

## **Consumer Concepts of Ideal Characteristics and Minimum Qualifications for Rehabilitation Counselors**

Henry McCarthy and Stephen J. Leierer, Louisiana State University Health Sciences Center

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Forty former rehabilitation counseling clients returned a mail questionnaire that requested them to write descriptions of "ideal" and minimally qualified rehabilitation counselors. Coders applied content analysis to classify the emergent defining criteria of these counselor prototypes. Relational values and qualities (Consumer•First Advocacy, Nurturing Traits) represented the most frequent categories for the ideal counselor de-scriptors; demographic characteristics (Disability Experience, Education, Maturity) were mentioned least. Predominant categories for the minimum qualifications were Credentials and Education and subcategories under Work Ethic and Approach, including Commitment to Client, Professional Behavior, and Competence. Broader use of discovery•oriented, qualitative methodologies in rehabilitation research is encouraged to capture consumers' phenomenological perspectives.

Extensive research effort has been devoted to documentation and validation of the roles and functions of rehabilitation counselors (RCs) from the view-point of rehabilitation practitioners, educators, and super-visors (see chapter 1 in Roessler & Rubin, 1998, for a summary and Thomas, 1990, for a critique of this body of research.) These investigations of what RCs do or should do have been based on either (a) criteria believed by aca-demic researchers to be significant or (b) the practices of expert counselors who had been selected by their col-leagues or supervisors (Cook, Bolton, Bellini, & Neath, 1997; Janikowski, 1990; Leahy, Szymanski, & Linkowski, 1993). The client perspective on the counseling process, however, has been neglected by rehabilitation counseling researchers. This neglect is especially evident when com-pared to what has been published within the sister fields of family therapy (Howe, 1996; Sells, Smith, Coe, Yosh-ioka, & Robbins, 1994), mental health counseling (Al-Darmaki & Kivlighan, 1993; Halstead, Brooks, Goldberg, & Fish, 1990), and psychotherapy (Andersen, 1997; Saunders, 1993). Indeed, this dearth of research stands in stark contrast to the importance of respecting and incorporating client input to the rehabilitation process, a value we have emphatically professed over the past four decades (Wright, 1960; Kosciulek, 1999).

An exception to the lack of consumer•based research in rehabilitation counseling is a study by Koch (2001), who administered a free•response survey to vocational re-habilitation (VR) applicants concerning their pending experience as VR clients. Koch adapted a questionnaire developed by Galassi, Crace, Martin, James, and Wallace (1992) for career counseling clients. She investigated six aspects of the VR process; services, counselor characteris-tics, meetings with the counselor, goals, counselor role, and client role. In brief, she found many discrepancies be-tween the applicants' preferences for their rehabilitation and what they anticipated, rather pessimistically, they would receive. Numerous studies (Bolton, 1978; Mena, pace, 1977; Tichenor, Thomas & Kravetz, 1975) have attributed disappointing outcomes of VR services to the disparity in counselor•client definitions of (a) priority needs, (b) appropriate services, and (c) acceptable out-comes. Clearly, we can benefit from proactive delineation of clients' and counselors' expectations and assumed role responsibilities

as a basis for developing interventions to improve consumer understanding of and satisfaction with rehabilitation services (Chan, Shaw, McMahon, Koch, & Strauser, 1997). Without direct, meaningful knowledge of how clients define and approach rehabilitation counseling, we are at a disadvantage for satisfactorily and collaboratively serving consumers.

An epistemological approach to research intending to discover the thoughts and values of any group would argue that meaningful assessment of such perspectives requires two strategies: (a) asking questions that members of the group can relate and respond to from their own frames of reference and ways of knowing; and (b) capturing individuals' responses in a way that optimally preserves what they wish to say. In short, the epistemological objective is to minimize the researcher's imposition of content (e.g., ideas) and structure (e.g., measurements) that are not naturally occurring to the respondents. The vast majority of studies of the opinions and experiences of rehabilitation clients have used (a) concepts and stimuli that were derived from a provider perspective, model, or theory and (b) response formats constrained by forced-choice scales or closed questions. A few rehabilitation studies (e.g., Koch, 2001; Murphy & Salamone, 1983; Trevino & Szymanski, 1996) have explored clients' perceptions and preferences through a qualitative synthesis of data elicited from their own schema of understanding and vocabulary of expression. The number of such studies is likely to increase, however, given the cumulative impact of two current movements. First is the evolving effort to move partnership with rehabilitation consumers beyond mere rhetoric or legislative mandate, as explained in several stimulating conceptual articles (Chan et al., 1997; Koch, Williams, & Rumrill, 1998; McAlees & Menz, 1992; Owen, 1992; Rubinfeld, 1988). Second is the growing acceptance of including phenomenological, qualitative research methodologies in many behavioral sciences (Ellis & Flaherty, 1992; Glesne & Peshkin, 1992; Spencer, 1993).

