Foundations of the Vocational Rehabilitation Process

Fourth Edition

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FOURTH EDITION

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Vocational Rehabilitation Process

To our wives,
Nancy and Janet;
our children,
Penelope, Jenny, Allison,
Jennifer, and Kristin;
and our parents,
Ruth and Frank
and
Kathryn and Ralph.

Preface

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In the fourth edition of *Foundations of the Vocational Rehabilitation Process,* we attempt to provide the historical, philosophical, legislative, and sociological foundations for allocating societal resources to the habilitation/ rehabilitation of persons with disabilities. These foundations are found primarily in Chapters 1 through 6 and 13. In Chapters 7 through 15, we have provided a comprehensive and rigorous overview of the operational procedures of our field. Our understanding of these foundations and procedures has evolved through teaching the introductory rehabilitation course to graduate students in rehabilitation education and through active research in rehabilitation. As our experience has grown, so too has the scope and depth of *Foundations.*

The fourth edition addresses mandates presented in the major pieces of disability legislation of the 1970s, 1980s, and early 1990s. This legislation emphasizes not only vocational, independent living, social, and educational rehabilitation services, but also the removal of environmental barriers and the civil rights of people with disabilities. Only through this dual focus on individual and environment can rehabilitation maximize accessibility to and participation in the mainstream of American society to persons with disabilities. Indeed, the right to this accessibility is the essential message of the fourth edition. Throughout the 15 chapters of the book, the reader encounters this groundswell movement, initiated and nurtured by people with disabilities and their advocates, for equal access to public services, transportation, accommodations, and telecommunications, as well as to economic and educational opportunities. Any environmental barriers to such freedom and responsibility, whether physical or attitudinal, are unacceptable. We believe that disability places normal

persons in abnormal situations and that these abnormal situations often far more limit the exercise of internal control and manifestation of personal competency than the medical, intellectual, or emotional condition ever could.

The legislation of the 1970s, 1980s, and early 1990s calls for (a) greater involvement of individuals with severe disabilities both in the development of their own rehabilitation plan and in the overall design of rehabilitation services, (b) alternative approaches to vocational placement, (c) the provision of independent living services, (d) major expansion of rehabilitation/habilitation services for those individuals with developmental disabilities, and (e) protecting the civil rights of people with disabilities. The implications of these features of recent legislation are many, and are still in the process of being fully understood and acted upon by the field. Hence, the reader will find that the chapters of this book provide both theoretical and practical information to help rehabilitation professionals incorporate the legislative mandates into practice.

The reader will find many changes in the fourth edition. More than 800 references are incorporated in the text, over 300 of which are new references (over 200 have post-1987 publication dates). In addition, over 300 of the references cited in the third edition have been eliminated. Finally, two new chapters have been added to the book. The new Chapter 3, "The Americans with Disabilities Act" (ADA), provides the reader with an overview of the content of the latest antidiscrimination disability policy legislation. The reader is introduced to how the ADA prohibits discrimination on the basis of disability in employment, public accommodations, public services, and telecommunications.

A second new chapter focuses on the societal values and ethical principles that influence the behavior of rehabilitation professionals. Chapter 6 discusses how certain basic values of rehabilitation professionals and of others in American society can be expected to be compatible since both groups are products of the same socialization process. These values, such as physical attractiveness, can limit what rehabilitation professionals see as possible and logical goals for persons with disabilities, as well as limit the opportunities of persons with disabilities to participate fully in everyday life. Chapter 6 also discusses how the ethical principles of beneficence, autonomy, and justice shape the rehabilitation professional's philosophy of helping by influencing their interpretation of the scope of their moral responsibility to their clients.

Chapter 2, "Current Rehabilitation History: 1970–1992" (previously named "The Current Rehabilitation Scene"), has been expanded and updated. It is worthy to note that sections have been added on the Rehabilitation Act Amendments of 1992 and on Social Security Disability Insurance (SSDI) Work Incentives (see section titled "Promoting Fuller Participation in Employment"). It retains comprehensive coverage of sig-

nificant topics such as tracing the history of post-1970 legislation per-taining to accessibility of public transportation by persons with disabili-ties. Civil rights implications of Title V (Sections 501–504) are discussed, as are perspectives comparing the treatment of persons with disabilities with that of other minority groups. Chapter 2 helps the reader under-stand the critical difference between the "minority group" position and the more traditional "functional limitations" position regarding barriers to rehabilitation.

