01-14 years		1						
14.01-16 years								
Marital Situation								
divorced		2	1					
married		1						
single		1	1					
Disability								
mental/emotional		1	1			1	1	1
muskeletal								
orthopedic		3	1					
Psychological Services								
counseling		3	2			1		1
adjustment		1					1	
Vocational Services								
miscellaneous		2	1			1		1
other		1	1					
transportation		2	1					
maintenance		1				1		
job referral		2				1	1	
job placement		1				1	1	
college training								
vocational training								

Table 7 shows that at 1997 fiscal year end (the second year of the project) 4 of the remaining 6 consumers in the ET group closed, while 2 remained open. Three ET subject cases were closed successfully having obtained employment and held the job for a period of 120 days. One ET subject closed unsuccessfully after having developed an Individualized Written Rehabilitation Plan. Closures demographics were as follows: 4 male, 2 Hispanic, 2 White, 4 with 12 years of education, 1 divorced, 3 never married, 2 with a mental or emotional impairment, 1 with a learning disability, and 1 with alcohol addiction. Of those who closed, psychological services were provided such that all received counseling and 2 received adjustment services. Vocational services, excluding psychological, were provided in cases that closed such that: 1 received miscellaneous services, 2 received maintenance service, 1 received transportation services, 1 received job referral, 1 received job placement, 2 received college training services, 2 received business or vocational training services and 3 received other services. As can be seen in Table 6 the mean case cost for closed cases was $2713 and the mean weekly earnings gain was approximately $0.

At 1997 fiscal year end (the second year of the project) 3 of 8 remaining consumers in the C group closed. During the 1997 fiscal period 1 subject, who had closed unsuccessfully in 1996 from the C group, re-established services and was added back into the C group, bringing the remaining open cases at 1997 fiscal year end up from 5 to 6. Of the 3 C cases that closed in 1997, 1 closed prematurely or dropped out prior to developing an Individualized Written Rehabilitation Plan and 2 closed unsuccessfully after IWRP development. Closures demographics were as follows: 1 male, 2 female, all were White, 1 had 10 years of education, 2 had 12 years of education, 2 had never married, 1 was separated, 1 had a malignant neoplasm, 1 had an unspecified disorder of the nervous system, 1 had an orthopedic impairment. Of those who closed, psychological services were provided such that all 3 received counseling and 1 received adjustment services. Vocational services, excluding psychological, were provided in cases that closed such that, 1 received college training, and 2 received other services. As can be seen in Table 6 the mean case cost for closed cases was $1400 and the mean weekly earnings gain was approximately -$24.

Table 7

Case Status, Subject Characteristics and Services Received at 1997 Fiscal Year End.

	1997 Fiscal Year End							
	Empowerment training				Control			
		Closed	Closed			Closed	Closed	
CASE STATUS	Open	Success	UnSuccess	Drop	Open	Success	UnSuccess	Drop
N	2	3	1	0	6	0	2	1
CHARACTERISTICS								
Race/Ethnicity								
African-American								
Caucasian		2					2	1
Hispanic		1	1					
Gender								
female							2	
male		3	1					1
Education								
less than 12 years								1
12 years		3	1				2	
12.01-14 years								
14.01-16 years								
Marital Situation								
divorced		1						
married		1					1	
single		1	1				1	1
Disability								
mental/emotional		3	1					1
muskeletal							1	
orthopedic							1	
Psychological Services								
counseling		3	1				2	1
adjustment		2					1	
Vocational Services								
miscellaneous		1						
other							1	1
transportation			1					
maintenance								
job referral		1						
job placement		1						
college training		2					1	
vocational training		1	1					

At 1998 fiscal year end (the third year of the project) the remaining ET subject closed prematurely or dropped out prior to developing an Individualized Written Rehabilitation Plan (refer to Table 8). This subject was an African-American, male with 9 years of education, was married, and had an orthopedic impairment. With the exception of diagnostic services (which every consumer receives) no services of any type were provided. As can be seen in Table 9 this case resulted in no cost and no gain in weekly earnings.

At 1998 fiscal year end (the third year of the project) 3 of 6 consumers in the C group closed, while 3 remained open. Two C subjects closed successfully having obtained employment and held the job for a period of 120 day. One closed unsuccessfully after IWRP development. Closures demographics were as follows: 3 female, 1 Hispanic, 2 White, 2 had 12 years of education, 1 with 15 years of education, 2 were married, 1 had never married, 1 with a mental or emotional impairment, 1 with a learning disability, and 1 with an orthopedic impairment. Of those who closed, psychological services were provided such that all received counseling. Vocational services, excluding psychological, were provided in cases that closed such that: 1 received

miscellaneous services, 2 received transportation services, 2 received job referral, 1 received college training, 2 received business or vocational training. As can be seen in Table 9 the mean case cost for closed cases was $10862 and the mean weekly earnings gain was $120.

Table 8

Case Status, Subject Characteristics and Services Received at 1998 Fiscal Year End.

