



CVRP Examination Study Guide©

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Important Note:

This material was based on the April, 2018 CVRP competency listing. As this is a “living document” specific competencies may change over time. Competencies could be added, deleted and/or modified over time. If this document is being used for a study guide for the CVRP examination or other similar purposes, it would be important to contact the College of Vocational Rehabilitation Professionals to assure the most up-to-date listing of competencies.

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Introduction:

The vocational rehabilitation profession in Canada has a long and honoured history. It began in the early twentieth century assisting those injured in World War I return home and become productive members of society. Today, it provides services coast-to-coast, to thousands of individuals with a wide variety of disabling conditions.

One of the greatest strengths of the vocational rehabilitation profession in Canada is that individuals who entered the field came from a wide variety of academic backgrounds. Rather than coming from just one discipline, this merging of disciplines provided a mixing of thoughts from different disciplines which results in the most effective practices for those being served. The fields of psychology, counselling, medical practice and others all added to the knowledge base of vocational rehabilitation professionals.

Even though this mixing of disciplines is a great strength for this profession, it also creates difficulties. One of the most significant difficulties is that it does not assure that all vocational rehabilitation professionals have the same foundational knowledge. In other professions, regardless of geographic location, every member in that discipline has the same base knowledge. In the vocational rehabilitation profession, those who practice in one area of the country may have a different body of knowledge compared to another geographic area. In fact, this difference is so significant, that different vocational rehabilitation professionals in one agency may have a different body of knowledge compared to others in the same agency.

One of the major reasons that the vocational rehabilitation profession differs from other professions is the lack of formalized education in the field. For example, if one wanted to be a psychologist there are a multitude of schools across the country that provide training for the individual. In addition, any individual who follows this academic path is required to pass a rigorous examination process. It is only after years of schooling and testing can the individual call themselves a psychologist.

Unfortunately, in the vocational rehabilitation profession, there are no such requirements. Any individual, no matter their background, training or education can call themselves a vocational rehabilitation professional. As there are no safe-guards on this process, the individuals which could suffer most are those members of the society who are the most vulnerable. At this time individuals who have no experience or training can offer vocational rehabilitation services, which could come with disastrous results.

In order to bring some semblance of order to the field, the College of Vocational Rehabilitation Professionals has developed an examination process which tests the individual on the foundational knowledge of the profession. The examination cannot test competency in the profession, but it can determine if the individual has the knowledge base on which to build competency.

One of the reasons this Study Guide was developed was to assist those individuals who are preparing for the CVRP examination to gain a fuller knowledge of the breadth of the field and areas of knowledge which are being tested.

Another reason for the development of this Study Guide (and the VRAC education modules) was to assist individuals who are:

- New to the profession
- In a situation where there is limited supervision and/or
- Desiring to increase their knowledge of the field

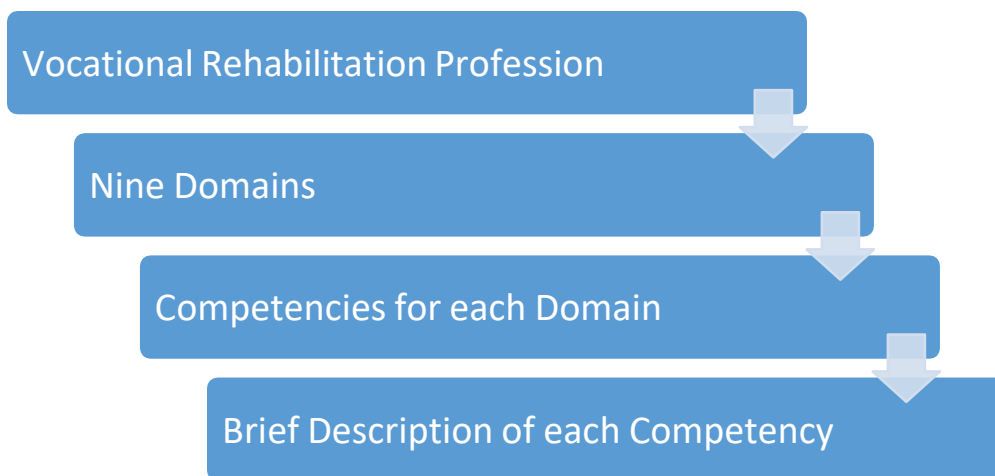
Currently, there are hundreds, if not thousands, of individuals across Canada who are performing the duties of a vocational rehabilitation professional, without a full understanding of the field. Almost every agency that works with those who have a disability, have at least one person assisting their clients into the work force or some form of advanced training. These individuals are undertaking the role of a vocational rehabilitation professional, even if they are not aware that is their role. This Study Guide and associated education modules can provide these individuals with the knowledge they need to undertake their roles more effectively. In the end, this provides it is hoped that this will provide a more effective level of service to their clients.

Structure of Study Guide

The Board of Directors of the College of Vocational Rehabilitation Professionals have determined that there are nine large areas (Domains) of knowledge a VRP needs to have adequate foundational knowledge of the profession:

- Domain One – Vocational Rehabilitation Theory and Practice
- Domain Two – Aspects of Disability
- Domain Three – Vocational Interviewing and Counselling
- Domain Four – Vocational Rehabilitation Assessment and Evaluation
- Domain Five – Diversity and the Vocational Rehabilitation Professional
- Domain Six – Job Development and Placement
- Domain Seven – Case Management and Disability Management
- Domain Eight – Ethical and Professional Conduct
- Domain Nine – Communication and Record Keeping

As can be seen by the titles of these Domains, they are very large and cover considerable areas of knowledge. In this study guide each of the Domains has been broken down into knowledge areas called “competencies”. These competencies go together to make up the knowledge a vocational rehabilitation profession would need to have an adequate grasp of the specific Domain. Further, each of the competencies in this document have a brief description of the meaning of the competency.



FAQ – Study Guide:

- 1. If I go through the Study Guide will I pass the CVRP examination?*

This is probably one of the most important question. This Study Guide should be a supplement to your own knowledge and not the sole source. Each of the sections of this guide could compose entire books and university courses. This Study Guide can serve as a good foundation but will not replace personal knowledge and study.
- 2. Does this Study Guide cover every area of knowledge in the CVRP examination?*

At the time of its writing (March, 2018) this study guide covered every area of knowledge in the CVRP examination. However, the competencies are a living document which change over time. Areas in this guide could be added to, deleted or changed. You need to go to the College's website to obtain the up-to-date listing of competencies.
- 3. Are there an equal number of questions for each Domain?* No, some Domains will have more questions compared to others, based on the perceived importance of the area. For example[,] Domain 1 would be seen as more important for the vocational rehabilitation profession compared to Domain 9.
- 4. How was the information obtained for this Study Guide?*

The Study Guide was based on hundreds of hours of research into best practices in the field of vocational rehabilitation. It has drawn on the expertise of vocational rehabilitation professionals across Canada and the most up-to-date texts in the field. However, even though great care has been taken in its development, as with all human endeavors there is no guarantee that the information is one hundred percent accurate.
- 5. What else do I need to pass the CVRP examination?*

Experience has shown that even those vocational rehabilitation professionals who have years in the field, if they do not study will either get very low marks or fail. For many

vocational rehabilitation professionals they become very familiar with what they are doing in their specific role and organization. They are very effective and proficient in what they do, but do not have an understanding or experience in the larger field of vocational rehabilitation. There are a number of things you could do to enhance the likelihood of passing the examination:

- Study more closely those Domains/Competencies which are outside your present role. For example if you do not work with unions, it would be a good idea to look at the information in Domain Seven. From this basic information you should undertake your personal study of the area and look for additional resources to enhance your knowledge.
- Take the VRAC education modules. These modules have also been constructed to cover each of the competencies. They are an invaluable addition to your studying for the examination. Ideally, if you have time, you should take all the modules. If not, take the ones which you are the weakest.
- Take the VRAC workshops. The one-day examination preparation workshops (if offered in your area) are a quick way to cover material in this Study Guide. As it is only a few hours in length it cannot provide all the information (and certainly not a substitute for your own study). However, it is a good way to brush up on some of the concepts in preparation for the examination.

6. *I haven't been in an examination for years – are there any suggestions to increase my likelihood of passing?*

- Perhaps the most important suggestion is do not start studying for the examination the night before the exam. Plan your time out over a number of weeks to make sure you understand the concepts.
- Get a study partner or study group together to prepare. This is a great way to prepare for the examination. By working with others you can cover a lot more areas and assure your understanding is correct.
- Get a good night sleep the night before. Nothing cuts down on your score like falling asleep in the afternoon while writing the examination.
- The examination is 300 multiple choice; with 150 in the morning and 150 questions in the afternoon. It is a fairly long and intensive examination so be prepared to work hard for a number of hours.
- The answers to the multiple choice exam have been randomized. This means there is no pattern to the answers. You could get 5 “A”s in a row or a series of questions alternating between two letters. If you believe an answer is correct, mark that answer, and don't consider what comes before or after.
- Don't have a heavy lunch between the morning and afternoon sessions. If you have a heavy lunch you may feel sluggish and not do your best (i.e. Have a salad instead of pasta).

- Typically (although not always) your first answer is the right answer. If you think an answer is right, don't spend a lot of time trying to talk yourself out of it.
- Don't get concerned if you are the first one finished a section or the last. Work at your own pace.
- There are four answers to each multiple choice question. Usually, you can rule out one of the answers as obviously wrong. Another of the answers is very probably wrong. This will usually leave you two answers that could be right. If you have absolutely no idea which of the two is right – take a guess. You have a fifty-fifty chance of being right – and wrong answers do not work against you.
- Make sure you put your answers in the right circle on the answer sheet. There have been occasions when someone started answering on the wrong number and went through the rest of the exam with the wrong circles filled in. They probably would have passed the examination without this one (big) error.

7. *There are review questions at the end of each Domain. What is their purpose?*

- The review questions are to assist in learning the material. They are not questions from the CVRP exam, but may give you an idea of the types of questions which may be asked.
- The review questions do not cover every competencies but a sampling of what should be reviewed.
- The review questions are for information only and should not serve as the source of your studies of the CVRP examination.

8. *There is repetition of some material in differing Domains. Why?*

- There are times when specific competencies are applicable to more than one domain. Foreexample information about vocational evaluations (Domain 4) may be needed when looking at Job Placement (Domain 6). There has been an attempt to modify the information to fit the specific Domain; however repetition of information cannot be avoided in some instances.

Thank you for your interest in this Study Guide.

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College of Vocational Rehabilitation Professionals

Domain One

Vocational Rehabilitation Theory and Practice

This is a large and complex domain in that it contains the foundational information of the profession. It includes such areas as: history of vocational rehabilitation profession, models of vocational rehabilitation, the value of vocational rehabilitation (e.g. why do it), theorists (personality and vocational), legal foundation, other professions which provide services to vocational rehabilitation professionals, legal implications (e.g. expert witness), etc.

A. Foundation of Vocational Rehabilitation Profession:

1.1 Define the profession of vocational rehabilitation:

The vocational rehabilitation profession is very unique in its role in providing assistance to those they serve. There are a variety of definitions of the profession:

Vocational rehabilitation is a highly sophisticated profession, grounded by a belief in the dignity and worth of all people and delivered by experts requiring unique multidisciplinary skills, experience, education and training who assist persons with functional, psychological, developmental, cognitive and emotional impairments and health conditions to overcome barriers to accessing, maintaining or returning to employment, to a position in the community and / or to quality of life.¹

Vocational rehabilitation (VR) is a set of services offered to individuals with mental or physical disabilities. These services are designed to enable participants to attain skills, resources, attitudes, and expectations needed to compete in the interview process, get a job, and keep a job. Services offered may also help an individual retrain for employment after an injury or mental disorder has disrupted previous employment.²

...a process that enables people with functional, psychological, developmental, cognitive and emotional impairments or health conditions to overcome barriers to accessing, maintaining or returning to employment or other useful occupation.³

...a dynamic process consisting of a series actions and activities that follow a logical, sequential progression of services related to the total needs of a person with a disability. The process begins with the initial case finding or referral, and ends with the successful placement of the individual in employment. Many activities and developments occur concurrently and in overlapping time frames during this process⁴.

...vocational rehabilitation... (is).. defined... as enabling a disabled person to secure, retain and advance in suitable employment and thereby to further such person's integration or reintegration into society⁵.