Chapter 4 discusses the philosophical underpinnings of rehabilita-tion, incorporating disability rights topics as well as the traditional argu-ments for rehabilitation services. Many interesting class debates can be planned using the issues in Chapter 4, including the right to medical treatment, the meaning and/or relevance of "quality of life" as a consid-eration in the service provision determination process, and viable argu-ments for independent living and vocational rehabilitation services.

Chapter 5, "Sociological Aspects of Disability," addresses the attitudi-nal and environmental features of handicapism in society. It analyzes the history of society's responses to persons with disabilities to illuminate the major determinants of such treatment. In so doing, Chapter 5 explains the roots of attitudinal barriers that block full integration of persons with disabilities into society. In its attempt to explain society's past and pre-sent responses to persons with disabilities, as well as interpret the predis-posing historical factors that shaped the emergence of rehabilitation services, Chapter 5 draws upon the contents of Chapters 1 and 2. Chap-ter 5 also has been expanded to include multiculturalism as a major sociocultural trend.

Additional information and updated references were added on the four disability types discussed in Chapter 7, "Rehabilitation Clients and Their Needs": physical disabilities, emotional disorders, mental retarda-tion, and learning disabilities. Again we thank Nancy Rubin and Joseph Ashley for their excellent chapter in the second edition, on which the sec-tion on learning disabilities still greatly rests.

The fourth edition also retains the strengths of previous editions in coverage of the role of the rehabilitation counselor and the four-stage re-habilitation process—evaluation, planning, treatment, and placement. Each of the chapters addressing the rehabilitation process has been updated. In addition, we have incorporated emphases from supported employment, such as the importance of situational assessment and inter-ventions at the job site. Rather than being presented as a four-stage process, rehabilitation services are viewed as cyclical in nature. For ex-ample, as people gain experience in a job placement, they may profit from additional vocational evaluation and counseling.

Chapter 11, "Utilizing Rehabilitation Facilities and Support Services," and Chapter 12, "Job Placement," were updated with current information

on professions in the field and on school-to-work transition and supported employment. Although its basic points remain the same, Chapter 13, "Independent Living" (previously named "Independent Living Rehabilitation"), has again been comprehensively updated and revised. It more fully captures the spirit of the independent living movement than did its predecessor in the third edition and provides an updated description of independent living services. We have updated Chapter 14, which was added to the textbook in 1987, to include advances in technology, as well as telephone numbers and addresses of technology information resources, an application of the problem-solving process in the use of technology, and a review of social attitudes and governmental policies that influence the development of assistive technology. The instructor is encouraged to devote at least one class session to exploring technology-related issues and new technological devices. Much of what is referred to as the "handicapping condition" can be removed by creative applications of assistive technology.

As in the "Private Sector Rehabilitation" chapter in the previous edition, Matkin again covers five major topics in the fourth edition: (a) evolution of disability insurance principles, (b) goals of private rehabilitation, (c) private and public sector rehabilitation, (d) working in the private rehabilitation sector, and (e) credentialing and accountability issues. The reader of the fourth edition will find an updated description of the work activities of private sector rehabilitation practitioners and associated knowledge required to perform those activities based on research data collected in 1991. The reader will also find that Matkin reports that "the number of Certified Rehabilitation Counselors working in private-for-profit firms exceeded their counterparts employed in public rehabilitation agencies in 1990 for the first time in the history of the field" (p. 394). A number of other significant updates are found in Chapter 15.

In closing, we call the reader's attention to the outdated sexist and disability language in several of the quotes used in the fourth edition (e.g., "disabled persons"). Because these quotes were taken from "another time and place," they do not reflect an editorial sensitivity to appropriate language. Rather than paraphrase these quotes, we included them as originally written, while at the same time pointing out here the problem associated with them.

Foundations of the Vocational Rehabilitation Process is designed for the first course at the master's level or a senior-level course in a bachelor's program on vocational or independent living rehabilitation. As with the third edition, the fourth edition provides the groundwork for further study of the rehabilitation counseling process as described in the second edition of our textbook entitled *Case Management and Rehabilitation Counseling* (PRO-ED, Austin, TX). When combined in a year-long study of the rehabilitation process, this two-volume set covers (a) the history and

philosophy of rehabilitation, (b) sociological aspects of disability, (c) the characteristics of clients with disabilities, (d) rehabilitation counseling, (e) case management, (f) the rehabilitation process, and (g) descriptions of rehabilitation services.