Numerous publications, ranging from lobbying reports by professional associations to chapters in academic textbooks, echo the profession's concern with the debate over what defines a "qualified rehabilitation professional" (Danek, 1996; Goetz, 1997; Leahy, 1997; Leahy & Szymanski, 1995; Tarvydas & Leahy, 1993). The major controversy swirls around legal definitions written into federal funding legislation or state licensing laws governing the scope of practice of those who deliver counseling, related rehabilitation services. The publicly expressed rationale for restricting who should be allowed to provide services is "to protect the client" by screening out "inappropriate" providers (Emener, 1993). A few frank articles in the rehabilitation literature have acknowledged how changes ostensibly introduced to protect the client by controlling entry to or practice of RC can be more self-serving than genuinely consumer protective (Noble & McCarthy, 1988; Scofield, Berven & Harrison, 1981; Thomas, 1993). Certainly, in all the discourse on what constitutes a qualified rehabilitation professional, the voice of consumers has been notably underrepresented. Our study sought to increase the input of consumers to ongoing discussions and decisions about RC education and practice. Our two research questions were as follows:

1. How do consumers of vocational rehabilitation services describe their "ideal" rehabilitation counselor?
2. What do they consider should be the "minimum qualifications" to become a rehabilitation counselor?

## **METHOD**

## Mail Questionnaire

Data were collected via a mail questionnaire, the first part of which requested respondents to describe in their own words their ideal RC and the minimum requirements that they believe all candidates should satisfy in order to be hired as an RC. For writing their responses, participants were provided with a sheet with 10 numbered lines under each of the two questions. This format encouraged them to express multifaceted schema. Also, it put the respondents in charge of delineating each RC prototype into its specific components. This section was designed to maximize the respondents' free expression of relevant concepts and criteria. The second, structured part of the questionnaire collected (a) minimal demographic data to enable a description of the respondent sample, (b) four evaluations of the personal impact of the rehabilitation counseling services respondents had received, and (c) importance ratings for four specified counselor factors.

## Recruitment of Participants

We solicited the cooperation of the Louisiana chapter of a national organization for spinal cord injury (SCI) survivors and were approved to receive a copy of its mailing list of current and former members. Our questionnaire was mailed to all 216 names on the list. However, 40 envelopes were returned by the post office because the addressee had moved and there was no current forwarding address. Ten questionnaires were returned blank by individuals who reported not meeting the criteria for participating; 7 of these declined because they were nondisabled (supporters of the chapter) and 3 because they did not recall going to an RC.

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TABLE 1. Respondents' Evaluations of Their Rehabilitation

Statement	M	SD	n
I'm satisfied with the work my RC did with me.	2.60	1.37	38
The rehab services I received improved my employment situation.	3.30	1.60	37
The rehab services I received improved my ability to live independently.	3.05	1.50	40
The rehab services I received improved my feelings about myself.	3.05	1.45	39

Note. Lower mean numbers indicate more agreement with the item.

This reduced the number of prospective respondents to 166. Two individuals wrote to us that they chose not to participate in the study for personal reasons. The 40 usable questionnaires that were returned represent a 24% response rate. Strategies that we employed to encourage participation included offering a \$5.00 incentive for completing the survey (16 participants declined payment); enclosing a stamped, self-addressed return envelope; providing the option of completing the questionnaire via a toll-free telephone call (which no one requested); and sending a follow-up mailing that mentioned the researchers' involvement in issues of concern to the disability community.

## Participant Characteristics and Experiences

All 40 respondents had neurological disabilities that limited their physical but not their intellectual functioning; a large majority (80%) had adult-onset, traumatic SCI; 6 (15%) reported a second disability, such as amputation. The mean number of years since acquiring the disability was 18.93 (SD = 13.38). Respondents ranged in age from 24 to 65 years (M = 43.64, SD = 9.27). The gender distribution was 23 (57.5%) men and 17 (42.5%) women.

Participants reported having had from none to eight different rehabilitation counselors (M = 2.60, SD = 1.83). Respondents' recollections of the amount of contact with their RC(s) revealed wide variation; accordingly, the medians of these distributions are a better measure of the average. Estimates of the number of sessions with RC(s) ranged from none to 117 (Mdn = 10, M = 22.14, SD = 30.61). Participants reported seeing their RC(s) over a period that averaged more than a year (Mdn = 13.5 months, M = 45.54 months, SD = 58.38). The positive skew of these distributions indicates that a few of the participants received much more rehabilitation counseling than the others in the sample. Even the few respondents who reported having had no RC are unlikely to have received no services from such a professional during their rehabilitation; however, other titles (e.g., case manager or vocational specialist) may have been used in their treatment setting.