Even though there are some differences in these definitions they all reflect commonalities including:

Person's served

The vocational rehabilitation profession historically has provided services for individuals with a disabling condition. In examining the multiple definitions for the profession it is clear that the focus of this profession is to assist individuals with a disability (either mental or physical). The International Labour Organization (oldest department in the United Nations) definition of a disabled person is: *"an individual whose prospects of securing, retaining and advancing in suitable employment are substantially reduced as a result of a duly recognised physical or mental impairment."*

Services provided

The vocational rehabilitation profession provides a variety of services to individuals with disabling conditions to enter, stay in or return to the work force. There is no definitive range of these services; however, history and the literature makes it clear that the (VR) professional should use whatever services necessary to enhance the individuals chances of moving towards successful employment, including, but not limited to, vocational counselling/guidance, placement and employment services.

Goal

The services provided by the vocational rehabilitation profession has a number of goals depending on the needs of the client. These goals include:

- First time entry into the work force.
- Retention within an occupation
- Return to pre-disability occupation or another occupation with client's employer
- Re-entry into the work force with another employer after the onset of a disabling condition

It is recognized that some individuals may not be able to enter or re-enter the work force due to the severity of their disabling conditions. For these clients the goal could be to move them into "avocational" positions which enhance their integration into society. Avocational activities could include unpaid work, volunteer work, etc.

Scope of practice

The vocational rehabilitation process is interdisciplinary by nature, and may involve functional, biopsychosocial, behavioural and / or vocational interventions. It demands due diligence in professional ethics and adherence to the law in practice, reporting, decision-making and application of policy.

The techniques utilized within this process may include, but are not limited to:

- Assessment, evaluation and appraisal;
- Vocational forensic analysis and reporting;
- Life care planning and reporting;
- Goal setting and intervention planning;
- Provision of health advice and promotion, in support of returning to work;
- Support for self-management of health conditions;
- Disability management including:
 - The provision of workplace audits
 - Disability management program development
 - Communication strategies
 - Policy development
 - Return to work coordination
 - Monitoring and other components of disability management
- Career (vocational) counselling;
- Individual and group counselling and other strategies and interventions focused on facilitating adjustments to the physiological and psychosocial impact of disability;
- Counselling, interviewing and interpersonal communications and coaching;
- Case management, referral, facilitation and service coordination;
- Program evaluation and research;
- Interventions to remove environmental, employment, and attitudinal obstacles;
- Consultation services among multiple parties and regulatory systems;
- Job analysis, job development and placement services, including assistance with employment, job accommodations and access to ergonomic solutions; and
- The provision of consultation about and access to rehabilitation technology.⁶

Professional credentials

3.2 Certified vocational rehabilitation professionals will practice only within the boundaries of their competence, based on their education, training, supervised experience, credentials, and appropriate professional experience. Certified vocational rehabilitation professionals will not misrepresent their role or competence.⁷

Credentialing Body	Credentials
College of Vocational Rehabilitation Professionals ⁸	Certified Vocational Rehabilitation Professional (CVRP) – Practicing Fellow, Diplomate Certified Vocational Rehabilitation Professionals – Provisional (CVRP(P)) Certified Vocational Rehabilitation Professionals – Intern (CVRP(I)) Certified Vocational Evaluator (CVE) – Practicing, Fellow, Diplomate
National Institute of Disability Management and Training (NIDMAR) ⁹	Certified Disability Management Professional (CDMP) Certified Return to Work Coordinator (CRTWC)
Commission on Rehabilitation Counselor Certification	Canadian Certified Rehabilitation Counselor (CCRC) Certified Rehabilitation Counselor (CRC)

1.2 Identify the various models of vocational rehabilitation¹:

- **Medical model:** The medical model looks at a person's impairment first and focuses on the impairment as the cause of disabled people being unable to access goods and services or being able to participate fully in society.¹⁰ For the vocational rehabilitation profession, this model would place their services within the rehabilitation phase. The client's diagnosis and prognosis are the central (and sole) consideration for assisting the person's entering or re-entering the work force.

Managed care is an example of a type of medical model. Managed care is often used by insurance systems, where a person's disability is compared to the "typical" individual with the same disabling condition. Prognosis is then delineated on "what would be expected" in similar circumstances. Typical manuals to assist in this process include: *Official Disability Guidelines*, published by the Work Loss Data Institute (Corpus Christi, TX); *Medical Disability Advisor — Workplace Guidelines for Disability*

¹ This section is also covered in Domain 7

Duration, published by the Reed Group Ltd. (Boulder, CO); The *Health Management Guidelines*, published by Milliman & Roberson (Seattle, WA); and the *ACOEM Guidelines*, published by OEM Press (Beverly, MA).

- **Environmental/Social model:** This model identifies the problems faced by disabled people as a consequence of external factors. For example, in the way organisations produce information (not offering a variety of formats such as Braille, large text etc.), or inaccessible venues.¹¹ For the vocational rehabilitation profession, this model places emphasis on external variables that can be modified so that the individual can fully function with their home or work life.
- **Forensic model:** Forensic vocational rehabilitations major focus is on the medico-legal aspects of disabilities. The goal of this model is not necessarily to assist the individual with a disability in entering the work force; rather the goal is to make a determination of the person's employability, future earning capacity, etc.
- **Biopsychosocial model:** The biopsychosocial model is in some respects a combination of the medical and the social models of disability. The vocational rehabilitation profession needs to focus attention on the individual's environment that can be changed to accommodate the disabling condition. They also need to focus on supporting the person's medical condition and working through the rehabilitation process. The biological, psychological and social issues which create barriers to entering or re-entering the work force are important considerations.

1.3 Understand and describe the vocational rehabilitation process¹²

- Vocational rehabilitation should ideally start at the onset of disability – the earlier in the rehabilitation process the vocational rehabilitation professional can begin services, the greater the effectiveness. It is important to begin to fully engage and work with the client at this stage and every step of the vocational rehabilitation process to ensure their input and agreement.
- Intake interview - this interview typically takes place shortly after referral. One of the interview's purposes is to determine the client's subjective view of their disabling condition. Their personal view may differ from the medical opinion which may impact on the individual entering or re-entering the work force. It also provides an opportunity to collect demographic information and begin to build a trust/counselling relationship.
- Vocational assessment - Vocational assessment is the process of determining an individual's interests, abilities and aptitudes and skills to identify vocational strengths, needs and career potential. Vocational assessment may use a variety of

standardized techniques (e.g., tests) or non-standardized approaches (e.g., interviews, observing people). Vocational assessment is part of the vocational guidance process and usually results in recommendations for training or employment¹³.

- Individual Written Vocational Plan (also called Individual Vocational Rehabilitation Plan) - In constructing an [IVRP], the Vocational Rehabilitation Professional is trying to “paint a verbal picture” of the present state of the client and delineate plans for the future. Prior to constructing this report the VRP should have:
 - Obtained appropriate third party professional information. This could include: medical reports, occupational therapy reports, rehabilitation reports, physiotherapy reports, psychological assessments, vocational assessments, etc.
 - Conducted an intake interview with client. The goal of this interview is to obtain subjective information regarding the individual’s view of their past and present situation.
 - Undertaken needed vocational rehabilitation sessions to determine potential future direction(s).

The typical IVRP has the following sections:

- Introductory data – name, claim number etc.
 - Back ground information – similar to the initial report
 - Vocational rehabilitation services provided – this could include the results of vocational rehabilitation counselling, test results, documented medical restrictions/limitations, transferable skills analysis. The intent of this section is to describe clearly the client’s present strengths and limitations.
 - Vocational direction – based on the results of the vocational rehabilitation services this section delineates the chosen client’s chosen vocational direction. There needs to be a clear demonstration how this matches such things as: client’s aptitudes/interests, within worker’s restrictions, wage rate, education requirements, etc.
 - Vocational Rehabilitation Plan – this section outlines the steps needed to move the client from their present situation to the chosen vocational goal. This could include such activities as: job club, resume preparation, job placement, formalized schooling/training, etc. This information should be as complete as possible with a thorough defense of the direction chosen.
-
- Labour market research – this steps is make a determination of such things as the availability of jobs, earning capacity, long term availability, etc. Labour market research could be undertaken prior to the construction of the Initial Written Vocational Plan or as part of the plan.

- Job Coaching – In some instances or significant disability, a direct placement is made of the client into a specific job (could be either pre-disability job or a new job). In some cases a “job coach” could be used to assist the client in learning/mastering the tasks associated with their job.
- Directed job search – As part of the Initial VR Plan, the client and the vocational rehabilitation professional could work together to find an appropriate job placement. This is a more intense process compared to the client looking for work on their own.
- Job modification/accommodation – In some instances cannot directly return to their pre-disability job or a new job due to residual effects of their disability. In many cases a modification/accommodation could be made to their tasks which takes into consideration their limitations (e.g. moving office to main floor, supplying a lifting device, having assistant to help with difficult tasks, etc.).
- Employability assessment – typically this occurs at the end of the return to work process. An employability assessment makes a determination of the present and future capacity within the work force. Often this is used for long-term pension purposes
- There are occasions when an individual has ongoing difficulties related to their disabling condition which goes beyond the end of the vocational rehabilitation process. These ongoing issues may require long-term medical, rehabilitation and their associated costs. In these instances, a “life-care plan” may be required.

1.4 Understand the stages of psychosocial adaptation to disability¹⁴:

Recent research has determined that individuals with chronic illness or injuries go through a series of phases in their adaptation. These adaptations are internally determined, but external events (e.g., counselling, environment changes) are capable of modifying the pace of the psychological reaction. The worker can progress through each of these phases in a consecutive matter, but these reactions usually fluctuate and blend with one another, providing for the experience of more than one reaction at a time. It has also been recognized that some individuals remain in an earlier stage and never progress (e.g., external anger, internal anger.)

The phases of adaptation include¹⁵:

- **Shock:** The initial reaction to the onset of a significant injury or illness is ‘shock.’ Individuals in shock feel mentally numb and confused. They may find it difficult to move about or even speak. The First Aid Attendant who is usually one of the first on the scene of an injury is often confronted with an injured worker who appears

confused and disoriented. This sense of shock is the body's way of dealing with a profound event. There is a distancing of the individual's psyche from the event. This state of shock is usually of limited duration, but can last a few days as the individual begins to understand the extent and severity of their injury.

- **Anxiety:** As the injured or ill worker begins to understand the extent and significance of their injury or illness, there is a panic-stricken reaction. This reaction is marked by confused thinking, a flood of thoughts and concerns, physical reactions (e.g., breathing problems, rapid pulse rate), and purposeless over-activity. The worker is often overwhelmed with medical tests, doctor's appointments, contemplation of forced life-style changes, fear of re-injury or re-occurrence of illness, and medical complications.
- **Denial:** This is a psychological retreat from the realities of the long-term implications of the worker's illness or injury. It involves negation or minimization of the chronic condition and its implications. Individuals may express wishful and unrealistic expectation of recovery. They often choose the information that supports their beliefs but reject anything that goes against what they want to believe.
- **Depression:** Almost all individuals who have experienced an illness or injury that will have long term consequences, experience some level of depression. Injured or ill workers go through 'bereavement' for their loss of body function/part or expected suffering. A depressed individual has feelings of helplessness, hopelessness, despair, isolation and distress.
- **Internalized anger:** This phase manifests itself in self-directed bitterness, resentment and self-blame. The individual looks to their behaviours, life-style or past personal events that caused the present problems. The physical disability is often believed by the individual to be linked to some past transgression. For some this reaction is so strong that it may lead to self-injurious acts or suicidal thoughts.
- **Externalized anger:** Individuals in this phase direct their frustrations towards others, with whom they associate their illness or injury. Often this anger is directed at such institutions as the Workers' Compensation Board, the disability management program, and the long-term disability carrier or against others such as doctors, care providers, family, friends and the return to work practitioner. Statements such as "if it wasn't for the wrong diagnosis..." or "the WCB caused my problems, if only they..." are indicative of a worker during this phase.
- **Acknowledgement:** This is usually the first indication that the worker has reconciled with permanency of their injury or illness. The individual accepts themselves as someone with a disability, gains a new sense of self-concept, reappraises life values

and seeks new meaning and goals. It is a closing of the door on what the person had prior to the accident or injury and focusing on the future.

- **Adjustment:** This is the final step in the adaptation process. During this phase the worker re-establishes a positive self-worth, realizes the existence of remaining and newly-discovered potentials, actively pursues and implements social and vocational goals and finally, successfully overcomes obstacles encountered during the course of pursuing these goals.