	1998 Fiscal Year End							
	Empowerment Training				Control			
CASE	Open	Closed Success	Closed UnSuccess	Drop	Open	Closed Success	Closed UnSuccess	Drop
N	0	0	0	1	3	2	1	0
CHARACTERISTICS								
Race/Ethnicity								
African-American				1				
Caucasian						1	1	
Hispanic						1		
Gender								
female						2	1	
male				1				
Education								
less than 12 years				1				
12 years						1	1	
12.01-14 years								
14.01-16 years						1		
Marital Situation								
divorced								
married				1		1	1	
single						1		
Disability								
mental/emotional						1	1	
muskeletal								
orthopedic				1		1		
Psychological Services								
counseling						2	1	
adjustment								
Vocational Services								
miscellaneous						1		
other								
transportation						1	1	
maintenance								
job referral						2		
job placement								
college training						1		
vocational training						1	1	

Table 9

Tracking of Case Cost and Earnings Gain for Case Closures

	ET			C			ET & C Combined
	1996	1997	1998	1996	1997	1998	1996-1998
N	6	4	1	3	3	3	20
Mean Cost	657	2713	0	1406	1400	10862	2789
Mean Weekly Gain	73	8	0	-22	-24	120	48

Chapter 5

Discussion

This chapter will begin with a brief statement reorienting the reader with the original problem. This is followed by global observations related to the research context, which will include discussion of the author's relationship to the field of rehabilitation counseling and counseling psychology. Then an interpretation of the results in light of the hypotheses of this study is presented. Then limitations of the study are discussed. Finally implications for practice and future research are presented.

Original Problem

Work is a significant activity that contributes to an individual's ability to care for and sustain the self financially, socially and psychologically. Most working age people with disabilities want to work, but 67% are unemployed. One of the primary tasks of public sector VR is to assist people with disabilities in the process of planning, preparing for, and finding employment. Public VR programs are funded by taxpayer money. It seems prudent to utilize practices that are ethical, efficient and cost-effective. Literature and popular opinion point to consumer

empowerment as a tool for enhancing outcomes in vocational counseling. However, few studies have systematically studied this belief. This study compared outcomes of 11 matched pairs of MJC/RS consumers with and without empowerment training.

Global Observations

While reading this document the reader may have noticed the sense of being 'pulled' between clinically significant and statistically non-significant findings. The experience of such inconsistencies between that which is deemed statistically significant (research focus) and clinically significant (practice focus) is reflective of the field. For example, while in the process of conducting this study rehabilitation counselors and administrators observed benefits that they attributed to the empowerment training. As a result they shared the training manual with other agencies without knowing what the study's statistical findings would be. Practitioners believed their observations and felt that the consumers' need for empowerment outweighed their need for statistical validation. This type of struggle is discussed in the literature as *relevance* versus *rigor* (Gelso, 1985). Words like, trend, pattern, practical or encouraging are often

used as a way to bridge the gap between statistical and practical significance.

This study attempted to bridge relevance and rigor by: utilizing the natural setting, implementation of an exemplary matching process that resulted in high confidence, limiting artificiality in the rehabilitation process, and through clearly reporting statistical and clinical findings regardless of the apparent inconsistencies. It is this authors opinion that rehabilitation counseling and counseling psychology benefit from exposure to gaps between research and practice.

This study's relevance to the field of rehabilitation counseling is clear. However, the study's importance to counseling psychology should not be understated. Counseling psychology's history with and relationship to career issues identify it as a special discipline within the broader field. Additionally, concepts such as self-efficacy were developed within the field of counseling psychology. For these reason alone this study is relevant to the field of counseling psychology. Perhaps more importantly, people with disabilities are part of the 'normal' population. Therefore, they are part of the population who will seek

services in a variety of settings that are typically staffed by counseling psychologists.

As the author of this study, I believe it is important to inform the reader that I am, among other things, a certified rehabilitation counselor, a counseling psychologist and a person with a disability. As such, I have received and provided vocational and counseling services. This study was conducted with attention to reducing potential author bias. However, research is never value free.

Interpretation

Empowerment training increased consumers' sense of self-esteem, self-confidence and ability to plan for employment (hypothesis 5) and consumers' sense of satisfaction with the training was affirmed (hypothesis 6). Throughout the process of this study these findings were extremely apparent in a practical, clinical sense. Counselors' informally shared observations of ET consumers' increase in active participation in vocational counseling and willingness to take risks with other counselors, administrators and the PFC project coordinator. Several ET consumers shared with their counselors that they would have liked empowerment training at the point of entry into the

MJC/RS system instead of having to wait until they were ready to develop an IWRP. In response to consumers, MJC/RS has made empowerment training available earlier in the process. Additionally, administrators shared the empowerment training curriculum with 5 other states.