Given the self-selected nature of samples generated from mail surveys, we were interested in collecting some correlative data that would capture a sense of the respondents' attitudes toward their own rehabilitation experience, feelings that might color their cognitive schema of RCs in general. Therefore, we included a few quantitative items on our mail questionnaire. Using a 5-point scale (1 = strongly agree, 2 = agree, 3 = neutral, 4 = disagree, 5 = strongly disagree), respondents answered four evaluative questions about their rehabilitation. Table I contains the average ratings obtained in response to these questions. Among these ratings, satisfaction with the counselor was strongest and the impact of the services on employment was the weakest. However, all the averages, which clustered around the midpoint of the scale, indicate that the respondents felt neutral about the rehabilitation services they received.

## ETHNOGRAPHIC CONTENT ANALYSIS

The approach we pursued to classify the respondents' ideas and expectations about counselors was discovery-oriented, collaborative, iterative, and grounded in the specific words expressed by the respondents (see Note). We began the analysis with no theoretical framework or coding categories. Our approach to capturing the respondents' concepts of counselors consisted of this sequence:

1. allowing category domains to emerge from careful reading and comparing of the statements by individual interpreters, an iterative process explained by Strauss and Corbin (1991);
2. collaboratively constructing a common coding scheme from the categories that evolved from the previous process;
3. coding the data according to the common scheme;

4. assessing the level of inter-coder reliability;

5. refining the categories as necessary and arriving at consensus in the final coding of the data; and

6. calculating and comparing category frequencies to quantify emphases and trends in the thematic domains identified.

This combining of qualitative elements (open-ended, free-response questions to elicit data stemming from the consumers' own perspectives; analyzing the results by evolving interpretation and consensus coding of the data) with quantitative comparisons among category frequencies is close to the method of ethnographic content analysis (Altheide, 1987; Smith, Sells, & Clevenger, 1994).

The statements that the respondents had given to each question were typed, proofread, and separated into small cards. Each card contained one item, either what had been written on a single numbered line of the questionnaire or a punctuated sentence that ran over to a second line. Three researchers independently sorted the cards into groups of statements perceived by them to have equivalent or similar meaning. They were encouraged to take time reading and sorting the items and to make any changes in the evolving categories until they felt comfortable both with the between, category separateness and the within-category homogeneity. Coders labeled each domain to summarize its distinctive content; they also wrote a reflection to document their general strategy and specific decision rules in coding the data.

## **Results**

### **Descriptions of the Ideal Counselor**

Thirty-six respondents wrote a total of 208 descriptions of the ideal counselor. The numbered statements ranged from a single word to a run-on sentence of more than 20 words, with the vast majority of items being short phrases. Descriptions given per respondent ranged from 2 to 9, with a median of 6 statements. Appendix A lists, in descending order of item frequency, the categories that the three coders consensually arrived at in interpreting these data. Review of the verbatim examples provided to illustrate each category shows how the coders, while making every attempt to keep their interpretations close to the respondents' words, did not code simply by words but by the inferred concept. For example, mention of the word "empathy" (represented in Categories 1 and 2) or "understanding" (in Categories 2 and 3) was categorized differently, depending upon how the statement was elaborated.

Almost half of the 208 descriptions of an ideal counselor were captured by the two most frequent categories. Both reflected the respondents' desire for a counselor dedicated to serving their welfare and developing a meaningful relationship. The category of Consumer-First Attitude and Advocacy garnered the most items (28.5%), followed by the category of Nurturing Traits That Promote Counselor-Client Relationship (20%). The next three most popular categories, representing more than one third of the responses, were close in frequency and similar in their focus on practical,

administrative aspects of the counselor's role. These categories are Knowledge about Disability and Rehabilitation (14%), Professional Standards of Practice (12.5%), and Traits that Promote Efficient Case Management (11 %) • The remaining categories included factors that although often assumed to be important to counseling expertise and success, were mentioned by only a small minority of the respondents. Specifically, these domains were Facilitative Counseling and Communication Skills (6%); Disability Experience in Personal Life (4%); Educational Background (2.5%); Maturity and Professional Experience (1.5%).