1.5 Understand WHO definitions related to disabilities¹⁶:

- **Disability** - a disability is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.
- **Impairment** - any loss or abnormality of psychological, physiological or anatomical structure or function. Impairment is considered to occur at the level of organ or system function. Disability is concerned with functional performance or activity, affecting the whole person.
- **Handicap** - a disadvantage for a given individual, resulting from an impairment or a disability, that limits or prevents the fulfillment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual.

1.6 Understand the types of disabling definitions:

- **Restrictions/limitation** - applies to a physical or mental impairment that may restrict an employee from fulfilling one or more specific job responsibilities¹⁷. This is typically provided by a clinical professional such as medical doctor psychologist, occupational therapist, etc.
- **Permanent/Temporary disability** - Permanent Disability is a phrase used in the insurance industry and in law. Generally speaking, it means that because of a sickness or injury, has a permanent restriction. A temporary disability means that the individual's restrictions/limitations improve over time to a point where the person returns to pre-injury/illness capacity.
- **Total/partial disability** - A total disability is one where the employee is prevented from performing any work at all on account of the injury or condition. Partial disability is defined as any type of disability in which the workers is unable to perform at full physical capacity.

- **Plateau/Maximum medical recovery** – Maximum medical recovery (MMR) means that a plateau in recovery has been reached and it is not likely that there will be any further significant improvement in the work-related injury/disease.
- **Permanent functional impairment** – A permanent functional impairment indicates that the limitations/restrictions which are caused by an injury or illness will not change for the foreseeable future.

1.7 Understand and apply the concept of the return to work hierarchy

The return to work hierarchy varies from jurisdiction to jurisdiction – however, they all have the similar principle of returning the worker with a disability as close to their pre-disability occupation as possible. Every step in the hierarchy should be thoroughly explored prior to moving to the succeeding steps. A general return to work hierarchy is:

- Return to pre-accident/illness occupation
- Return to work in another position with pre-accident/illness employer
- Return to work in same industry
- Return to work with any position in any industry
- Retraining

Some jurisdiction have “self-employment” as an additional step.

1.8 Identify the role of health care professionals:

- **General Practitioner** - A physician whose practice is not oriented to a specific medical specialty but instead covers a variety of medical problems in clients of all ages.
- **Specialists** – This could include such medical practices as cardiologist (heart), endocrinologist (glands/hormones), gastroenterologist (digestion), neurologist (nervous system), oncologist (cancer), etc.
- **Physiatrist** – A medical doctor specializing in physical medicine and rehabilitation.
- **Psychiatrist** – A medical doctor specializing in emotional and mental health difficulties.
- **Psychologist** – A non-medical doctor (holds a PhD) specializing in emotional and mental health difficulties. Also performs cognitive and neuropsychological assessments. Organizational health psychology studies the psychosocial characteristics of workplaces that contribute to health-related problems, e.g. accidental injury, cardiovascular disease, psychological distress, burnout, depression.
- **Physiotherapist** – A therapist who treats injury or dysfunction with exercises and other physical treatments of the disorder.
- **Occupational Therapist** - The role of an occupational therapist is to work with a client to help them achieve a fulfilled and satisfied state in life through the use of "purposeful activity or interventions designed to achieve functional outcomes which

promote health, prevent injury or disability and which develop, improve, sustain or restore the highest possible level of independence.”

- **Massage Therapist** – An individual who practices therapeutic massage.
- **Kinesiologist** - An individual who specializes in understanding anatomically and mechanically how the human body moves.
- **Chiropractor** – An individual who specializes in the hands on or hand-held instrumental movement of the bone structure of the body to improve the function of the joints and/or nervous system.
- **Life Care Planner** – An individual who develops a dynamic document based upon published standards of practice, comprehensive assessment, data analysis and research which provide an organized plan for current and future needs with associated costs for individuals who have experienced catastrophic injury or have chronic health needs.

B. Historic foundations of vocational rehabilitation

1.9 Thomas Gallaudet (1787-1851): principal of first school for deaf in North America. Helped develop American Sign Language¹⁸.

1.10 Dorothea Dix (1824-1880): social reformer for the mentally ill. She was responsible for establishing or enlarging 32 mental hospitals in N. America, Europe, and Japan¹⁹.

1.11 Samuel Gridley Howe (1801-1886): Dr. Howe originated many improvements in teaching methods, as well as in the process of printing books in Braille.²⁰

1.12 Hawthorne effect: Although technically not part of the history of vocational rehabilitation, the “Hawthorne effect” is seen as the initial social service experiment. The original research at the Hawthorne Works in Cicero, Illinois, on lighting changes and work structure changes such as working hours and break times was originally interpreted by Elton Mayo and others to mean that paying attention to overall worker needs would improve productivity. Later interpretations, such as that done by Landsberger, suggested that the novelty of being research subjects and the increased attention from such could lead to temporary increases in workers' productivity. This interpretation was dubbed "the Hawthorne effect".

1.13 Vocational rehabilitation history in Canada

- **World War I – Invalid Soldiers’ Commission – Vocational Branch** – The vocational rehabilitation profession was initially developed in Canada to address the needs of World War I veterans. During World War I, disabled veterans were the responsibility of the Military Hospitals Commission (MHC), but by 1918, the government faced an even greater challenge: the demobilization of Canada’s army

at the end of hostilities. A Department of Soldiers' Civil Re-establishment (DSCR) was established in February 1918 to develop plans for the postwar reintegration of Canadian veterans in society. At the same time, the MHC was renamed the Invalid Soldiers Commission with the ongoing responsibility for the rehabilitation and retraining of the disabled and was absorbed by the new department – the DSCR. Although there would be a continuing role for no-government agencies in the care of war veterans, the development and coordination of policies and programs were now centralized within the federal government. These policies and programs included medical treatment, vocational retraining and assistance in finding employment.

- Canadian Association for the Deaf – 1940 - first and oldest national-level disabled persons' organization in Canada.
- Easter Seals - 1945
- Canadian Paraplegic Association – 1945
- Canadian Association for Community Living – 1948
- March of Dimes – 1951 (Polio)
- Council of Canadians with Disabilities – 1976
- Year of Disabled Persons – Obstacles Report – 1980

C. Canadian and International legislation

1.14 International and National Legislation addressing Vocational Rehabilitation²:

- ***Vocational Rehabilitation and Employment (Disabled Persons) Convention*** (*International Labour Organization, 1983*): Although Canada is not a signatory to this Convention; it is probably one of the most important pieces of international legislation regarding the vocational rehabilitation profession. Part 2 of Convention (159) outlines the obligations of countries in regards to vocational rehabilitation²¹.
- ***International Bill of Human Rights (United Nations 1948)***: Article 23 of this Bill defines a person's right to employment, right to equal pay for equal work, the right to just and favourable remuneration and social protection and the right to form or join trade unions.²²
- ***Declaration of the Rights of Disabled Persons (United Nations 1975)***: This Declaration defines the rights of people with disabilities; the right to measures that encourage self-reliance; the right to treatment, rehabilitation, counselling, placement and other

² Canadian legislation is also covered in Domain 7

services to promote integration into the community and work environment; the right to employment and the right to have special needs taken into consideration²³.

- **Convention on the Rights of Persons with Disabilities:** In 2006 the United Nations passed the *Convention on the Rights of Persons with Disabilities*, to which the Government of Canada along with over one hundred other countries is a signatory²⁴.
- **Constitution Act – 1982:** The Constitution Act, 1982 is a part of the Constitution of Canada. Section 60 states that the Act may be called the Constitution Act, 1982, and that the Constitution Acts can be collectively called the Constitution Acts, 1867 to 1982. The act was introduced as part of Canada's process of patriating the constitution, introducing several amendments to the British North America Act, 1867, and changing the latter's name in Canada to the Constitution Act, 1867.

Part of the Constitution Act is the Charter of Rights and Freedoms. The Canadian Charter of Rights and Freedoms is a bill of rights. The Charter is intended to protect certain political and civil rights of people in Canada from the policies and actions of all levels of government. It exists to unify Canadians around a set of principles that embody those rights. The Charter was preceded by the Canadian Bill of Rights, which was introduced by the government of John Diefenbaker in 1960. However, the Bill of Rights was only a federal statute, rather than a constitutional document. Therefore, it was limited in scope and was easily amendable. This motivated some within government to improve rights protections in Canada. The movement for human rights and freedoms that emerged after World War II also wanted to entrench the principles enunciated in the Universal Declaration of Human Rights. Hence, the government of Prime Minister Pierre Trudeau enacted the Charter in 1982.

Of important note is that the Charter of Rights and Freedoms guarantees the equality of all Canadians, including those with a disability. The Canada Elections Act was specifically aligned to the Charter to allow those individuals with “mental disabilities” to vote.

- **Canadian Human Rights Act²⁵**
 - Scope of Act - The Act applies throughout Canada, but only to federally regulated activities; each province and territory has its own anti-discrimination law that applies to activities that are not federally regulated.
 - Duty to Accommodate - One of the key concepts of the Canadian Human Rights Act is the *duty to accommodate*. The duty to accommodate is the obligation to meaningfully incorporate diversity into the workplace. The duty to accommodate involves eliminating or changing rules, policies, practices and behaviours that discriminate against persons based on a group characteristic, such as race, national or ethnic origin, colour, religion, age, sex (including pregnancy), sexual orientation, marital status, family status and disability.

- Undue hardship - The *Canadian Human Rights Act* requires that clients be accommodated up to the point of undue hardship. Undue hardship describes the limit, beyond which employers and service providers are not expected to accommodate. Undue hardship usually occurs when an employer or service provider cannot sustain the economic or efficiency costs of the accommodation.
- Grounds for discrimination protection - Discrimination against a client can occur if the employer can prove a legitimate business reason (as above). However, they must be able to demonstrate that the workplace rule, policy, standard or criteria relied upon is a “bona fide occupational requirement.”
- **Canadian Multiculturalism Act²⁶** - The Canadian Multiculturalism Act, created for the preservation and enhancement of multiculturalism in Canada, became law on July 21, 1988. It acknowledges the contributions of Canadians of all origins and their communities to the building of Canada and reminds us of the rights and responsibilities of citizenship set out in Canadian legislation. The Canadian Multiculturalism Act encourages us to work together to build a society in which principles of multiculturalism are fully realized.
- **Canada Pension Plan Disability** – To qualify for a disability benefit under the Canada Pension Plan (CPP), a disability must be both “severe” and “prolonged”, and it must prevent the individual from being able to work at any job on a regular basis.
 - **Severe** means that the individual has a mental or physical disability that regularly stops them from doing any type of substantially gainful work.
 - **Prolonged** means that the person’s disability is long-term and of indefinite duration or is likely to result in death.

The Disability Vocational Rehabilitation Program is a voluntary program that helps Canada Pension Plan (CPP) disability benefit recipients return to work.

- **Canada Election Act** - Charter - individuals in mental health and training institutions – Bill C-114 (1993) – allowed individuals with mental disabilities to vote
- **Personal Information Protection and Electronic Documents Act²⁷** - Canadian federal legislation that came into effect on July 1, 1983. The act sets out rules for how institutions of the federal government must deal with personal information of individuals.
- **Obstacles Report** - In respect of the International Year of Disabled Persons – 1981, the Government of Canada appointed an all-party Special Committee on the Disabled and the Handicapped to undertake a comprehensive review of federal legislation pertaining to persons with disabilities. The special committee’s report, *Obstacles*, was the impetus for a number of reforms aimed at promoting the inclusion of persons with disabilities in Canadian society.

After hearing witnesses from every level of government as well as from consumer and service organizations, the Special Committee on the Disabled and the Handicapped made 130 recommendations that touched every aspect of the social, economic and legal situation of persons with disabilities, including human rights, leadership and coordination of disability issues, employment, income, disability supports, access to information and communications, transportation, and issues affecting Aboriginal people with disabilities, among others.