There are at least two possible reasons for the affirmation of hypothesis 5. First, it is possible that ET participants responded to questions about themselves and the training as they believed the professionals (i.e., IL trainer, counselor, interviewer) wanted them to. Given the methodological safeguards incorporated in this study, it is unlikely that responses were significantly biased. Second, ET subjects' self-reported gain mirrored changed beliefs. Self-efficacy theory predicts that when individuals believe they can perform and that the consequences of performance are expected to be positive, they are more likely to attempt a task. ET participants' reports of increased knowledge, positive sense of self and perceived ability to engage in the processes necessary to obtain employment are an indication that the empowerment training had the expected intra and interpersonal outcomes. It appears that ET subjects' change in beliefs contributed to increased involvement in treatment planning.

ET participants' overwhelmingly reported satisfaction with the empowerment training experience (hypothesis 6). This finding was the result of both curriculum content and characteristics of those who presented the materials. It is interesting to note that a few subjects reported that being in the group had a positive impact. Specifically, the group provided them an opportunity for social comparison, vicarious learning and provided reciprocal support (i.e., encouragement). This finding is consistent with theories and models of empowerment. However, subjects tended to omit the element of group when discussing the components of empowerment training that contributed to their satisfaction. Although subject volunteer status could have biased self reports and subject omissions may have occurred, it appears that satisfaction with the content reflects the precision with which the PFC project coordinator, steering committee and focus groups collaborated in the development of the empowerment training modules. ET participants' reported satisfaction with the CIL-IL trainers is less prone to bias based on volunteer status. Some, but not all, CIL-IL trainers had a disability. Additionally, all trainers had been provided brief training that emphasized pedagogical techniques and on-going pedagogical support. It seemed that

IL trainers were perceived as credible based on their connections within the disability community and their ability to communicate the usefulness of curriculum. Because CIL-IL trainers were models that ET participants could easily identify with, ET participants may have been more willing to form a working alliance with the trainer.

Results of tangible outcomes seem cloudier than results of intangible outcomes. The small number of participants provided less than adequate power for the statistical analyses. There is a possibility that the lack of statistical significance to support hypotheses 1, 2 and 4 is 'real' and will hold even if the study was replicated with a larger number of subjects. It may be that empowerment training does not increase the likelihood of experiencing specified tangible outcomes. If this is the case, it seems prudent to consult with all parties (e.g., administrators, counselors, and consumers) before deciding to continue such programming efforts.

In spite of insignificant statistical findings, the trend for ET participants to have more success in obtaining employment and to drop out less than their matched controls, with minimal difference in case cost, indicated that there may be a practical significance of providing empowerment

training. Clinically speaking, empowerment training seemed to contribute to positive measurable case outcomes while increasing the speed at which consumers move through the rehabilitation process. In successful cases (status 26 closures), it may be that ET participants perceived themselves and were perceived by their counselors as having more systematically thought through their vocational goals than control subjects. Therefore, counselors' support of and confidence in the consumer's choice of vocational goals increased. Control subjects may have experienced more indecision related to vocational goals, may have set goals with less reasonable chances of obtainment, or may have been less supported by their counselors. To restate this finding, it seemed that empowerment training increased the likelihood that consumers would set, and act toward obtaining, short-term vocational goals with the support and confidence of their MJC/RS counselor.

Theoretically, an empowered individual within the context of an oppressive or non-supportive system will choose to distance him or herself from the system (i.e., drop out). Therefore, the potential for empowerment to result in increased unsuccessful case closure or drop must be considered. Empowerment training did not lead to

increased drop out in this study. ET participants dropped out less frequently than controls and at a rate that was less than expected. One explanation for this finding is that MJC/RS is not perceived as oppressive. However, it is also possible that connection to other people with disabilities and to the CIL-IL trainer provided motivation to succeed or established a buffer against frustrations that typically would result in discontinuing services.

Empowerment training, as provided in the PFC project, seemed to provide a tool that addresses two of the primary criteria for continued funding of public sector rehabilitation services (i.e., satisfaction with services and consumer involvement) at minimal cost. Although significant differences in tangible outcomes (i.e., obtaining employment and not dropping out) between groups was not found, there was a trend for a consumer who received empowerment training to fare slightly better than someone like him or herself that did not receive training. Clearly, ET participants attributed gains in psychological well being, practical skills, and knowledge to the training.

Limitations

The number of people involved in this project is one of this study's strengths. However, it is also a limitation.

As a strength the diversity present in groups of consumers receiving empowerment training, as well as among the counselors and trainers, adds to the robustness of findings. For example, the pattern of satisfaction was consistent across variables such as: characteristics within the members of the empowerment training group, regions of the state, gender of counselor or trainer, experience level of the counselor or trainer. However, because each individual within a matched pair may have been exposed to a different counselor or trainer it is unclear whether or, to what extent the counselor or trainer may have impacted the findings. This lack of control or measurement of counselor and trainer impact serves to limit confidence that the reported findings are the result of the empow3rment training intervention.