### **Importance Ratings of Specified Factors for an Ideal Counselor**

Participants were asked to rate how selected factors would contribute to the person who would be their ideal RC. The four items were rated on a 6~point scale (0 = not at all important, 1 = a little important, 2 somewhat important, 3 = important, 4 = very important, 5 extremely important). These judgments were made after the respondents had completed their own free•response descriptions of the ideal and minimally qualified counselors that constitute the primary data for this study. This part of the questionnaire was designed to serve as a supplementary quantitative measure of the participants' qualitative descriptions. The respondents' ratings of importance of these counselor factors were (a) "the way they behave toward me" (M = 4.70, SD = .61); (b) their education and training (M = 4.28; SD = 1.04); (c) the experiences they have had in life (M = 4.22, SD = 1.10); and (d) their personal characteristics (M = 4.03; SD = 1.33). Through a multivariate repeated•measures analysis, an overall significant difference among these ratings was found,  $F(3, 37) = 7.08, p = .001$ . Univariate analyses subsequently demonstrated that the difference was attributable to the higher rating (4.70) of the importance of the counselor's behavior; there were no significant differences among the ratings of the three other listed factors. These quantitative ratings corroborate the findings from the qualitative analysis, which revealed the overwhelming predominance of various relational behaviors over the credentials, experience, or demographics of the counselor.

### **Descriptions of Minimum Qualifications for Rehabilitation Counselors**

Question 2 ("List the basic requirements anyone should fulfill, in order to be hired as a rehab counselor. What do you think should be the minimum qualifications and essential requirements?") elicited a total of 148 responses from 38 participants. The number of responses per participant ranged from 1 to 8 with a median of 3 statements. Appendix B lists in rank order of frequency the categories of factors expressed by the respondents with respect to minimum qualifications for RCs. Twelve of the 148 statements were coded in two categories, so the percentages are based on all 160 codes assigned. The top•ranked category was Credentials and Educational Achievement. This is an understandable priority when discussing entry•level requirements, and it was most reflected in general statements to the effect that RCs should have "a good, sound educational background."

The second most frequently expressed theme was the one we labeled Work Ethic and Approach. The items in this category reflected a variety of traits and behaviors that inspire confidence, trust, and acceptance. They seem most closely related to the "bonds" between counselor and client, a concept discussed by Bordin (1976) in his theory of the working alliance and elaborated by Horvath and

Greenberg (1989). About 20 different terms for Personality Characteristics such as "flexible" and "psychologically fit" composed the third-most-frequent category. Only 5 personality characteristics were mentioned by more than one person: "honest," "patient," and "understanding" were noted by two individuals each; a positive attitude by three; and a good personality by three. The next most commonly expressed main category captured several types of Exposure to Relevant Experience. Having an internship or supervised experience was the most frequently cited single criterion, mentioned by 10 respondents, under the Exposure to Relevant Experience main category. A few respondents simply stated "experience" as an expectation, and these were subsumed under the Life Experience subcategory, which totaled seven statements. An additional five descriptions specified that RCs should have had some type of "hands-on" experience encountering people with disabilities. Three respondents listed having a disability (or a family member with one) as a minimum qualification.

Only 11% of the responses specifying essential requirements for RCs mentioned any of the fundamental communication processes of counseling: listening; expressive communication; interpreting; creating an atmosphere conducive to communication. Practical knowledge about disability issues and rehabilitation resources accounted for a mere 9% of the coded statements given by this sample to define the basic requirements anyone should fulfill in order to be hired as an RC.

### **Comparison of the Ideal vs. Minimally Qualified Counselor**

Virtually all respondents had a more multifaceted schema and generated more descriptions ( $M = 5.2$ ) of the ideal counselor than they did of the minimum qualifications for RCs ( $M = 3.7$ ). Similarly, Galassi et al. (1992) and Koch (2001) found that clients expressed a clearer concept of what they preferred than of what they expected to get from counseling. We speculate that the implication of our second question (standards for screening out inadequately prepared personnel) is probably less important to consumers than that of the first (counselor awareness of what clients want in a counseling relationship).

Very little redundancy was evidenced within individuals' responses to the two questions. One respondent explicitly wrote that she felt the same about both questions and repeated the 6 statements to describe the minimally qualified counselor that she had given for ideal counselor. Thirteen other respondents gave one or two statements that were identical or similar in answering the two questions. In total, however, only 23 of the 208 statements (11 %) given in response to Question 1 were also written by the same respondent for Question 2. This includes not only exact repeats but also (and more often) substantively equivalent statements that were similarly worded. Thus, the respondents' freely expressed schema of ideal characteristics and minimum qualifications were largely independent.