- **Canadian workers' compensation laws:** Workers' compensation is a no-fault insurance program administered by independent provincial boards which protects workers and their dependants/survivors by providing compensation and other benefits to workers who incur occupational injuries and illnesses. Another function is to promote health and safety in workplaces with the goal of preventing illness and injury and facilitate return-to-work and worker recovery. Other services include payment of healthcare costs, rehabilitation services and vocational rehabilitation. Services can differ from province to province
 - Workers' Compensation Boards funding
 - Workers' compensation premiums assessments
 - Worker's compensation accident fund go toward providing what services
 - Wage loss benefits
- **Canada Labour Code** - The Canada Labour Code is an Act of Parliament of the Canadian government to consolidate certain statutes respecting labour. Generally speaking, the code only applies to those industries in which the federal government has jurisdiction instead of the provinces. These industries include: broadcasting, telecommunications, chartered banks, postal service, airports and air transportation, shipping and navigation, interprovincial or international transportation (i.e. road, railway, ferry or pipeline). It also applies to businesses in the Territories, on First Nations reserves, and certain crown corporations.

D. Schools of psychology³

Psychology is the study of the human mind and its functions, particularly as it relates to behaviours. As such it becomes a concern for the vocational rehabilitation professional as they provide service to their clients.

³ Important Note: When describing some of the schools of thought for convenience the term "vocational rehabilitation professional" has been used in place of "counsellor" or "therapist". The assumption is that a vocational rehabilitation professional would not undertake any form of therapy without the appropriate training.

At the present time there are over 40 variant schools of psychology. Some are relevant due to the impact they have had on the entire field (e.g. psychoanalysis); whereas others have had a strong impact on the vocational rehabilitation profession (e.g. behaviourism).

For the practicing vocational rehabilitation professional, understanding some of the major schools of psychology is important as they can provide a basic understanding of why individuals think and behave in a particular manner.

1.14 Understand the basics of Structuralism:

Structuralism as a school of psychology seeks to analyze the adult mind (the total sum of experience from birth to the present) in terms of the simplest definable components and then to find how these components fit together to form more complex experiences as well as how they correlated to physical events. To do this, psychologists employ introspection, self-reports of sensations, views, feelings, emotions, etc.²⁸

- **Wilhelm Wundt** - Wundt founded experimental psychology as a discipline and became a pioneer of cultural psychology. He created a broad research programme in empirical psychology and developed a system of philosophy and ethics from the basic concepts of his psychology – bringing together several disciplines in one person.²⁹ Wundt was important because he separated psychology from philosophy by analyzing the workings of the mind in a more structured way, with the emphasis being on objective measurement and control.
- **Edward Titchener** - Titchener is best known for creating his version of psychology that described the structure of the mind: structuralism. Titchener's ideas on how the mind worked were heavily influenced by Wundt's theory of voluntarism and his ideas of Association and Apperception (the passive and active combinations of elements of consciousness respectively). Titchener attempted to classify the structures of the mind in the way a chemist breaks down chemicals into their component parts—water into hydrogen and oxygen, for example. Thus, for Titchener, just as hydrogen and oxygen were structures, so were sensations and thoughts. He conceived of hydrogen and oxygen as structures of a chemical compound, and sensations and thoughts as structures of the mind. A sensation, according to Titchener, had four distinct properties: intensity, quality, duration, and extent. Each of these related to some corresponding quality of stimulus, although some stimuli were insufficient to provoke their relevant aspect of sensation. He further differentiated particular types of sensations: auditory sensation, for example, he divided into "tones" and "noises." Ideas and perceptions he considered to be formed from sensations; "ideational type" was related to the type of sensation on which an idea was based, e.g., sound or vision, a spoken conversation or words on a page.

Titchener believed that if the basic components of the mind could be defined and categorised that the structure of mental processes and higher thinking could be

determined. What each element of the mind is, how those elements interact with each other and why they interact in the ways that they do was the basis of reasoning that Titchener used in trying to find structure to the mind.

1.15 Understand the basics of behavioural schools of thought

Also called the learning perspective (where any physical action is a behaviour), is a philosophy of psychology based on the proposition that all things that organisms do—including acting, thinking, and feeling—can and should be regarded as behaviours, and that psychological disorders are best treated by altering behaviour patterns or modifying the environment.³⁰ According to behaviourism, individuals' response to different environmental stimuli shapes our behaviours, including career choice. Behaviourists believe behaviour can be studied in a methodical and recognizable manner with no consideration of internal mental states. Thus, all behaviour can be clarified without the need to reflect on psychological mental states. The behaviourist school of thought maintains that behaviours as such can be described scientifically without recourse either to internal physiological events or to hypothetical constructs such as the mind.³¹ Behaviourism comprises the position that all theories should have observational correlates but that there are no philosophical differences between publicly observable processes (such as actions) and privately observable processes (such as thinking and feeling).³²

- **Contiguity theory** - Edwin Guthrie: Guthrie's contiguity theory specifies that "a combination of stimuli which has accompanied a movement will on its recurrence tend to be followed by that movement"³³. According to Guthrie, all learning is a consequence of association between a particular stimulus and response. Furthermore, Guthrie argued that stimuli and responses affect specific sensory-motor patterns; what is learned are movements, not behaviours.

The general principles of Contiguity Theory are:

1. In order for conditioning to occur, the organism must actively respond (i.e., do things).
2. Since learning involves the conditioning of specific movements, instruction must present very specific tasks.
3. Exposure to many variations in stimulus patterns is desirable in order to produce a generalized response.
4. The last response in a learning situation should be correct since it is the one that will be associated.

- *Classical Conditioning*

- *Ivan Pavlov*

Perhaps the most well-known figure associated with classical conditioning is Ivan Pavlov (1849 – 1936). His theory of Classical Conditioning confirms the crucial part that antecedents play in learned behaviour. Unconditioned stimuli produce unconditioned or natural responses, such as Pavlov's dogs salivating at the smell of meat powder. By combining a known stimulus and a natural response with a neutral stimulus such as a ringing bell, Pavlov found dogs would begin to salivate upon hearing the bell alone, a conditioned stimulus producing a conditioned response. Since such classical conditioning creates both behavioural and emotional responses, it is used to explain and treat phobias, anxieties and aberrant behaviours.

- **Conditioned stimulus** - the conditioned stimulus is a previously neutral stimulus that, after becoming associated with the unconditioned stimulus, eventually comes to trigger a conditioned response.
- **Unconditioned stimulus** - In the learning process known as classical conditioning, the unconditioned stimulus (UCS) is one that unconditionally, naturally, and automatically triggers a response.
- **Unconditioned response** - In classical conditioning, an unconditioned response is an unlearned response that occurs naturally in reaction to the unconditioned stimulus. For example, if the smell of food is the unconditioned stimulus, the feeling of hunger in response to the smell of food is the unconditioned response.
- **Conditioned response** - Classical conditioning occurs when a conditioned stimulus (CS) is paired with an unconditioned stimulus (US). ... After pairing is repeated (some learning may occur after only one pairing), the organism exhibits a conditioned response (CR) to the conditioned stimulus when the conditioned stimulus is presented alone.
- **Stimulus generalization** - A conditioned stimulus is repeated along with another like stimulus until the latter alone produces the response. For example, if a child has been conditioned to fear a stuffed white rabbit, it will exhibit fear of objects similar to the conditioned stimulus such as a white toy rat.
- **Extinction** - A conditioned response fades over time as a conditioned stimulus is repeated without the unconditioned, natural stimulus. A teacher has been using positive reinforcement to encourage good behaviour in her classroom. When a student raises his or her hand instead of shouting out the answers, the teacher rewards the student with a fruit-flavored candy. After several days of this, the children become sick of the candy, and stop raising their hands. Because the children have become satiated and the candy is no longer rewarding, extinction of the trained behaviour has occurred.

- **Counter conditioning**- A conditioned stimulus is coupled with another stimulus to evoke a response contrary to that produced by the original stimulus. For example, a dog is afraid of men wearing hats. When a man wearing a hat approaches, the dog is repeatedly fed his favorite food. The goal is to replace the animal's apprehension with the pleasure elicited by the food. Counter-conditioning must be done gradually, however; if the process is rushed, the favorite food may take on the fear association instead.

- *Joseph Wolpe*

Wolpe applied classical conditioning theory to psychotherapy, originating reciprocal inhibition and systematic desensitization. To treat anxiety, he joined relaxation with an anxiety-causing stimulus to render the stimulus harmless.

- **Systematic desensitization** - The process of systematic desensitization occurs in three steps. The first step of systematic desensitization is the identification of an anxiety inducing stimulus hierarchy. The second step is the learning of relaxation or coping techniques. When the individual has been taught these skills, he or she must use them in the third step to react towards and overcome situations in the established hierarchy of fears. The goal of this process is for the individual to learn how to cope with, and overcome the fear in each step of the hierarchy.

- *Operant Conditioning*³⁴

B. F. Skinner (1904-1990)

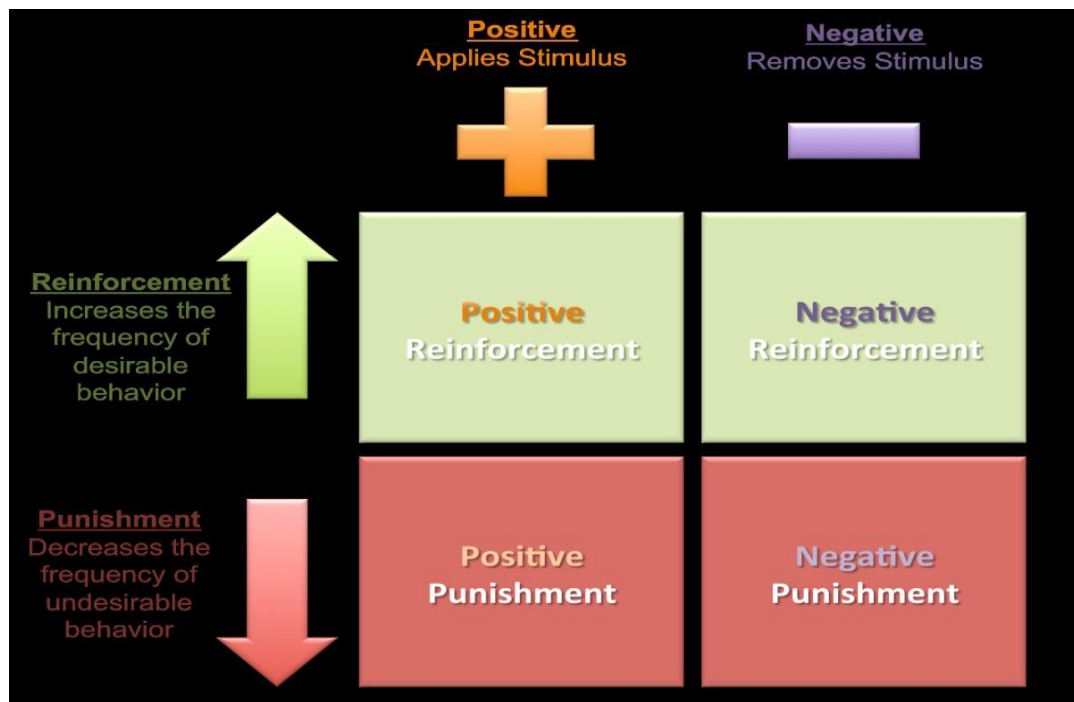
The concept of operant conditioning is one of using consequences to alter the form and frequency of behaviour, focusing on modifying voluntary behaviour. Operant behaviour acts on the environment and is sustained by consequences, whereas classical conditioning is concerned with conditioning respondent behaviours elicited by antecedent conditions. Operant responses can be developed and altered by reinforcing learning and approximations of desired behaviour responses. There are four methods employed in operant conditioning: positive reinforcement, negative reinforcement, positive punishment, and negative punishment³⁵.

- **Positive reinforcement** - the offering of desirable effects or consequences for a behaviour with the intention of increasing the chance of that behaviour being repeated in the future.
- **Negative reinforcement** - is a psychological reinforcement by the removal of an unpleasant stimulus when a desired response occurs.
- **Avoidance learning** - Avoidance learning acts similarly to negative reinforcement except, "the desired behaviour serves to prevent the onset of a noxious stimulus, or in a variant, terminates such a stimulus that already

exists." Criticism from a supervisor could serve as a noxious stimulus. While avoidance learning can serve to be effective in some cases, positive reinforcement is often preferred. Avoidance learning can be seen in the workplace when an employee exhibits the desired behaviour in an effort to avoid the consequence, such as being criticized by one's supervisor.