In terms of inservice applications, *Foundations* offers valuable information to practicing counselors who are dedicated to staying abreast of developments in the field. The book is also a valuable resource for those newly entering the profession who are preparing to become Certified Rehabilitation Counselors (CRCs). Finally, we hope that the fourth edition will assist inservice training directors in their efforts to develop informative training programs for their staff members.

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Historical Roots
of Modern
Rehabilitation Practices

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The history of rehabilitation of people with disabilities focuses on the treatment of individuals who deviate negatively from the majority of society in regard to one or more of the following: physical appearance, physical functioning, intellectual functioning, and behavior. Society's willingness at any point in time to attend to the needs of persons with disabilities has been greatly determined by the perceived cause of the disability, the perceived threat of the disability group to the nondisabled community, the prevailing economic conditions, the existing medical knowledge, and the prevailing sociocultural philosophy. The influence of these factors will become apparent as the history of the treatment of people with disabilities unfolds in the subsequent sections of this chapter.

GREEK AND ROMAN ERAS

Early attitudes toward persons with physical disabilities were far from compassionate. The Greek philosophy of the unity of body and soul, with a blemish on one signifying a blemish on the other (Dickinson, 1961, p. 95), could not have helped but predispose the Greeks to a negative attitude toward persons with disabilities. The extreme manifestation of that negative attitude was found in Sparta where "the immature, the weak, and the damaged were eliminated purposefully" (Nichtern, 1974, p. 14).

Spartan children were considered more the property of the state than of their parents. Whether a newborn child was to be raised or exposed to die was determined "within the first week following birth" by a council of city elders who had closely inspected the child (Preen, 1976, pp. 8–9).

The Spartans, however, had no monopoly on the practice of infanticide in Ancient Greece. In the fourth century B.C., an overpopulated Athens was utilizing exposure of infants with physical disabilities as one means of population control (Preen, 1976). Both Plato and Aristotle sanctioned infanticide, "the former for eugenic, . . . the latter for economic reasons" (Deutsch, 1949, p. 334).

Centuries later in Rome, persons with disabilities fared no better. Romans could legally exterminate puny or deformed children because the newborn child had no rights until officially entering a household 10 days after birth. At that point, the infant was brought to the father who decided whether to admit the child into the family. If rejected, the child "was taken away to be killed or exposed in some lonely place—baskets for this very purpose were offered for sale in the marketplace" (Sand, 1952, p. 350). Some of those unwanted Roman children were disposed of "in sewers located, ironically, outside the Temple of Mercy" (Garrett, 1969, p. 31).

In early Greece, mental illness was considered the result of "divine or demoniacal visitations." Greek mythology contains many references "to madness set down upon human beings by angry and displeased deities" (Deutsch, 1949, p. 5). Because the treatment was logically based on the perceived cause, numerous healing shrines were established and staffed by priest–physicians claiming descent from the gods (Deutsch, 1949, p. 6).

The supernatural etiology was later rejected by Hippocrates (460 B.C. to 370 B.C.), the Greek physician, in favor of a brain pathology and environmental hypothesis. Hippocrates's thesis was at least partially accepted by the Greeks who developed first-rate sanitariums in Alexandria, Egypt, where individuals with a mental illness received humane treatment. These sanitariums provided a pleasant setting where recovery from a mental illness was augmented by the provision of "constant occupation, entertainment, and exercise" (Coleman, 1964, pp. 26–27).

Treatment of persons with a mental illness in Rome was dependent on social class. The well-to-do were likely to receive humane treatment similar to that found in the sanitariums of Greece. However, the remaining Romans who suffered from mental illness were more likely to be treated with brutal methods, including "chaining, flogging, semistarvation diet, and the application of terror and torture" (Sand, 1952, p. 101). Members of the poorer classes with mental illness in both Greece and Rome may have met an even less fortunate fate—being "put to death as undesirable or intolerable burdens, in the absence of public provision for their care" (Deutsch, 1949, p. 11).