A few identical or equivalent categories emerged in the process of synthesizing the responses to the two questions. For each of these instances, the difference in relative emphasis that the equivalent categories were given was often notable. Sharpest among these differences was the 10-to-1 proportion of responses that referred to the counselor's Education/Credentials: 25% as a minimum qualification versus 2.5% as an aspect of the ideal counselor. Other discrepancies in emphasis were evident in the respondents' mentioning of (a) the ideal counselor's Consumer-First Advocacy (28.5%), a category paralleled by Commitment/ Sensitivity to Client (7%) as an essential requirement,

and (b) Nurturing Traits That Promote Relationship (20%), compared to approximately 9% of the minimum qualification descriptions that were similar but categorized under either Professional Behavior or Personality Characteristics.

The exception to the above contrasts in emphasis was the expression of a preference versus an expectation that the counselor have a disability. The frequencies of mentioning this personal experience were almost equivalent (4% for ideal and 2% for essential qualification). Moreover, these very low frequencies seem surprising, given the popularity of both the self-help paradigm in society at large and the independent-living movement in rehabilitation, each of which endorses the widespread lay wisdom about consulting a person who has been through the same experience. However, the finding that counselor disability status is of comparatively limited import is consistent with the majority of studies of this variable (Strohmer, Leierer, Cochran, & Arokiasamy, 1996). Koch (2001) also reported that only 9% of her respondents mentioned a preference (and only 3% an anticipation) for an RC similar to them in having a disability or having "been in the same position at one time.

## **DISCUSSION AND IMPLICATIONS**

The clearest findings from the data are discussed below around the most frequent themes—advocacy, nurturing relationship, and the role of knowledge and credentials—that emerged from the participants' responses to the two research questions. Limitations are then addressed.

### **Consumer-First Attitude and Advocacy**

Commitment to advocacy for the client was clearly the counselor characteristic most desired by the respondents. This finding from the voice of consumers stands in sharp contrast to the various skills and attributes consistently selected by researchers who investigate how clients perceive counselors. For example, the function of advocacy in counseling does not appear in any of the seven most frequently utilized psychometric instruments for assessing perceptions of and expectations about counseling (Hayes & Tinsley, 1989). Nor does advocacy appear in social influence theory, the most popular model of how counselor characteristics shape clients' perception of and interaction with counselors (Heppner & Claiborn, 1989; Strong, 1968; Wilson & Yager, 1990).

Bureaucratic, legislated, and societal changes are increasing the pressure to involve clients in the design and implementation of their own individualized service plans. Such comanagement requires mutual understanding and negotiating of (a) client expectations and preferences and (b) provider capacities for fulfilling them. Without this mutual appreciation, the comanagement mandate is likely to generate conflicts (whether acknowledged or covert) that are often detrimental to the counseling process. RCs complete about 2 years of academic and fieldwork professional training to learn how to perform their role. Although stipulated as an integral component of RC curricula, hands-on education to understand the disability experience from interacting with people who have one is substantially less extensive. We question whether such controlled, intermittent experiences constitute enough exposure to the everyday world of managing a disability for RC students to anticipate and fathom the perspective of consumers, in order to advocate on their behalf. Furthermore, we wonder why advocacy is listed as neither a topic nor even a term among the subject domains from the knowledge



validation study jointly sponsored by the Council on Rehabilitation Education and the Commission on Rehabilitation Counselor Certification (Leahy, 1997; Leahy, Szymanski, & Linkowski, 1993). This otherwise comprehensive list contains 10 domains established as the essential content areas for RC curricula and the certification exam. The 58 subdomains include several topics that would seem more marginal to most RCs' work than advocacy, such as expert testimony and family counseling theories. We would encourage educators to invest more effort and ingenuity in developing counselors' capacity and motivation to perform advocacy alongside their clients than is currently set into formal standards. Such an investment in pre-service and continuing education about advocacy seems warranted in order to enable RCs to practice in accord with the profession's code of ethics, which specifies that "At all times, rehabilitation counselors shall endeavor to place their clients' interests above their own" (Canon 2) and highlights the responsibilities of client advocacy in Canon 3 (Commission on Rehabilitation Counselor Certification, 1997).

We have a related concern that clients are not given adequate orientation about the counseling process, how to approach the relationship, and how to express their expectations to the counselor. Too many clients find themselves thrust into the process without understanding what their role and the counselor's role are. Add to this the fact that counselors and clients often come from different educational, ethnic, and economic backgrounds (Alston & Bell, 1996; Locust, 1995). The result is that much of the shared knowledge that could serve to facilitate open and smooth exchange in counseling is missing, including the profession's awareness or responsiveness to how it is perceived by current clientele. To address these interlocking concerns, the RC profession should extrapolate models and tools proposed in the burgeoning multicultural counseling literature for bridging the gaps in understanding between clients and counselors. One easily implemented example is to have counseling students and supervisees develop a portfolio to document and demonstrate their competency not only in multicultural counseling as described by Coleman (1996), but also in advocacy.