- **Negative punishment** – Remove what individuals like when they have performed the undesired behaviour
- **Positive punishment** – Give individuals what they do not like when they have performed the undesired behaviour. Positive punishment is what we think of when we think of a "punishment"
- **Extinction** - involves withholding the pleasing stimulus that is maintaining the unwanted behaviour *each time* the behaviour occurs. This happens until the behaviour gradually decreases to zero or the desired level
- **Fixed interval** - Reinforcement is repeated at timely intervals (for example, every 10 seconds)
- **Variable interval** - Reinforcement interval changes (such as reinforcement after 2 seconds, then after 7 seconds, then after 4 seconds and so on)
- **Fixed ratio** - Reinforcement occurs at fixed response intervals (for example, giving reinforcement after every fifth response)
- **Variable ratio** - Reinforcement happens at a rate tied to the number of responses (the actual number of responses to each reinforcement may fluctuate like payments on a capped variable rate mortgage, but the ratio, on average, stays constant)
- **Satiation** - refers to the effectiveness of a consequence being reduced when the source of the stimulant has satisfied the individual or the individual was not 'hungry' for the stimulant
- **Immediacy** - refers to the closeness in time that feedback is given to a response. The more immediate the consequence or feedback, the better the response
- **Contingency** - refers to the schedule of reinforcement or level of consistency of delivery of the consequence following the behaviour consistently over time
- **Size** - refers to the determination the individual makes about the consequence (positive or negative) about whether or not the behaviour is worth the effort
- **Premack principle** - The principle was derived from a study of Cebus monkeys by Professor David Premack, but has explanatory and predictive power when applied to humans. This is evidenced by the fact that therapists use the principle in behaviour modification. Premack's Principle suggests that if a person wants to perform a given activity, the person will perform a less desirable activity to get at the more desirable activity. In behaviourist terms, activities become reinforcers

- **Flooding therapy** - Flooding is a form of behaviour therapy and based on the principles of respondent conditioning. It is sometimes referred to as exposure therapy or prolonged exposure therapy.
- **Token economy** - This method rewards desired behaviours with tokens such as poker chips, stars and scrip that can be saved and traded for reinforcement, such as an outing to a restaurant or a movie.
- **Shaping** - This conditioning is used to encourage specific behaviour by rewarding actions that come increasingly closer to the desired behaviour.
- **Differential reinforcement** - This program combines extinction of unwanted behaviour with positive reinforcement for desirable behaviour.
- **Vicarious conditioning (primary and secondary)** - Dismissed by Thorndike and Watson, vicarious conditioning or learning by observation was later demonstrated by Bandura's work with children. Bandura discovered a child could learn by observing another's experience with classical or instrumental conditioning.
- **Avoidance learning** - Refers to a form of learning that seeks to stop an aversive stimulus or an unpleasant situation by engaging the new or learned behaviour. For example, a spouse may learn to avoid an argument by providing their partner time and space the first hour they are home from work.
- **Noncontingent reinforcement** - The delivery of a reinforcing stimulus on a response independent basis. This element of behavioural therapy is commonly used in addressing aberrant behaviours in persons with developmental disabilities.



1.17 Understand the basics of cognitive-behavioural models:

The key principles in cognitive-behaviour therapy are that maladaptive behaviours are associated with patterns of thinking and response that do not result in mentally healthy outcomes. The focus of the therapy is on the present rather than the past. The central premise is that behaviour is maintained by its consequences:

- Consequences that accelerate behaviours are called reinforcers
- Consequences that decelerate behaviours are called punishers

Cognitive Therapy – Aaron Beck

The cognitive therapy developed by Aaron Beck involves the identification of automatic thoughts (similar to preconscious). Both cognitive therapy and the Beck Depression Inventory utilize a client's thought patterns or cognitive schemas. The negatively oriented internal dialog of depressed individuals results in low self-esteem and negative self-concept. Beck believed a client's difficulties are a result of a distorted construction of reality on three levels:

- View of Self
- View of Experiences
- View of the Future

When a client's thinking is modified, biochemical changes occur in the brain relieving feelings of depression. This therapy is most effective for clients with phobias and/or depression.

Cognitive-behaviour Therapy – Donald Meichenbaum

Working to move clients from self-defeating thoughts to coping ones, Donald Meichenbaum's cognitive-behaviour therapy includes the technique termed "self-talk" in which a client examines automatic illogical thoughts with the intent of changing the underlying assumptions responsible for beliefs and therefore for actions. Stress inoculation is the practice of making positive self-statements. The client keeps a daily journal of dysfunctional thoughts, noting situations and emotions that trigger the irrational beliefs and learning to counter irrational beliefs with rational responses.

Rational-emotive Behavioural Therapy – Albert Ellis

Rational emotive behaviour therapy (REBT), previously called rational therapy and rational emotive therapy, is a comprehensive, active-directive, philosophically and empirically based psychotherapy which focuses on resolving emotional and behavioural problems and disturbance. A fundamental premise of REBT is humans do not get emotionally disturbed by unfortunate circumstances, but by how they construct their views of these circumstances through their language, evaluative beliefs, meanings and

philosophies about the world, themselves and others³⁶. REBT uses a direct confrontational approach as part of counselling technique.

REBT assumes that human thinking, emotion, and action are not really separate or disparate processes, but that they all significantly overlap and are rarely experienced in a pure state. Much of what we call emotion is nothing more nor less than a certain kind — a biased, prejudiced, or strongly evaluative kind — of thought. But emotions and behaviours significantly influence and affect thinking, just as thinking influences emotions and behaviours. Evaluating is a fundamental characteristic of human organisms and seems to work in a kind of closed circuit with a feedback mechanism: First, perception biases response, and the response tends to bias subsequent perception. Also, prior perception appears to bias subsequent perceptions, and prior responses appear to bias subsequent responses. What we call feeling almost always have a pronounced evaluating or appraisal element.

REBT differs from other clinical approaches like psychoanalysis in that it places little emphasis on exploring the past, but instead focuses on changing the current evaluations and philosophical thinking-emoting and behaving in relation to themselves, others and the conditions under which people live.

1.18 Understand the basics of existential psychology:

The key principle in this type of therapy is that psychological dysfunction and mental illness are nonexistent. Any manifestation of “being” is simply an expression of how one chooses to live. The important issues for existential therapists are choices and coming to terms with the resulting anxieties. Focus is on the here-and-now.

The goals of existential therapy are:

- Increase the client's awareness and understanding of goals, purposes and responsibility for personal actions
- Acceptance of freedom
- Use of normal anxiety to promote growth

Logo Therapy – Viktor Frankl

Logo Therapy is founded upon the belief that it is the striving to find a meaning in one's life that is the primary, most powerful motivating and driving force in humans.

The following list of tenets represents basic principles of logo therapy:

- Life has meaning under all circumstances, even the most miserable ones.
- Our main motivation for living is our will to find meaning in life.
- We have freedom to find meaning in what we do, and what we experience, or at least in the stand we take when faced with a situation of unchangeable suffering³⁷.

Self-actualization – Abraham Maslow

Maslow postulated there was a pyramid of “Hierarchy of Needs”.

- At the bottom of the pyramid are the “Basic needs or Physiological needs” of a human being, food and water and sex.
- The next level is “Safety Needs: Security, Order, and Stability.” These two steps are important to the physical survival of the person. Once individuals have basic nutrition, shelter and safety, they attempt to accomplish more.
- The third level of need is “Love and Belonging,” which are psychological needs; when individuals have taken care of themselves physically, they are ready to share themselves with others, such as with family and friends.
- The fourth level is achieved when individuals feel comfortable with what they have accomplished. This is the “Esteem” level, the need to be competent and recognized, such as through status and level of success.
- Then there is the “Cognitive” level, where individuals intellectually stimulate themselves and explore.
- After that is the “Aesthetic” level, which is the need for harmony, order and beauty.
- At the top of the pyramid, “Need for Self-actualization,” occurs when individuals reach a state of harmony and understanding because they have achieved their full potential. Once a person has reached the self-actualization state they focus on themselves and try to build their own image. They may look at this in terms of feelings such as self-confidence or by accomplishing a set goal³⁸.



Trait Theory – Gordon Allport

Allport developed the trait theory of personality. He did this by looking through a dictionary and writing down any terms that described a person's personality. He then divided these terms into 3 types of traits; cardinal, central and secondary.

- **Cardinal trait** - This refers to a trait that dominates the individual's life, personality and behaviours. This type of trait is uncommon because people usually have more than one trait that shapes their lives.
- **Central trait** - These are traits that everyone has to one degree or another.
- **Secondary trait** - These characteristics are unique to the individual.

1.19 Understanding the basics of humanistic psychology: Rejecting determinism and putting an emphasis on subjective meaning and positive growth, humanistic therapy departed from the psychodynamic and behavioural based schools of psychotherapy. Growth and self-fulfillment are the primary focus in humanistic therapy. The unconscious and environmental issues are considered, but freedom of choice in creating one's experience is the key.

The vocational rehabilitation professional interacts with the individual in a genuine and nonjudgmental manner. Using empathy, open-ended responses, reflective listening and hypothetical interpretations, the VRP guides the client to a place where his perceptions of self are more consistent with his actual self.

Multimodal therapy – Arnold Lazarus

Multimodal therapy was founded by Arnold Lazarus. It is a holistic approach with behavioural components broken down into seven classifications of a person's personality termed by the acronym BASIC I.D.:

- **B** Behaviour (habits, actions, reactions)
- **A** Affective response (emotions and moods)
- **S** Sensation (taste, touch, smell, sight, hearing)
- **I** Images (self-concept, memory, dreams)
- **C** Cognitions (constructs, ideas, insights)
- **I** Interpersonal relationships (interactions)
- **D** Drugs (nutrition, biological functions)³⁹

Person-centered therapy – Carl Rogers

Carl Rogers viewed human nature as basically good. He believed that if given the appropriate environment of acceptance, warmth and empathy, the individual would move towards self-actualization. Self-actualization is the motivation that makes the individual move toward growth, meaning, and purpose. The phrase most commonly used with Rogers' approach is "person-centered".

Rogers believed that there are six conditions which are necessary and efficient for personality changes to occur:

- Two persons are in physiological contact
- First, the client is experiencing incongruence
- Second, the vocational rehabilitation professional, is congruent or integrated in the relationship
- The therapist experiences unconditional positive regard or real caring for the client
- The therapist experiences empathy for the client's internal frame of reference and endeavors to communicate this to the client
- The communication to the client is, to a minimal degree, achieved⁴⁰

Roger also believes that there are three characteristics a counsellor needs three characteristics:

- Congruence
- Empathy and
- Unconditional/positive regard

Gestalt psychology – Fritz Perls

Gestalt therapy, founded by Fritz Perls, is a form of psychotherapy that relates to the process of human perception and works on a basic concept of the Gestalt approach (The whole is different from the sum of its parts.) This approach in Gestalt psychotherapy describes the process of perception in addition to the psychic equipment in general. In this theory's view of human nature, the emphasis is on the present and what is happening around the individual.

Gestalt psychology relates to the interconnection of the individual and the increase in awareness where the individual's senses and behaviours merge together. Gestalt therapy was created to help individuals with problem solving. Fritz Perls noticed that the concept of individualism was a positive one but there was also a reverse side to this theory. The people who were looking for the answer to their hopes and dreams looked to Gestalt therapy as the answer which eventually became a weak point in the methodology. He added that for a person to reach their full potential they must build relationships and collaborate with others to reach a common goal and so he created Gestalt psychotherapy.

An example that relates to Gestalt psychotherapy is when you look at an object that has a geometric shape. Human perception views it as a single object as opposed to four lines and four angles which are perceived as the whole in which the final outcome differs from the sum of all the parts. Consequently, this means that the properties of a system must be analyzed in its entirety rather than being described solely on its components.

When Gestalt psychotherapy is applied to human beings it creates a vision of each individual as a whole being that is much greater than the parts that make up the individual. The parts include the individual's body, mind, thoughts, imagination, and movement that are viewed as the entire human being. When looked at from this point of view, you cannot treat one aspect of the individual as the cause of a problem because this means that you would be creating a synthetic fragment of something that in reality, works as a whole.

According to this theory, one of the primary objectives of Gestalt therapy is the ability to restore the self-awareness which is lost when a psychological disorder becomes evident. This is accomplished by restoring the individual's ability to differentiate, which helps the individual to identify what is and what is not a true part of the self, what provides the individual with a sense of self-realization and achievement and what leads to frustration. The person is guided towards a sense of integration, in the search for an appropriate balance in terms of the limit between the self and the rest of the world.