Sampling problems are typical in field based research. Overall, the sampling efforts in this study were adequate for several reasons. First, when approached (i.e., responding to the Consumer Survey) nearly all respondents desired empowerment training and agreed to participate in the PFC project. Therefore, there did not appear to be anything atypical about the subjects who participate in this research. Secondly, randomization procedures that placed

subjects into ET or C groups minimized sample selection bias. Therefore, the likelihood that the group receiving empowerment training represented the larger population was enhanced. Third, the process of comparing subjects in the ET group with C subjects based on matching characteristics (e.g., type of primary disability, severity of disability, race/ethnicity, gender, level of education) maximized the similarity between groups on factors that have been shown to impact vocational rehabilitation outcomes.

Despite the strengths of the sampling plan, a major deficiency in this study is the small number of participants. In studies where small numbers of subjects are used, randomization cannot insure validity. In these research situations a single case with unusual characteristics can bias the results. Furthermore, even though subjects were matched on several identified variables, it is impossible to match on every possible variable. There is always the chance that the researcher failed to match on an important variable and had this variable been controlled the results may be different. The sample size is insufficient for achieving minimal standards of power. Additionally, the small sample resulted in statistical analysis with insufficient numbers of cases in

all cells. Finally, because the sample size is small, using the results of this study to make inferences or generalizations to a larger population should be done with great caution.

Another limitation is the use of self-report data. Self-report data, especially in situations where subjects have volunteered for a treatment, may lead to spurious results. ET subjects may have felt in some way special or pressured to respond in a specific way, which may have influenced their perceptions and reports. Because the subjects in the C group initially reported a desire to participate in empowerment training, it is possible that their not being selected to receive training may have negatively influenced their performance in the vocational counseling process. In spite of the possibility of bias in self-report data, it is very clear that the ET group was satisfied with training and believed that it made a positive contribution to their overall MJC/RS experience.

Finally, empowerment is a broadly defined construct. Perhaps because it is broadly defined, there have been limited numbers of studies that have attempted to measure it. This study is limited in that it does not directly measure empowerment. Instead it measures specific outcomes

relevant to criteria formulated specifically for the evaluation and continuation of state-federal funded rehabilitation services in the public sector. The empowerment training curriculum used in this study was developed and guided based on several components of empowerment that emerge from theoretical and empirical literature. For example, one tenet of empowerment is that the group serves as a source of learning and support for increasing an individual's sense of power and control (Bolton & Brookings, 1996). Another example is the congruency of providing practice situations (i.e., creating an Action Plan) and research that indicates past practice is the strongest contributor to self-efficacy beliefs (Lent & Brown, 1992). In short, this study is limited by the assumption that empowerment training increased empowerment instead of obtaining pre and post training measures from a validated instrument.

Implications for Practice

1. Empowerment training produced no statistical difference in tangible outcomes. However, there appeared to be a trend suggesting potential and practical difference. Therefore, empowerment training should be offered as a

trial intervention to those MJC/RS consumers who indicate desire for such training.

2. Empowerment training may specifically benefit consumers who lack self-esteem or confidence in their ability to become employed or make vocational decisions. Therefore, when agency resources are limited, counselors may want to differentially procure empowerment training giving priority to consumers who want training and display vocational indecision or limited confidence.
3. Consumer feedback indicated a desire to have the opportunity for empowerment training early in the vocational rehabilitation process. Providing empowerment training as part of the orientation process may result in consumers sensing an increase in timing of service delivery with consumer need.
4. Empowerment training does not appear to increase the cost of cases. It may even be related to decreased costs. VR administrators may benefit by utilizing this type of program evaluation information in their planning and requests for continued funding.

Directions for Future Research

The findings of this exploratory study may be utilized as a springboard for future research. The following is a

partial list of unanswered questions related to the impact of empowerment training within the VR system and suggestions for enhancing the usability of future research findings.

1. Incorporate pre and post test measures of empowerment using recently developed scales (e.g., Bolton & Brookings, 1998). This could provide a clearer picture of the extent to which this type of intervention produces intangible outcomes or ipsative change and could provide direction related to who is likely to benefit most from empowerment training.
2. Replicate current research with a larger sample. This will provide evidence that addresses the issue of robustness and statistical versus practical significance.
3. Explore tangible outcomes in light of the question, 'Does empowerment training work more effectively for one group versus another?' It may be that empowerment training is differentially effective based on subject characteristics. For example, intuitively it seems that chronic, or progressive disability may make a difference in the short and long term impact of empowerment training.

4. Systematically explore the question of the 'timing' of empowerment training (i.e., status 2 versus 10). Although consumers seem to want empowerment training early in the vocational rehabilitation process, there may be a critical point that enhances the likelihood that empowerment training will contribute to positive tangible vocational outcomes.
5. Does it matter who provides the empowerment training (trainer with a disability versus without a disability)? Currently it is unclear what, if any, of consumers' reported satisfaction is attributable to characteristics of the presenter.
6. What is the optimal amount of counselor involvement in empowerment training? ET participants in this study seemed to indicate only moderate satisfaction with counselors' involvement. It may be that counselor behaviors impact the extent to which empowerment training satisfaction transfers into overall satisfaction with the vocational rehabilitation process.