### **Communicating Support for and Affirmation of the Client**

Nurturing traits were the second most prominent characteristic that respondents wanted in their ideal counselor. Bachelor (1995) found nurturance to be the most commonly expressed attribute of clients' perception of the therapeutic alliance they had with their counselor. Despite the widely accepted notion that the counseling professions attract people with nurturant personalities and proclivities, this skill area can actually be a source of relative disappointment for counselees. Specifically, a study of counseling psychologists' perceptions of their clients' expectations revealed that 66% of the counselors reported having clients with "unrealistically high" expectations for nurturance (Tinsley, Bowman, & Barich, 1993). Of the 17 factors that these researchers investigated, the perceived overexpectation of being nurtured was second only to the percentage of counselors who reported clients with unrealistically high expectations for counselor directiveness. Overall, our data demonstrate that respondents placed clear emphasis on the relational behaviors that underlie the process they undergo as clients. This finding supports Murphy's (1988) conclusion that "Clients focused far more on the process they experienced than did counselors ... If [their] priority needs were not adequately addressed, were obstructed by counselors, or were not perceived to be achieved by counselor or agency actions, clients did not judge their rehabilitation successful even if they eventually achieved employment" (pp. 190-191). Given the personal condescension and societal

discrimination that they continue to experience, many people with disabilities are likely to seek affirmation and support from helping professionals like RCs. Therefore, treating consumers with dignity and respect should be a fundamental aspect of all services RCs provide.

## **Counselor's Knowledge and Credentials**

Factual knowledge with which to assist clients' rehabilitation was mentioned much less often by our respondents (14%) as a preferred characteristic of counselors than by Koch's (2001) respondents (41.5%). A probable contribution to this difference is the fact that Koch's respondents were just starting their VR program; hence, they had an immediate need for an informed counselor to maximize their access to resources of the rehabilitation system. The participants in this study had a more distant perspective on such a need. However, in their capacity as members of a self-help organization, many of them also served as resources for newly disabled individuals who were frequently referred to them. Therefore, their expectations and preferences probably reflect not only their personal needs as prospective clients (as they experience new deficits from the interaction of aging and disability), but also their awareness of the expressed needs of these usually younger current clients.

The responses given as a minimum requirement for RCs and coded in the predominant category of Education and Credentials reflected diversity of opinions about the level and type of training that should be required of RCs. Only one respondent listed certification, and five indicated a master's degree, two less than noted a bachelor's degree. The content areas of training that were listed as essential suggest that as many of these consumers would favor a generic human services training curriculum as would favor one specializing in rehabilitation counseling. At the very least, it is evident that a master's degree and certification in rehabilitation counseling was either unfamiliar or unimportant to the vast majority of the respondents, who did not mention it either as an ideal characteristic or a minimum qualification. Similarly, in an analogue study that manipulated three levels of counseling credential (peer counselor, certified RC, licensed mental health counselor), Leierer et al. (1998) found no significant differences in the ratings by adults with disabilities of the attractiveness, expertness, or trustworthiness of a videotaped counselor.

These findings are germane to a controversy over entry-level credentials that the RC profession has had with itself (Evenson & Holloway, 2000) as well as with the state/federal VR agency system (as the major employer of RCs) and the Independent Living Centers (as providers of peer counseling services). Complicating this decades-old disagreement is the fact that accountability has become an increasingly prominent feature of our society in general and the human service professions in particular. The unquestioning deference that professionals like doctors, teachers, and counselors were traditionally accorded has largely been replaced with a consumerist culture that encourages everyone to evaluate the services they receive and to be assertive about getting satisfaction. In light of this cultural trend, it behooves the RC community to (a) be aware of the criteria by which their customers (consumers, employers, service agencies) evaluate them; (b) use these criteria as one source for guiding on-going self-assessment and efforts to demonstrate responsiveness to customers; and (c) be prepared to educate clientele by explaining the larger context or to resolve negotiable differences of expectations and priorities between RC professionals and customers. For example, our findings suggest that increasing RC credibility and acceptance by consumers is much more likely to

be accomplished by communicating caring, committed attitudes during sessions than by adding content and hours to the preservice curriculum or the continuing education requirement.