The process of awareness is one of the primary methods used in this approach which focuses on extending the individual's knowledge of self and their understanding of the external environment in every aspect. When this method is applied during Gestalt therapy, awareness is created by the implementation of five principle questions:

1. What do you do?
2. What do you feel?
3. What do you want?
4. What do you avoid?
5. What do you expect?

During Gestalt therapy the individual's awareness starts with multiple levels of examination which begins at the surface and then works through layers to reach the emotions and eventually the cognitive and unstable processes. This is accomplished through the five principle questions as well as non-verbal responses or body language of the individual.

Gestalt therapy assists patients to build up their support for preferred contact or withdrawal. Support means anything making contact or withdrawal achievable, such as energy, support of body, breathing, data, interest in others, language, and et cetera. Support activates means for either contact or withdrawal. For instance, to support the enthusiasm coming with contact, one should have sufficient oxygen.

The Gestalt therapist is occupied with involving the client into dialogue rather than by means of manipulation aimed to reach certain therapeutic goal. The signs of this contact are simple caring, warm attitude, approval and self-responsibility. As therapists lead patients to certain aim, the clients cannot be responsible for their development and self-support. Dialogue is founded on experiencing the individual to make him reveal the real self and share this way phenomenological awareness. The Gestalt therapist explains

what the person means and persuades the client to act the same way. Gestalt dialogue is based on genuineness and responsibility.

Gestalt therapy can help shed light on unfinished business by helping the individual to focus their awareness on their feelings (or lack of feelings) moment to moment. Once they recognize their unfinished business,(i.e. uncomfortable feelings, stuck patterns of behaviour, or ways in which we perceive themselves and others that are based on their experiences as opposed to reality), they are better equipped to understand themselves and to choose whether they want to make changes or not. According to Gestalt psychology the most frequent and worst kind of unfinished business is resentment.

Transactional analysis – Eric Berne

This is a psychoanalytic theory and method of therapy wherein social transactions are analyzed to determine the ego state of the client (whether parent-like, child-like, or adult-like) as a basis for understanding behaviour⁴¹. In transactional analysis, the client is taught to alter the ego state as a way to solve emotional problems. The method deviates from Freudian psychoanalysis which focuses on increasing awareness of the contents of unconsciously held ideas. Eric Berne developed the concept and paradigm of transactional analysis in the late 1950⁴².

1.20 Understand the basics of reality therapy:

William Glasser maintains that people act on a conscious level and that they are not driven by instincts and the unconscious. He felt that there is a health/growth forces in every person that seeks both physical and psychological health/growth. He separates these into the old brain or primitive physical needs and into the new brain or psychological needs. While the old brain contents itself with maintaining life, the new brain seeks belonging, power, freedom and fun.

Reality Therapy teaches that behaviour involves thinking, feeling, doing and physiology.

There are nine basic steps involved in Reality Therapy:

- Having established a friendly relationship, the vocational rehabilitation professional finds out from the client what he/she wants
- Vocational rehabilitation professional and client determine what the client is doing to achieve the desired end
- The vocational rehabilitation professional helps the client evaluate how effective his/her behaviour is to achieve the goal
- The vocational rehabilitation professional helps the client make a plan to gain effective control over the situation/environment
- The vocational rehabilitation professional exacts a commitment to follow through on the plan

- Excuses for failure are not accepted
- If possible, the vocational rehabilitation professional imposes reasonable consequences if the plan is not carried out, such as temporary restrictions of freedom or temporary removal of privileges
- The client is not allowed to control the vocational rehabilitation professional by simply giving up
- If one plan does not work, the vocational rehabilitation professional and client amend it or create another, until the client implements a plan and begins to take control of his/her life

1.21 Understand the basics of psychoanalytic/psychodynamic theories:

These models of therapy originated with Sigmund Freud in which free association, dream interpretation and analysis of resistance and transference are used to explore repressed or unconscious impulses, anxieties and internal conflicts, in order to free psychic energy for mature love and work. Key figures in this area include: Sigmund Freud, Carl Jung, Alfred Adler and Erik Erikson.

Psychoanalytic theory – Sigmund Freud

The term psychoanalysis is used to refer to many aspects of Freud's work and research including Freudian therapy and the research methodology he used to develop his theories. Freud relied heavily upon his observations and case studies of his clients when he formed his theory of personality development.

Freud believed that personality has three structures: the id, the ego and the superego.

The id is the Freudian structure of personality that consists of instincts, which are an individual's reservoir of psychic energy. In Freud's view, the id is totally unconscious; it has no contact with reality.

As children experience the demands and constraints of reality, a new structure of personality emerges – the ego, the Freudian structure of personality that deals with the demands of reality. The ego is called the executive branch of personality because it uses reasoning to make decisions. The id and the ego have no morality. They do not take into account whether something is right or wrong.

The superego is the Freudian structure of personality that is the moral branch of personality. The superego takes into account whether something is right or wrong. The superego can be thought of as our "conscience".

- **Development stages:** Freud believed that individuals progress through a number of developmental stages. He postulated that a person can successfully transition from one stage to the next or “stick” in one particular stage of development.
 - **Oral Stage (Birth to 18 months).** During the oral stage, the child is focused on oral pleasures (sucking). Too much or too little gratification can result in an Oral Fixation or Oral Personality which is evidenced by a preoccupation with oral activities.
 - **Anal Stage (18 months to three years).** The child’s focus of pleasure in this stage is on eliminating and retaining feces. Through society’s pressure, mainly via parents, the child has to learn to control anal stimulation.
 - **Phallic Stage (ages three to six).** The pleasure zone switches to the genitals. Freud believed that during this stage boys develop unconscious sexual desires for their mother. Because of this, he becomes rivals with his father and sees him as competition for the mother’s affection.
 - **Latency Stage (age six to puberty).** It’s during this stage that sexual urges remain repressed and children interact and play mostly with same sex peers.
 - **Genital Stage (puberty on).** The final stage of psychosexual development begins at the start of puberty when sexual urges are once again awakened. Through the lessons learned during the previous stages, adolescents direct their sexual urges onto opposite sex peers; with the primary focus of pleasure is the genitals.

- **Defense mechanisms:** In order to deal with conflict and problems in life, Freud stated that the ego employs a range of defense mechanisms. Defense mechanisms operate at an unconscious level and help ward off unpleasant feelings (i.e., anxiety) or make good things feel better for the individual.
 - **Repression:** this is the unconscious blocking of unacceptable thoughts, feelings and impulses. For example a client “forgetting” sexual abuse from their childhood due to trauma and anxiety.
 - **Reaction Formation:** is the converting of unwanted or dangerous feelings, thoughts or impulses into their opposite. For example a vocational rehabilitation professional having a bias against a culture or race then embracing that culture or race to an extreme.
 - **Projection:** is where the individual assigns their own undesirable emotions and characteristics to another individual. For example, a spouse may be angry at their significant other for not listening, when in fact it is the angry spouse who does not listen.
 - **Sublimation:** this is acting out unacceptable impulses in a socially accepted manner. For example when an individual has sexual impulses they would not like to act upon, they may instead focus on religious activities.

- **Regression:** this is where the individual returns to an early level of development. For example, an individual may regress when under a great deal of stress, refusing to leave their bed and engage in normal activities.
 - **Rationalization:** this is where an individual creates a sensible explanation for an unacceptable or illogical behaviour making it appear acceptable or sensible. For example a client stating that they were fired from a job for not “kissing up” to the boss, when in reality they were fired for poor performance.
 - **Denial:** This is where an individual does not acknowledge an event or situation that may be unpleasant or traumatic. For example, a client denying the medical prognosis regarding their disability and seeking multiple medical opinions.
 - **Displacement:** This is where the energy generated toward a potentially dangerous or inappropriate target is refocused to a safe target. For example, after getting reprimanded by a boss the individual is angry and rather than taking out their aggression on the boss they slam the door on the way out of the office.
 - **Compensation:** This is process of psychologically counterbalancing perceived weakness by emphasizing strengths in other areas. For example a client may say: “I may not be able to complete all the tasks, but the ones I do complete are better than the other workers.”
- **Phobias** - A phobia is an overwhelming and unreasonable fear of an object or situation that poses little real danger but provokes anxiety and avoidance. Unlike the brief anxiety most people feel when they give a speech or take a test, a phobia is long-lasting, causes intense physical and psychological reactions, and can affect your ability to function normally at work or in social settings.
 - **Resistance** – In the context of the field of psychoanalysis, refers to oppositional behaviour when an individual’s unconscious defenses of the ego are threatened by an external source.

Analytic psychology

Carl Jung (1875 – 1961) was heir apparent to Freud until he split with him over the importance Freud placed on sexuality and his own concept of a collective unconscious. Jung proposed and developed the concepts of the extraverted and the introverted personality, archetypes, and the collective unconscious. His work has been influential in psychiatry and in the study of religion, literature, and related fields.

- **Archetypes** - The contents of the collective unconscious are called archetypes. Jung also called them dominants, images, mythological or primordial images, and a few other names, but archetypes seem to have won out over these. An archetype is an unlearned tendency to experience things in a certain way.
- **Collective unconscious** - This is a term coined by Jung. It is proposed to be a part of the unconscious mind, expressed in humanity and all life forms with nervous systems, and describes how the structure of the psyche autonomously organizes experience. Jung distinguished the collective unconscious from the person

unconscious, in that the personal unconscious is a personal reservoir of experience unique to each individual, while the collective unconscious collects and organizes those personal experiences in a similar way with each member of a particular species.

Individual psychology

Alfred Adler (1870 – 1937) examined personality around the same time as Carl Jung and Sigmund Freud. They worked on some theories together until Adler rejected Freud's emphasis on sex, and maintained that personality difficulties are rooted in a feeling of inferiority deriving from restrictions on the individual's need for self-assertion.

Adler believed that one's early experiences as child generate what he called a "worldview." Then, based on this worldview, the child plans for the future by creating "guiding fictions" (future goals). The result is the formation of a "lifestyle" that determines how one interacts with the world. For Adler, a truly effective lifestyle is one that strives for the betterment of society. The alternative is a "mistaken lifestyle," whose job it is for the therapist to correct. Adler did not accept the Freudian notion that persons are victims of their past. Instead, he believed that humans are free to choose their own destiny, which he embraced in his concept of the "creative self." He believed that therapists need to view the world from the client's frame of reference.

Importance of Birth Order in Personal Development: Adler espoused the belief that the birth of each child changed the family substantially. He thought that the birth order of the children in the family influenced many aspects of their personality development.

Briefly, characteristics of these birth positions are:

- *Oldest children* are usually high achievers, parent pleasers, conforming, and are well behaved.
- *Second born* children are more outgoing, less anxious, and less constrained by rules than first borns. They usually excel as what the first born does not.
- *Middle children* have a feeling of being squeezed in and are concerned with perceived unfair treatment. These children learn to excel in family politics and negotiation. However, they can become very manipulative. This position also tends to develop areas of success that are not enjoyed by their siblings.
- The *youngest child* is the most apt at pleasing or entertaining the family. While they run the risk of being spoiled, they are also the most apt at getting what they want through their social skills and ability to please. They are often high achievers, because of the role models of their older siblings.

Psychosocial Development

Erik Erikson (1902 – 1994) was trained as a lay psychoanalyst and his contribution to personality theory was the *epigenetic principle*. This principle states that human development progresses in sequential stages, and that each stage must be satisfactorily

resolved for development to proceed unimpaired to the next. If problems occur at any stage, they will influence and affect development that follows. Erikson's eight stages stretch across the life span, and unlike Freud, who believed everything critical in human development occurred in childhood, Erikson held that significant developmental challenges existed throughout the life cycle.

- Stages of Development:
 - Trust vs mistrust (0 to 1 year)
 - Autonomy vs shame and doubt (1 to 3 years)
 - Initiative vs guilt (3 to 5 years)
 - Industry vs inferiority (5 to 11 years)
 - Identity vs role diffusion (12 to adolescence)
 - Intimacy vs isolation (21 to 40 year)
 - Generativity vs stagnation (40 to 65 years)
 - Integrity vs despair (65 to death)

E. Schools of vocational counselling

1.22 Understand the basics of career counselling:

Career development theories serve as guide for vocational rehabilitation counseling, and by tying together research about career choices and adjustments with ideas about these issues, career development theories provide a conceptual framework within which to view the types of career-related problems that emerge with a client attempting to enter or re-enter the world of work.