From ancient history, little more can be derived than the fact that individuals with mental retardation existed. For all practical purposes, there was a total absence of organized efforts to provide for the "shelter, protection, or training" of persons with mental retardation in Greek or Roman society (Kanner, 1964, p. 3). The only occupation reported for persons with mental retardation in ancient literature was that of the "fool" or "jester" kept in some wealthy Roman households for entertainment purposes (Kanner, 1964, p. 5).

MIDDLE AGES THROUGH THE SEVENTEENTH CENTURY

During the Middle Ages, the world was viewed as a battleground where the angels of God and the infernal demons of Satan fought for the souls of men (Deutsch, 1949, pp. 16–17). Dr. Johann Weyer identified over 7 million demons in the world ready "to cripple, maim, confuse, and destroy men and women" (Obermann, 1965, p. 56). Because disability was frequently seen as either God's punishment or the result of demonic possession, it is not surprising that persons with disabilities "were feared, hated, and often persecuted and tortured as collaborators of the Evil One and bringers of all kinds of misfortune to their towns and their fellow men" (Safilios-Rothschild, 1970, p. 6). The state of medical knowledge did little to ameliorate the situation. Physicians were poorly trained and relatively ineffective. Surgery, which was held in general disrepute, was often conducted by barbers. Progress in medical knowledge was extremely difficult to achieve due to strong public opposition to the dissection of human bodies for anatomical study. "As late as 1750 European medical schools which engaged in this practice were in danger of destruction by irate mobs" (Burns & Ralph, 1958, p. 49).

Mental illness during the Middle Ages was also seen as the result of possession "by the Evil One." Therefore, individuals with a mental illness were treated by monks and priests rather than by physicians (Deutsch, 1949, pp. 16–17). Treatment was located in monasteries where, during the early Middle Ages, gentle and humane methods, such as exorcism via the gentle "laying on of hands," were used. However, as the Middle Ages progressed, cruel treatment methods, such as starving, whipping, and immersion in hot water, were more typically applied to make the body of a person with mental illness a very unpleasant place for a self-respecting devil to reside (Coleman, 1964, pp. 31–32).

By the sixteenth century, the belief that mental illness resulted from possession began to be replaced by the belief that those with mental illness were sick (Coleman, 1964, p. 37). As a result, persons with mental

illness were more likely to be sent to asylums than to monasteries and prisons. Unfortunately, the treatment in these early asylums was often far from therapeutic. It was not unusual for patients to be found chained to the wall in dark cells. In the sixteenth century at the London asylum known as "Bedlam," the "more violent patients were exhibited to the public for one penny a look" (Coleman, 1964, p. 37). Overall, the asylums for persons with mental illness during the sixteenth, seventeenth, and eighteenth centuries were more like prisons than hospitals.

Some of the earliest recorded rehabilitation attempts occurred during this period. A deaf pupil was taught to write in the fifteenth century. During the sixteenth century, deaf pupils were taught "to speak, read, write and understand arithmetic" (Obermann, 1965, p. 64) and "the much more difficult task of teaching a blind deaf-mute by forming the letters on his arm" was achieved (Sand, 1952, p. 409). The seventeenth century saw the development of a controversial two-handed means of communication for individuals who are deaf (Obermann, 1965, p. 65).

Education and training for persons with mental retardation during this period were precluded by society's view of mental retardation as inherited and, therefore, incurable. With the prevailing belief being "Once retarded, always retarded" (Dunn, 1961, p. 14), there was an almost total absence of reference to individuals with mental retardation in the medical literature during this period (Kanner, 1964, p. 7).

REHABILITATION IN EARLY AMERICA

The energies of colonial Americans were devoted primarily to survival. These already overburdened settlers preferred to avoid assuming responsibility for those incapable of self-support in this highly challenging environment. "Laws in the Thirteen Colonies excluded settlers who could not demonstrate an ability to support themselves independently. Immigration policy forbade people with physical, mental, or emotional disabilities to enter the country" (United State Commission on Civil Rights, 1983, p. 18). However, immigration laws do not eliminate the presence of persons with disabilities in a society. Children with disabilities were born in the colonies and some colonists acquired disabilities through illness or injuries. Unfortunately, the outlook for most of these persons with a disability was far from rosy (United States Commission on Civil Rights, 1983, p. 18).

With the typical colonist barely able to scratch out a living from the soil and with disability perceived as the result of God's punishment, conditions were not ripe in Colonial America for the development of rehabilitation programs. In addition, medical practices in the colonies precluded