Appendix A

Partnerships For Choice Steering Committee

Partnerships For Choice

Steering Committee

Mike. Fosler, Director
The Disability Network
877 E. 5th Ave., Bldg. 5
Flint, MI 48503

Rick Webster, Staff Representative
Grand Rapids CIL
3500 Camelot Dr. SE
Grand Rapids, MI 49546

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Midland CIL
1206 James Savage
Midland, MI 48640

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Center for Handicapper Affairs
918 Southland
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P.O. Box 30010
Lansing, MI 48909

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Michigan Jobs Commission, Rehabilitation Services
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Detroit, MI 48226

Joe Skiba, Director Client, Employee & Organization Services
Michigan Jobs Commission, Rehabilitation Services
P.O. Box 30010
Lansing, MI 48909

Sandy Peck, District Manager
Michigan Jobs Commission, Rehabilitation Services

910 Southland
Lansing, MI 48910

Lydia McCue, Rehabilitation Counselor
Michigan Jobs Commission, Rehabilitation Services
100 McMorran, 5th Floor
Port Huron, MI 48060

Dave Lehman, Rehabilitation Counselor
Michigan Jobs Commission, Rehabilitation Services
2450 VanOmmen Dr., Ste. 2
Holland, MI 49423

Consumer 1 (anonymous)

Consumer 2 (anonymous)

Nancy Erickson, Executive Director
Michigan Association of Centers for Independent Living
3001 N. Coolidge Rd., Ste. 125
Lansing, MI 48823

Judy Ferris, Project Coordinator
Partnerships For Choice
3001 N. Coolidge Rd., Ste. 125
Lansing, MI 48823

Appendix B

Empowerment Training Manual

Full copies of Empowerment Training Modules 1 and 2 are available upon request. Please make request in writing to:

Judy Ferris, Ph.D.
Michigan State University
207 Student Services building
East Lansing, MI 48824

Appendix C

Contributors to Curriculum Development

A Partial List of Contributing Sources to the

Partnerships For Choice, Empowerment Training Manual

Staff from Centers For Independent Living or MJC/RS

Baker, B. (August, 1994). Kalamazoo Center for Independent Living, Kalamazoo, MI.

Burge, N. (September, 1994). Midland Center for Independent Living, Midland, MI.

Knapp, L. (August, 1994). Center of Handicapper Affairs, Lansing, MI.

Magyar, J. (October, 1994). Ann Arbor Center for Independent Living, Ann Arbor, MI.

McCue, L. (August, 1994). Michigan Jobs Commission, Rehabilitation Services, Port Huron, MI.

Peck, S. (October, 1994). Michigan Jobs Commission, Rehabilitation Services, Lansing, MI.

Webster, R. (October, 1994). Grand Rapids Center for Independent Living, Grand Rapids, MI.

Focus Group Host Sites

Center for Handicapper Affairs, Lansing, MI

Disability Network, Flint, MI

Grand Rapids Center for Independent Living, Grand Rapids, MI.

Kalamazoo Michigan Jobs Commission, Kalamazoo, MI

Oakland/Macomb Center for Independent Living, Detroit, MI.

Saginaw Michigan Jobs Commission, Saginaw MI.

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Appendix D

Consent to Participate

Partnerships for Choice

Authorization for Release of Information

From Michigan Jobs Commission Rehabilitation Services

To The Michigan Association of Centers for Independent Living Partnerships for Choice Project.

Name (please print)	Date of Birth
Street Address	Social Security Number
City, State Zip Code	Current MJCRS Counselor

I authorize Michigan Jobs Commission Rehabilitation Services to release information and discuss my case to/with The Michigan Association of Centers for Independent Living - Partnerships for Choice Project. I understand that all information will remain confidential and will be used solely for the purpose of Partnerships for Choice program evaluation and intervention outcome research.

This release extends from the date of initial signing to the same day in the year 1998 or until such time as I request revocation of this release agreement in writing.

Name(Please Write)	Date

MACIL

Choice, Challenge and Change
3001 N. Coolidge Road, Suite 125
East Lansing, Michigan 48823
(517)3334253, FAX (517)333-4244, MI Relay (800)649-3777

Empowerment Training Student Contract

My participation in this empowerment training indicates that I agree to take responsibility for my work search in the following ways:

1) I will be on time for all scheduled meetings.

2) I will participate on a regular basis.

3) I will treat this training like a job.

4) I will be evaluated on my performance and participation.

5) I will provide and receive feedback.

6) I will notify the trainer if I have any problems related to training.

7) I will ask for additional help when it is needed.

8) It is my goal to successfully complete this training and to use what I have learned to become a more active part of my rehabilitation planning.

9) I will evaluate myself at the end of each training session.

10) I will contact my MJC/RS counselor following this training to share information and arrange a partnership meeting.

PARTICIPANT_____ **DATE**_____

TRAINER_____ **DATE**_____

Partnerships for Choice

Authorization for Release of Information

From _____ Center for Independent Living
To The Michigan Association of Centers for Independent Living Partnerships for Choice Project.