In order to determine the relevance of a particular career development theory to their practices, vocational rehabilitation professionals must have confidence in the theory as well as make judgments about the appropriateness and applicability of that theory to their clients' needs. They should also consider their own style of counseling because their theory of counseling is likely to influence their selection of a theory of career development. Most important, they should select a career development theory that is manageable and tentatively easy to draw upon or infer from a vocational counselling session with clients.

An understanding of career development theories will enable vocational rehabilitation professionals to understand various approaches they could use to meet the diverse needs of their clients, especially those about to commit to a new vocational direction. The way counseling theories provide a framework for the conceptualization and rationalization of client problems, career development theories provide a framework with which counselors help with client' vocational adjustment problems.

Hence, career development theories are the foundation of the process of counseling that offers a means of conceptualizing clients' vocational concerns. Although counseling skills are used to provide feedback about vocational assessments and inventories or to give information about occupations, it is career development theories that can assist counselors in providing help to their clients about what the eventual outcome of career counseling could be

A discussion of some of the more prominent theories that have formed the basis for career development and counseling practices including their implications for counseling practitioners follow. The ultimate aim of each theory or framework is to provide explanations of the concepts and principles behind an individual's vocational choice processes.

1.23 Understand the basics of Trait-Factor models of career counselling:

In 1909, Frank Parsons described the concept of vocational guidance in his book *"Choosing a Vocation"*. His views served as the foundation for what later became known as Trait-Factor Theory. The word trait refers to a characteristic of an individual that can be measured through testing. The word factor is a characteristic required for successful job performance. Used together, the terms trait and factor refer to the assessment of characteristics of the person and a specific job.

The writings of Edmund G. Williamson, known as the "Minnesota point of view," epitomize the trait and factor approach. Williamson's methods involve information giving and direct suggestion. According to Williamson, the vocational rehabilitation professional should share his or her wisdom with the client in guiding the client to a correct vocational decision⁴³.

Key Concepts:

Four key assumptions of trait and factor theory⁴⁴:

1. Each individual has a unique set of traits that can be measured reliably and validly.
2. Occupations require that workers possess certain very specific traits for success, although a worker with a wide range of characteristics can still be successful in a given job.
3. The choice of an occupation is a rather forward process, and matching is possible.
4. The closer the match between personal characteristics and job requirements, the greater the likelihood of success (productivity and satisfaction).

The trait and factor approach has been widely used in many programs, including vocational rehabilitation counselling. Parsons identified three steps in the career decision making process in trait and factor theory: 1) gaining self-understanding, 2)

obtaining knowledge about the world of work, and 3) integrating information about oneself and the world of work.

Many of the aptitude, personality and interests tests and occupational information that emerged from this approach have evolved and remain in use today (e.g. True Colours, General Aptitude Test, Data-People-Things Interest Test, and occupational profiles).

1.24 Understand the basics of Holland's Career Typology:

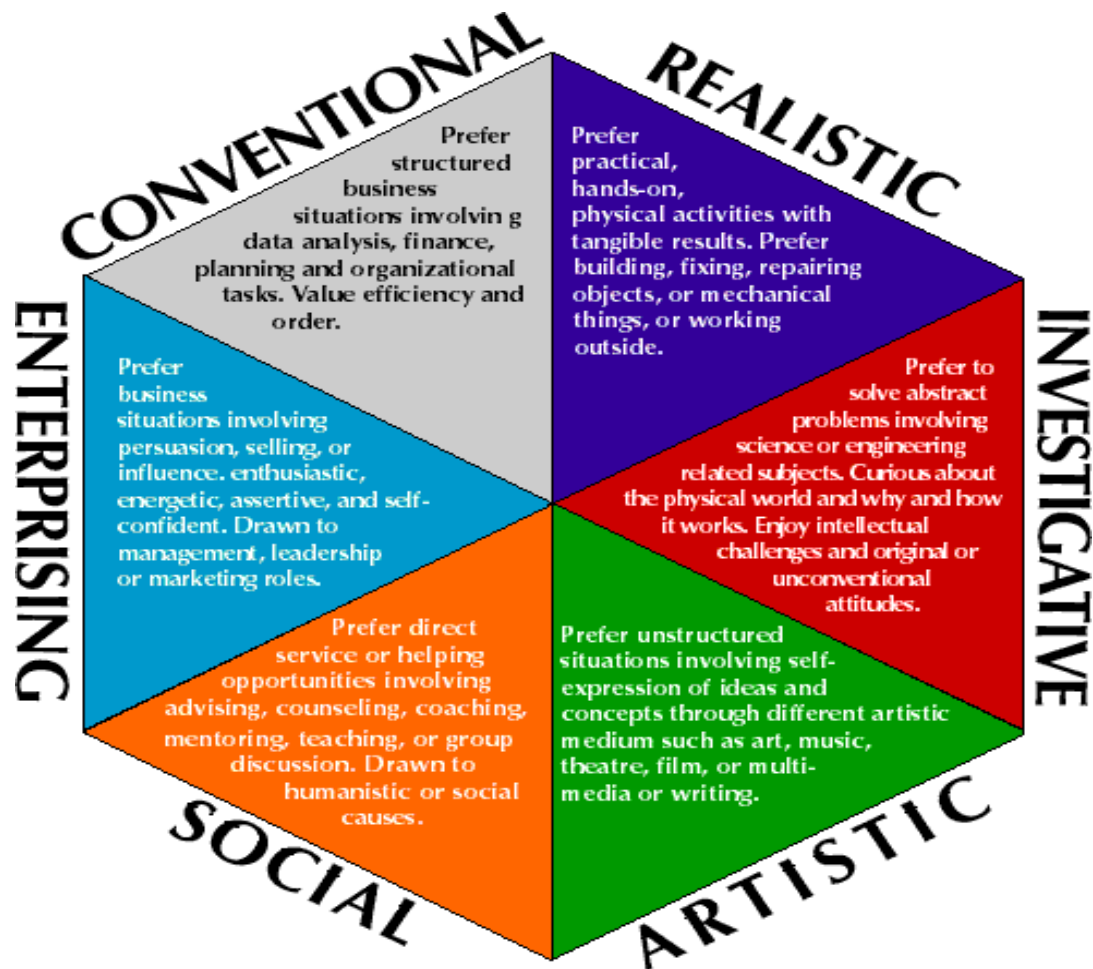
John Holland's model holds that different *personality types* are best suited to different careers. He proposed six basic personality types and then identified careers they were best suited to enter. Holland's model is a modern trait-factor theory that has been very influential in vocational counselling. It is employed by popular interest inventories such as the *Self-Directed Search*, *Vocational Preference Inventory*, and *Strong Interest Inventory*.

Holland's six personality types are arranged along a hexagonal model with opposite work environments across from one another on the hexagon and more closely related work environments next to one another. The Realistic type contrasts most sharply with the Social type, the Investigative with the Enterprising, and the Conventional with the Artistic.

- **Realistic:** These individuals deal best with an environment that is objective and physical. They like stereotypical masculine, outside and hands-on activities. They are most comfortable in work environments dealing with machines, equipment, tools, nature, athletics and crafts. They tend to dislike Social occupations.
- **Investigative:** These individuals deal best with an environment that is intellectual. They enjoy working with ideas, words or symbols. They prefer scientific and theoretical pursuits that can largely be pursued through their individual effort. They tend to dislike Enterprising occupations.
- **Social:** These individuals deal best with an environment that involves working with people in some helping, teaching, or serving capacity. They enjoy social interaction and being around others. They tend to dislike Realistic occupations.
- **Conventional:** These individuals deal best with an environment that is concrete and predictable. They enjoy structure and routine, and often like office practices and computational work. They tend to dislike Artistic occupations.
- **Enterprising:** These individuals deal best with an environment that is adventurous, energizing and challenging. They are extroverted and enjoy power, dominance, and

persuasive communication. Business and supervisory occupations are chosen, and they tend to dislike Realistic occupations.

- **Artistic:** These individuals deal best with an environment that allows for creative self-expression. They like music, drama, literature, fine arts, and other self-expressive activities. They tend to dislike Conventional occupations



1.25 Understand the basics of Super's Life-Span Theory:

The roots of Donald Super's extensive writings on vocational development are in the Self Theory of Carl Rogers. According to Super, when making vocational choices individuals act in relation to their understanding of themselves. Psychologically, career choices are driven by Self-Concepts.

It follows that making satisfying vocational choices requires an accurate understanding of self. This is achieved through Person-Centered values clarification. Understanding self

is the key to making a successful vocational choice. It is also necessary, however, to understand the requirements and work activities of different occupations. If knowledge of any occupation or its demands are inaccurate, that occupation cannot be properly evaluated in relation to one's Self-Concept.

- **Five Stage Psycho-Social Theory of Vocational Development:**
 - **Growth (Birth to 14):** During this period the child is developing physically and psychologically, and is laying the foundation for a self-concept that will be critical to future vocational choices.
 - **Exploration (15 to 24):** Here the individual begins to develop an awareness of occupations. In the early or fantasy period of this phase the individual's choices are frequently unrealistic and related to play life. The tentative period comes next and choices are narrowed, but there is still incomplete knowledge of self and the world of work. In the final period of this phase the individual further narrows the list of possible choices to more realistic goals given improved knowledge of self and the world.
 - **Establishment (25 to 40):** Here the individual is in actual work situations, experiencing some that fit and others that do not. An occupation is selected that offers the best chance to obtain satisfaction.
 - **Maintenance (Middle age to 65):** Here the individual continues in and attempts to improve their situation in a chosen occupation. They try to maximize the satisfying aspects of their work and minimize the unsatisfying aspects.
 - **Decline (65 and over):** This includes the preretirement phase where the individual's attention is on continuing to meet the minimum requirements of the job rather than on enhancing their position. It culminates in leaving the work force.

Although Super originally presented the stages and tasks in a sequential manner, he later added that we cycle and recycle throughout our life span as we adapt to changes in ourselves as well as to the trends in the work place.

1.26 Understand the basics of Bandura's social cognitive career theory:

Social cognitive career theory (SCCT) is a relatively new theory that is aimed at explaining three interrelated aspects of career development: (1) how basic academic and career interests develop, (2) how educational and career choices are made, and (3) how academic and career success is obtained. The theory incorporates a variety of concepts (e.g., interests, abilities, values, environmental factors) that appear in earlier

career theories and have been found to affect career development. Developed by Robert W. Lent, Steven D. Brown, and Gail Hackett in 1994, SCCT is based on Albert Bandura's general social cognitive theory, an influential theory of cognitive and motivational processes that has been extended to the study of many areas of psychosocial functioning, such as academic performance, health behaviour, and organizational development.

Three intricately linked variables—self-efficacy beliefs, outcome expectations, and goals—serve as the basic building blocks of SCCT. Self-efficacy refers to an individual's personal beliefs about his or her capabilities to perform particular behaviours or courses of action. Unlike global confidence or self-esteem, self-efficacy beliefs are relatively dynamic (i.e., changeable) and are specific to particular activity domains. People vary in their self-efficacy regarding the behaviours required in different occupational domains. For example, one person might feel very confident in being able to accomplish tasks for successful entry into, and performance in, scientific fields but feel much less confident about his or her abilities in social or enterprising fields, such as sales. SCCT assumes that people are likely to become interested in, choose to pursue, and perform better at activities at which they have strong self-efficacy beliefs, as long as they also have necessary skills and environmental supports to pursue these activities.

- **Self-efficacy beliefs** are assumed to derive from four primary sources of information: personal performance accomplishments, vicarious experiences (e.g., observing similar others), social persuasion, and physiological and emotional states. Personal accomplishments (successes and failures with specific tasks) are assumed to offer a particularly compelling source of efficacy information, but the nature of the social models and reinforcing messages to which one is exposed, and the types of physiological states one experiences while engaged in particular tasks (e.g., low levels of anxiety), can all affect one's self-efficacy regarding different performance domains.
- **Outcome expectations** refer to beliefs about the consequences or outcomes of performing particular behaviours (e.g., what will happen if I do this?). The choices that people make about the activities in which they will engage, and their effort and persistence at these activities, entail consideration of outcome as well as self-efficacy beliefs. For example, people are more likely to choose to engage in an activity to the extent that they see their involvement as leading to valued, positive outcomes (e.g., social and self-approval, tangible rewards, attractive work conditions). According to SCCT and the larger social cognitive theory, persons' engagement in activities, the effort and persistence they put into them, and their ultimate success are partly determined by both their self-efficacy beliefs and outcome expectations.
- **Personal goals** may be defined as one's intentions to engage in a particular activity (e.g., to pursue a given career) or to attain a certain level of performance (e.g., to move up the corporate ladder). In SCCT, these two types of goals are, respectively, referred to as choice goals and performance goals. By setting goals, people help to organize and

guide their own behaviour and to sustain it in the absence of more immediate positive feedback and despite inevitable setbacks. Social cognitive theory posits that goals are importantly tied to both self-efficacy and outcome expectations: People tend to set goals that are consistent with their views of their personal capabilities and of the outcomes they expect to attain from pursuing a particular course of action. Success or failure in reaching personal goals, in turn, becomes important information that helps to alter or confirm self-efficacy beliefs and outcome expectations.