## **Research Trade-Offs and Limitations**

By the standards of quantitative research, which is designed to test hypotheses statistically and generalize the results from a probabilistic sample, our sample is limited in its (a) representativeness (all respondents lived in Louisiana, had spinal injuries, and were Caucasian); (b) size ( $N = 40$ ); and (c) selection method (24% response rate from an identified self-help group). However, within the paradigm of consensual qualitative research, the nature of our sample is considered acceptable (Creswell, 1994; Gay, 1996; Hill, Thompson, & Williams, 1997; Taylor & Bogdan, 1984). This is because qualitative methodologies focus on the lived experience of purposive, homogeneous, small samples in order to identify relevant variables and discover how meaning is constructed. In the qualitative research tradition of elucidating context in order to enhance understanding of findings, we offer the following observations and information. Our sample is likely to express somewhat more "sophisticated" expectations of RCs than those of the average VR client. We conjecture this based on the following characteristics of our respondents: (a) their relative maturity (mean age of 44), (b) their opportunity to have experienced and "adjusted to" the challenges that disability introduces (mean of 19 years post-onset), and (c) their identification with and promotion of the disability community through active involvement in a chapter of a national self-help organization. Thus, their views of RCs are likely to be more seasoned by experience and perspective than are those of a newly disabled group.

The focus of the research prototypes of ideal and minimally qualified counselors was purposely restrictive, relative to all the components of consumers' rehabilitation that could have been studied. We collected only a modicum of contextual data, such as time since onset of disability, perceived impacts of rehabilitation on respondents' lives, and number of counselors they had had. We did not obtain corroborating information from other sources. For example, we do not know anything about the actual counselors—their work characteristics, qualifications, or values—whom the respondents had. Whether their RCs shaped their expectations and preferences by positive example or by memorable negligence we do not know. Certainly, various extensions of our research effort would be valuable in furthering the understanding of clients' concepts of RCs.

## **CONCLUSION**

This study leads us to suggest two recommendations to those investigating the client-counselor relationship. The first is epistemological: researchers should "triangulate" by employing in each study both quantitative and qualitative methodologies and/or by relying on more than one type of data source (Gay, 1996; Hagner & Helm, 1994; Trevino & Szymanski, 1996). We strongly recommend at least including some opportunity for the participants to respond in their own voice and from their own experience, unconstrained by the conceptual framework and methodological tools chosen and brought to the exchange by the researcher. What often results from that freedom of expression is exemplified in the comparison of the quantitative and qualitative data from this study of ideal counselor characteristics. Mean ratings of the four specified counselor factors demonstrated little differentiation in importance among them. In contrast, free-response descriptions of what was important to the respondents in a counselor revealed a rich collection of factors and higher priorities.

Similarly, Bachelor (1995) concluded from her phenomenological analysis of clients' open-ended descriptions of their therapeutic relationship with their counselor that "theoretician-defined alliance variables are not equally relevant for clients and that some crucial features of the perceived working relationship are not accounted for in current alliance theory" (p. 323). In addition to increasing the practical meaningfulness and validity of findings, qualitative methods are especially suited to research in counseling because of the many parallels both in skills and values that qualitative research and the counseling process share (McCarthy & Leierer, 1999; Merchant & Dupuy, 1996).

Our second suggestion is to give more attention, in research as well as training efforts, to the possibilities represented by advocacy as one of the strategies in the counselor's repertoire. Doing so will require recognizing and remedying systemic disincentives to advocacy by RCs discussed by Murphy (1980), some of which remain institutionalized today. However, the current zeitgeist offers greater opportunity and support for continuing the movement toward comanagement between RCs and their clients that has increasingly been formalized in the regulations and subsequent reauthorizations of the Rehabilitation Act of 1973. Overall, the most resounding message of our respondents was their desire for a counselor to communicate to them that she or he was committed to serving as their advocate while relating to them in an affirming, nurturant way.

## **ABOUT THE AUTHORS**

Henry McCarthy, PhD, CRC, and Stephen J. Leierer, PhD, CRC, are associate professors in the Rehabilitation Counseling Department at Louisiana State University Health Sciences Center in New Orleans. This article is a result of their shared interest in researching the relationship between rehabilitation consumers and providers. Address: Henry McCarthy, Rehabilitation Counseling Department, LSU Health Sciences Center, 1900 Gravier Street, New Orleans, LA 70112-2262; e-mail: hmccar@lsuhsc.edu

## **AUTHORS'NOTES**

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## **NOTE**

A report detailing the phases and processes through which the research team of five coders developed their interpretations and consensus decisions in content-analyzing the data is available from the senior author.