_____	_____
Name (please print)	Date of Birth
_____	_____
Street Address	Social Security Number
_____	_____
City, State Zip Code	Current CIL Trainer

I authorize _____ Center for Independent Living to release information and discuss my case to/with The Michigan Association of Centers for Independent Living - Partnerships for Choice Project. I understand that all information will remain confidential and will be used solely for the purpose of Partnerships for Choice program evaluation and intervention outcome research.

This release extends from the date of initial signing to the same day in the year 1998 or until such time as I request revocation of this release agreement in writing.

_____	_____
Name(Please Write)	Date

MACIL

Choice, Challenge and Change
3001 N. Coolidge Road, Suite 125
East Lansing, Michigan 48823
(517)3334253, FAX (517)333-4244, MI Relay (800)649-3777

Appendix E

Sites

Centers for Independent Living

Ann Arbor CIL
J. Magyar, Director
2568 Packard Road
Ann Arbor, MI 49104

Lakeshore CIL
R. Stegman, Director
720 E. Eighth Street, #3
Holland, MI 49423

Midland CIL
C. Holloway, Interim Director
1206 James Savage
Midland, MI 48640

Center of Handicapper Affairs
J. Golden, Director
918 Southland
Lansing, MI 48910

Grand Rapids CIL
B. Harvey, Director
3600 Camelot Drive, SE
Grand Rapids, MI 49546

Kalamazoo CIL
K. Duckworth, Director
4026 Westnedge Avenue
Kalamazoo, MI 49008

Great Lakes CIL
A. Humphrey, Director
4 E. Alexandrine Towers, Ste. 104
Detroit, MI 48210

Blue Water CIL
R. DeVary, Director
804 Huron Avenue
Port Huron, MI 48060

Centers for Independent Living (continued)

Oakland/Macomb CIL
A. Humphrey, Interim Director
3765 E. 15 Mile Road
Sterling Heights, MI 48310

The Disabililty Network
M. Fosler, Director
877 E. Fifth Avenue
Flint, MI 48503

MJC/RS Sites

Ann Arbor
T. Tomsik, Manager
3810 Packard Road, Ste.170
Ann Arbor, MI 48108

Detroit/Southwest
D. Hill, Manager
1200 Sixth Street, Ste.1603
Detroit, MI 48226

Flint
G. Grantner, Manager
303 W. Water Street, Ste.204
Flint, MI 48503

Holland
B. Herbst, Manager
2450 VanOmmen Drive, Ste.2
Holland, MI 49423

Kalamazoo
D. Hart, Manager
4210 S. Westnedge
Kalamazoo, MI 49008

MJC/RS Sites (continued)

Lansing
S. Peck, Manager
910 Southland
Lansing, MI 48910

Monroe
C. Monroe, Supervisor
1066 S. Telegraph Road
Monroe, MI 48161

Port Huron
D. Kuzma. Manager
100 S. McMorran, 5th Floor
Port Huron, MI 48060

Saginaw
T. Burge, Manager
411 E. East Genessee
Saginaw, MI 48607

South Macomb
S. Newman, Manager
14200 Eleven Mile Road
Warren, MI 48089

Appendix F

Consumer Survey

The full Consumer Survey is available by request. Please make written request to:

Judy Ferris, Ph.D.
Michigan State University
207 Student Services Building
East Lansing, MI 48824

Appendix G

Empowerment Training Self Report Forms

POST-TRAINING EVALUATION

1) Do you feel more in control of decision-making? If so, in what areas?

2) How do you feel about the training you received in this session?

3) Which (if any) of the topics discussed where important to you?

4) Which (if any) of the topics discussed where not important to you?

5) Did you get what you expected out of this training? If not, please explain.

6) How comfortable was the form and style of training? What if anything about how the session was presented should be changed?

7) Do you see yourself differently now that you've been through the training? If so, please explain.

8) What other information or topics would you like to have discussed?

9) How would you rate the trainer?

Excellent Good Fair Poor No Opinion

PRE-TRAINING QUESTIONNAIRE

1) Circle the areas of your life in which you feel satisfied.

Daily Living Activity Family Activity Personal Growth

Leisure Activity Social Activity Rehab Planning

Work Activity Educational Activity Other _____

2) Circle the most important item in the list that you expect to get from this training program.

Information Confidence Meet New People

Personal Work Plan Decision Making Other_____

3) What are the 3 most important topics you want discussed in this training?

1._____
2._____
3._____

4) Circle who is most responsible for making sure the training is helpful to you.

1. You
2. The Presenter
3. The Counselor
4. Both 2 & 3
5. All are equally Responsible

5) How involved are you with making decisions about your life?

Very involved Somewhat involved Not involved

6) How satisfied are you with your current level of decision making involvement?

Very satisfied Somewhat satisfied Not satisfied

7) Will you need special accommodations to attend this training?

No Yes, please describe what you will need_____

TRAINING SELF-EVALUATION

Post-Test

1. I was on time to today's training.	YES	NO
2. I was dressed appropriately.	YES	NO
3. I participated in the training.	YES	NO
4. I asked for help when I needed it.	YES	NO
5. I received help when I asked for it.	YES	NO

7. This is what I learned today:

_____

_____

_____

8. This is what it meant to me;

_____

_____

_____

Appendix H

Correlation Matrix of all MJC/RS Tangible Variables

Correlation Matrix of All MJC/RS Tangible Variables

Race	.12													
Xcass	-.34	-.13												
Stats	.03	.13	-.15											
Spmed	-.24	-.08	-.11	.35										
Sever	.09	-.03	-.09	-.08	-.12									
Marit	-.08	.18	.11	.03	.02	-.01								
Vet	.21	.05	-.00	-.03	-.13	.26	-.08							
Xdepn	.04	-.05	-.19	.19	.09	.12	-.60	.15						
Ihrwk	.17	.08	-.20	.12	.04	.05	.07	.08	.08					
Ccost	.07	-.14	-.01	-.14	-.14	-.10	-.34	-.06	.32	-.19				
Iothr	-.16	.01	-.06	.01	-.07	.15	-.17	.05	.70	-.06	-.04			
Ispa	-.00	-.08	-.11	.09	-.10	.26	-.08	.06	.20	-.12	-.12	-.07		
Isssi	-.13	-.11	.13	.23	.09	-.33	.24	-.02	-.20	.00	-.01	-.09	-.13	
Issdi	-.18	-.12	.16	-.10	.05	-.60	-.16	-.44	-.08	-.15	-.00	-.08	-.15	-.16
Iwkm	.16	.05	-.18	.11	.02	.06	.02	.07	.00	.92	-.17	.95	-.10	-.07	-.12
Iunmp	.06	-.04	.08	.21	.25	.06	-.04	.03	.10	-.06	-.10	-.04	-.05	-.07	-.08
Chrwk	-.11	-.15	-.12	.05	.23	.07	.15	.11	.10	.04	-.06	-.02	.16	.13	-.02
Cwem	-.12	-.15	-.12	.05	.30	.07	.15	.06	-.10	.03	.03	.05	-.02	-.04	-.08
Cssi	-.07	-.05	-.06	-.10	-.10	-.05	.05	-.17	-.25	-.11	.03	-.00	-.13	.48	.12
Cssdi	-.08	-.06	.12	-.01	.16	-.03	.21	-.39	-.14	.13	.07	-.00	-.11	-.12	.39
Cwc	-.12	-.05	-.05	.01	-.08	.09	-.21	.03	.20	-.07	.19	-.01	-.05	-.08	-.04
Coth	-.12	-.05	.16	-.03	-.08	-.14	-.13	-.56	-.09	-.07	.18	-.01	-.05	-.08	-.42
Cpbs	-.12	-.05	-.16	-.03	-.08	-.14	-.13	.07	.00	-.03	-.02	.05	.28	-.15	-.08
Diag	.19	.16	.01	-.02	.01	.13	.00	-.13	.19	.02	.05	-.02	.11	-.32	.16
Resto	-.17	-.02	-.04	.04	.33	-.01	-.18	-.03	-.10	-.13	.04	-.02	-.10	.00	.18
Ojt	-.16	-.19	-.06	-.04	-.15	-.10	-.01	.04	.10	-.07	.02	-.01	.36	-.08	-.04
Plcmt	-.12	-.05	-.05	-.03	-.08	.09	-.21	-.08	-.16	-.17	.03	-.00	.00	.18	-.02
Coll	-.24	.35	.06	-.06	-.04	-.08	-.07	.05	-.07	.14	.07	.11	-.07	-.11	-.06
Bsvoc	-.06	-.06	-.06	-.02	-.11	-.06	-.07	.07	-.16	-.05	-.01	-.02	-.11	.15	-.09
Trans	-.19	-.22	.03	-.00	-.16	-.02	-.12	.13	-.05	-.21	-.01	.03	.06	-.09	-.13
Maint	-.05	.12	.01	-.00	.27	.12	-.10	.09	-.21	-.17	.01	-.01	-.14	.12	-.08
Other	.10	.06	-.02	-.02	-.20	.20	.19	.13	.15	-.14	.09	-.03	-.02	.08	-.07
Misc	-.07	-.17	.04	-.01	-.12	.07	-.16	-.14	-.12	.01	.02	.04	-.12	.09	.12
Couns	.06	.31	-.08	-.01	-.14	-.15	.14	.00	.17	.21	.02	-.01	.33	.00	.00
Adj	.08	.00	.00	-.03	.05	-.08	-.20	.06	-.04	-.11	.04	-.01	.01	.24	-.07
Jbref	-.09	-.08	.11	-.04	-.13	-.03	.03	-.08	-.14	-.10	.02	-.01	-.02	.29	-.04
Age	-.20	.21	.11	-.08	-.08	-.06	.05	.03	.27	-.11	.09	.11	-.01	-.26	.21
Corr:	Gendr	race	Xcass	stats	Spmed	sever	marit	Vet	xdepn	Ihrwk	ccost	Isoth	Ispa	Isssi	Issdi