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## **APPENDIX A: CONSENSUAL CATEGORIZATIONS OF CLIENTS' DESCRIPTIONS OF AN "IDEAL" COUNSELOR**

(Listed in descending order of item frequency, with representative responses)

### **Consumer-First Attitude and Advocacy (28.5%, n = 59)**

- someone with empathy who puts my needs ahead of bureaucratic "BS"
  - respecting client's decision when it doesn't agree with program
- a passionate advocate for the human dream
  - someone that won't push you and will let you work at your own pace

### **Nurturing Traits that Promote Counselor-Client Relationship (20%, n = 42)**

- Understanding

- nice and kind
- nonjudgmental
- mentor
- caring
- supportive
- has empathy, not pity or sympathy
- relaxed attitude
- willing to be a friend

### **Knowledge about Disability and Rehabilitation (14%, n = 29)**

- knowledgeable about available services
- has resource information for parents
- someone with understanding of the needs of special equipment
- someone with understanding of the needs of special equipment
- understanding of the "barriers" secondary to disability

### **Professional Standards of Practice (12.5%, n = 26)**

- easy to reach at all times not have casework load that could jeopardize results educate self regarding needs of specific client
- Traits That Promote Efficient Case Management (11%, n = 23)
- willing to find ways to get things done
- straightforward in dealing with issues••clear, direct, honest
- one that makes suggestions on ways to work on problems

### **Facilitative Counseling and Communication Skills (6016, n = 13)**

- must be able to get client to open up feelings
- able to put themselves into the person's condition
- having excellent people skills

### **Disability Experience in Personal Life (4%, n == 8)**

- one that is handicapped so that they understand your plight
- the most important to me is someone who's been there before

### **Educational Background (2.5%, n = 5)**

- formal studies, but only as a base to build on
- Maturity and Professional Experience (1.5%, n = 3)
- a mature individual

## **APPENDIX B: CONSENSUAL CATEGORIZATIONS OF CLIENTS' DESCRIPTIONS OF "ESSENTIAL REQUIREMENTS" FOR REHABILITATION COUNSELORS**

(Listed in descending order of item frequency, with representative responses)

### **Credentials and Educational Achievement (25%, n = 40)**

#### **Level Specified (16)**

Bachelor's Degree (7)

Master's Degree (4)

Associate's Degree (2)

Working toward a Dr.'s degree (1)

Certification (1)

High School Diploma (1)

#### **Content Specified (14)**

Disabilities/Rehabilitation (6)

Counseling (3)

Advocacy (1)

Communication (1)

Psychology (1)

Sensitivity Training (1)

Social Work (1)

#### **Unspecified Endorsement of Education (10)**

- Well-educated
- Good grades at school
- Continuing education

### **Work Ethic and Approach (21 %, n = 33)**

#### **Commitment and Sensitivity to Client (11)**

- Willing to learn from client. Will go an extra mile to help you.
- Someone who sees you as a person and not a patient.

#### **Professional Behavior and Dedication (8)**

- Should not have had a previous job that caused them to be abrupt with others.
- Individual who will respect client's rights of confidentiality.
- A desire for continued education in their field.

### **Competence and Effectiveness (7)**

- I am more interested in ability to produce than rigid educational requirements.
- Good financial management skills.
- Someone who can easily see through to the solution.

### **Active Collaboration with Doctors or Therapists (4)**

- Offer to meet with client and treating physician.

### **Work-Related Conditions (3)**

- Not have an overburdened caseload,

### **Personality Characteristics (175%, n = 28)**

- Understanding
- Honest
- Patient
- Caring
- A-1 personality
- A positive disposition
- Assertive person
- Has punctual habits
- Compassionate but to the point
- Someone who has a zest for life

### **Exposure to Relevant Experience (16%, n = 25)**

#### **Internship or Other Counseling Practice Experience (10)**

- Supervised experience••at least 1 year

#### **Life Experience (incl. "Experience" unspecified) (7)**

- I can see a former basketball coach, business executive, lawyer or convict or housewife being an excellent counselor.

#### **Hands-on Experience Dealing with People with Disability (5)**

- Interaction with disability community

### **Personal or Family Experience Living with a Disability (3)**

- Have had or experienced at some point a disability• self or family

### **Counseling and Communication Skills (11%, n = 17)**

#### **Listening Skills (6)**

- Good listener• "advisor" not "dictator"

#### **Expressive Communication Skills (oral, written, nonverbal) (6)**

- Has good or acceptable writing skills

#### **Interpretation Skills (3)**

- Be able to read an individual's true feelings and needs

#### **Creating a Comfortable Atmosphere for Counseling (2)**

- Contributing to a happy and positive counseling session

### **Disability•Related Knowledge (9%, n = 14)**

#### **Grasp and Appreciation of Disability Issues and Impact (9)**

- Knowledge and ability to help lead people through the confusion which accompanies the onset of disability
- Understanding behaviors of newly disabled clients

#### **Awareness of Community Resources or Rehabilitation Options (5)**

- Knowledge of medical personnel appropriate for disabled

### **Uncodable Comments (2%, n = 3)**

- In the case of your children the parents need help