Race															
Xcass															
Stats															
Spmed															
Sever															
Marit															
Vet															
Xdepn															
Ihrwk															
Ccost															
Iothr															
Ispa															
Isssi															
Issdi															
Iwkrn															
Iunmp	-.05														
Chrwk	-.07	-.19													
Cwern	-.01	-.17	-.02												
Cssi	-.15	-.04	.12	-.03											
Cssdi	-.11	-.07	-.19	-.06	-.25										
Cwc	-.06	-.04	-.01	-.13	-.13	-.06									
Coth	-.06	-.04	-.14	-.13	-.13	.73	-.03								
Cpbs	-.05	-.07	-.14	.03	-.25	-.11	-.06	-.06							
Diag	.05	.09	.14	-.08	-.10	.31	.24	.24	.09						
Resto	-.11	-.08	-.14	-.13	-.11	.33	.11	.11	-.11	.00					
Ojt	-.06	-.04	-.02	.10	-.13	-.06	-.30	-.03	.09	.24	-.06				
Plcmt	-.16	-.13	-.23	.02	.21	-.01	-.10	-.10	-.05	-.29	-.15	.12			
Coll	-.28	-.05	-.13	.16	.10	-.08	-.04	-.04	-.08	-.02	-.08	-.04	-.13		
Bsvoc	-.08	-.08	-.07	.16	.00	-.12	-.06	-.06	-.11	-.36	-.11	-.06	.46	-.08	
Trans	-.19	-.15	-.13	.02	-.21	.15	.08	-.11	.27	-.08	-.12	-.08	.31	.02	.00
Maint	-.14	-.10	.21	.05	-.06	-.09	-.08	-.08	-.14	-.20	.10	-.08	.12	-.10	.16
Other	-.14	-.08	.06	.14	.07	-.12	.63	-.11	-.07	.04	.02	-.11	-.15	-.15	.03
Misc	-.09	-.15	-.22	-.26	.03	.12	.12	.12	.02	-.30	.16	-.11	.30	.06	.29
Couns	.12	-.30	-.02	.27	.00	.00	.00	.00	.33	.41	-.05	.49	.10	.00	.00
Adj	-.09	-.07	-.05	.12	.16	-.10	.19	-.05	-.09	-.18	-.02	-.05	.10	-.07	-.10
Jbref	-.14	-.17	-.16	.16	.28	-.04	-.13	-.13	-.08	-.42	-.20	.14	.87*	-.17	.50
Age	-.05	.13	-.00	-.04	-.15	.19	.01	.18	.03	.11	.18	-.04	-.16	-.15	-.09
Corr:	Iwkrn	iunmp	chrwk	cwkrn	cssi	cssdi	Cwc	Coth	Cpbs	Diag	resto	ojt	plcmt	coll	Bsvoc

KEY **p=.01 *p=.05

Race = race/ethnicity
Xcase = case number
Stats = status of case
Spmed = special medical condition
Sever = severity level
Marit = marital situation
Vet = served in military
Xdepn = number of dependents
Ihrwk = number of hours worked per week at intake
Ccost = case cost
Iothr = other income at intake
Ispa = income from public assistance at intake
Isssi = income from supplemental social security at intake

Race							
Xcass							
Stats							
Spmed							
Sever							
Marit							
Vet							
Xdepn							
Ihrwk							
Ccost							
Iothr							
Ispa							
Isssi							
Issdi							
Iwkrn							
Iunmp							
Chrwk							
Cwern							
Cssi							
Cssdi							
Cwc							
Coth							
Cpbs							
Diag							
Resto							
Ojt							
Plcmt							
Coll							
Bsvoc							
Trans							
Maint	.01						
Other	.02	.05					
Misc	.20	.16	.80				
Couns	.03	.05	.00	-.07			
Adj	.13	.24	.38	.13	-.08		
Jbref	.19	.03	.01	.17	.13	.10	
Age	.09	.02	.03	-.07	-.04	-.01	-.17
Corr:	trans	maint	othr	Misc	Couns	adj	Jbref

KEY (continued) **p=.01 *p=.05

Issdi = income from social security disability at intake
Iwkrn = earning from work at intake
Iunmp = income from unemployment at intake
Chrwk = number of hours worked per week at close
Cwern = earning from work at close
Cssi = income from supplemental social security at close
Cssdi = income from social security disability at close
Cwc = income from workers' compensation at close
Coth = other income at close
Cpbs = income from public assistance at close
Diag = diagnostic services
Resto = restoration services
Ojt = on the job training services
Plcmt = job placement services
Coll = college training services
Bsvoc = business or vocational training services
Trans = transportation services
Misc = miscellaneous services
Couns = counseling services
Adj = adjustment services
Jbref = job referral services
Age = age of case

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