Self-efficacy, outcome expectations, and goals play key roles in SCCT's models of educational and vocational interest development, choice making, and performance attainment. Interests in career-relevant activities are seen as the outgrowth of self-efficacy and outcome expectations. Over the course of childhood and adolescence, people are exposed, directly and vicariously, to a variety of occupationally relevant activities in school, at home, and in their communities. They are also differentially reinforced for continuing their engagement, and for developing their skills, in different activity domains. The types and variety of activities to which children and adolescents are exposed is partly a function of the context and culture in which they grow up. Depending on cultural norms, for example, girls are typically exposed to and reinforced for engaging in different types of activities than are boys.

Through continued activity exposure, practice, and feedback, people refine their skills, develop personal performance standards, form a sense of their efficacy in particular tasks, and acquire certain expectations about the outcomes of activity engagement. People are most likely to develop interest in activities at which they both feel efficacious and from which they expect positive outcomes. As people develop interest in an activity, they are likely to develop goals for sustaining or increasing their involvement in it. Further activity involvement leads to subsequent mastery or failure experiences, which, in turn, help to revise self-efficacy, outcome expectations, and, ultimately, interests within an ongoing feedback loop.

Interest development may be most fluid up until late adolescence, the point at which general interests (e.g., in art, science, social, or mechanical activities) tend to become fairly stable. At the same time, data on the stability of interests suggest that interest change does occur for some people during their post-adolescent years. SCCT posits that such changes, when they do occur, can be explained by changes in self-efficacy beliefs and/or outcome expectations—more precisely, by exposure to potent new learning experiences (e.g., parenting, technological advances, job training or restructuring) that enable people to alter their sense of self-efficacy and outcome expectations in new occupational and avocational directions.

In sum, people are likely to form enduring interest in an activity when they view themselves as competent at performing it and when they expect the activity to produce valued outcomes. Conversely, interests are unlikely to develop in activities for which people doubt their competence and expect negative outcomes. Furthermore, SCCT

posits that for interests to blossom in areas for which people have talent, their environments must expose them to the types of direct, vicarious, and persuasive experiences that can give rise to robust efficacy beliefs and positive outcome expectations. Interests are impeded from developing when individuals do not have the opportunity to form strong self-efficacy and positive outcome beliefs, regardless of their level of objective talent. Indeed, findings suggest that perceived capabilities and outcome expectations form key intervening links between objective abilities and interests.

1.27 Understand the basics of Krumboltz' Career Choice Theory

The basis of the Krumboltz Career Choice Theory is that humans pick their careers as a result of experiences and influences they have had in their life. These experiences and influences may include a parent, a mentor, a hobby or interest that propels the individual to explore occupations associated with those elements in their life. Influences such as where they live or what is taught to them also play a part, according to the theory⁴⁵.

According to Krumboltz there are three goals of career counselling:

- Altering maladaptive behaviour
- Learning the decision-making process
- Preventing problems

The four main factors that influence career choice are: genetic influences; environmental conditions and events; learning experiences and task approach skills (e.g. self-observation; goal setting and information seeking).

The consequences of these factors and most particularly learning experiences lead people to develop beliefs about the nature of careers and their role in life (self-observational generalizations). These beliefs, whether realistic or not, influence career and work related behaviours.

Learning experiences, especially observational learning stemming from significant role models (e.g. parents, teachers, heroes), have a powerful influence on career decisions, making some occupations more attractive than others.

Positive modelling, reward and reinforcement will likely lead to the development of appropriate planning skills and career behaviour.

Krumboltz saw his theory as a way of explaining the origin of career choice and a guide to how career practitioners⁴ might tackle career related problems. The practitioner starts with understanding how a client came to their career related view of themselves

⁴ The term "career practitioner" is used in this section as it was the term used by Krumboltz.

and the world and what is limiting or problematic about this view. Once this has been established, the practitioner and client identify what career relevant learning experiences, modeling or skill building will help them reframe their view. Using Krumboltz's approach a practitioner plays a major role in dealing with all career problems, not just occupational selection.

1.28 Understand the basics of the Constructive Theory/Models of Career Development:

Constructivist Theory of Career Development is related to existential theory and is more a philosophical framework within which career counselling can be done. Two thinkers associated with this approach are M.L. Savickas and Vance Peavy. Constructivist career development is based on the concepts of "constructivism" which include the following:

- There are no fixed meanings or realities in the world, there are multiple meanings and multiple realities. Individuals create or construct their own meaning/reality of the world through the experiences they have.
- People "construct" themselves and the world around them through the interpretations they make and the actions they take. These "constructs" or perceptions of events may be useful or may be misleading.
- Individuals differ from each other in their construction of events. Two people may participate in the same or similar event and have very different perceptions of the experience.
- People are self-organizing and meaning-makers. Their lives are ever evolving stories that are under constant revision. An individual may choose to develop "new constructs" or write new "stories" in their life.
- To be an empowered or fulfilled person requires critical reflection of the assumptions that account for our daily decisions and actions.

1.29 Understand the basics of Gottfredsons' Circumscription/Compromise Theory:

In contrast to the established notion that choice is a process of selection, Gottfredson's theorised that career choice and development could instead be viewed as a process of elimination or circumscription in which a person progressively eliminates certain occupational alternatives from further consideration. Circumscription is guided by salient aspects of self-concept emerging at different developmental stages. Gottfredson maintained that the career aspirations of children are influenced more by the public (e.g., gender, social class) than private aspects of their self-concept (e.g., skills, interests). A developmental model was proposed consisting of four stages of circumscription. The first is called "orientation to size and power" (ages 3–5), and the child perceives occupations as roles taken up by big people (adults). The second stage is

called “orientation to sex-roles” (ages 6–8), and in this stage sex-role norms and attitudes emerge as defining aspect of a child’s self-concept. The child evaluates occupations according to whether they are appropriate to one’s sex, and eliminates from further consideration alternatives that are perceived to be gender inappropriate (i.e., the wrong sex-type). The third stage is called “orientation to social valuation” (ages 9–13) as social class and status become salient to a child’s developing self-concept. Accordingly, the emerging adolescent eliminates from further consideration occupations that are too low (i.e., occupations with unacceptable prestige levels) or too high (i.e., high prestige occupations beyond one’s efficacy level) in prestige. The fourth stage is called “orientation to the internal, unique self” (ages 14 and above), in which internal and private aspects of the adolescent’s self-concept, such as personality, interests, skills, and values, become prominent. The young adolescent considers occupations from the remaining pool of acceptable occupations according to their suitability or degree of match with one’s internal self.

Another career development process is compromise. In response to external realities and constraints such as changes in the structure of the labour market, economic depression, unfair hiring practices, and family obligations, individuals have to accommodate their occupational preferences so that their eventual choices are achievable in the real world. Compromise is a complex process in which compatibility with one’s interest is often compromised first so as to maintain a greater degree of correspondence with one’s preference for prestige and sex-type.

1.30 Understand the basics of Ginzberg’s Theory of Occupational Choice:

Eli Ginzberg postulated that career decision making is a process. This process happens from puberty through the early 20s. He stated that the process of career decision making is usually irreversible, once crystallized. The resolution of the career choice process is a compromise, according to the theorists.

According to Ginzberg, career decision-making occurs in three phases.

1. **Fantasy:** Takes place until about the age of eleven. Children role play and imagine themselves in various work situations. During this phase, children begin to think about which careers they might like to do in the future.
2. **Tentative:** Children begin to make tentative or preliminary career choices based upon information gathered through the following sub-phases:
 - Interests (Age 11 or 12): The child makes more concrete decisions about him or her likes, dislikes, and interests.
 - Capacity (Age 13 or 14): The teenager becomes more aware of his or her particular abilities as they relate to potential career.
 - Values (Age 15 or 16): The teenager considers their personal values and priorities in life, as well as his or her occupational lifestyle.

- Transition (Age 17 or 18): At this point, the individual becomes aware of the decision for making a vocational choice.
3. **Realistic:** Adolescents start to crystallize and specify occupations of interest. This final phase is made up of the following sub-phases.
- Exploration: After considering options, the individual begins to narrow his or her career choices.
 - Crystallization: The individual commits to a specific career field.
 - Specification: The individual selects a job or professional training program as required by their career of choice.

Later on in his career, Ginzberg stressed that "career choice is a lifelong process of decision-making for those who seek major satisfactions from their work."

According to Ginzberg, the point of his theory is that people make their career decisions which balance their interests and values with the opportunities and talents available, as well as the cost of pursuing the opportunities.

Review:

1. The primary reason an individual would be referred to a vocational rehabilitation profession would be due to difficulties related to:
 - a. Socio-economic issues
 - b. Cultural-linguistic issues
 - c. Disability issues
 - d. Psycho-social issues
2. Which of the following model addresses a person's impairment first and focuses on the impairment as the cause of disabled people being unable to access goods and services or being able to participate fully in society.
 - a. Environmental/Social Model
 - b. Medical Model
 - c. Forensic Model
 - d. Biopsychosocial Model
3. Which of the following is not one of the stages of psycho-social adaptation to a disability:
 - a. Shock
 - b. Depression
 - c. Adjustment
 - d. Pain
4. According to the WHO definition any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being is termed a:
 - a. Disability
 - b. Handicap
 - c. Impairment
 - d. Disadvantage
5. Maximum Medical Recovery (MMR) is:
 - a. A plateau in recovery has been reached and it is not likely that there will be any further significant improvement in the work-related injury/disease.
 - b. The client has returned to the level of functioning they had prior to the onset of their disabling condition.
 - c. The level of recovery needed prior to more extensive rehabilitation procedures (e.g. surgery).
 - d. A plateau in recovery based on the present rehabilitation regime, prior to attempting new rehabilitation processes.

6. Which of the following individuals is a medical doctor dealing with physical medicine and rehabilitation:
 - a. Psychiatrist
 - b. Oncologist
 - c. Physiatrist
 - d. Internist
7. The first Canadian social service agency to provide service and advocacy in support of individuals experiencing a disability was:
 - a. Canadian Association for Community Living
 - b. Easter Seals
 - c. Canadian Association for the Deaf
 - d. Canadian Paraplegic Association
8. The *Canadian Human Rights Act* applies to:
 - a. Only federally regulated activities
 - b. All government activities (i.e. Federal, Provincial and Municipal)
 - c. Only Canadian citizens
 - d. All business operating anywhere in Canada
9. The workers' compensation systems across Canada (e.g. Worksafe BC, WSIB, WCB) are:
 - a. Federally regulated
 - b. Employer regulated
 - c. Insurance company regulated
 - d. Provincially regulated
10. Initially combining a known stimulus and a natural response with a neutral stimulus and then using the neutral stimulus as a conditioned stimulus producing a conditioned response is an example of:
 - a. Operant conditioning
 - b. Negative reinforcement
 - c. Shaping
 - d. Classical conditioning
11. Removing what individuals like when they have performed the undesired behaviour is an example of:
 - a. Positive reinforcement
 - b. Negative punishment
 - c. Negative reinforcement
 - d. Positive punishment

12. The concept that humans do not get emotionally disturbed by unfortunate circumstances, but by how they construct their views of these circumstances through their language, evaluative beliefs, meanings and philosophies about the world, themselves and other, is central to which school of psychology:
- Rational-emotive Behaviourial Therapy
 - Psychoanalysis
 - Existential psychology
 - Logo therapy
13. Which theorist developed the concept of “hierarchy of needs”:
- Ellis
 - Maslow
 - Erikson
 - Freud
14. Carl Rogers viewed human nature as basically:
- Neutral
 - Bad
 - Good
 - Non-existent
15. Which psychology school of thought saw “unfinished business” as important:
- Gestalt psychology
 - Humanistic psychology
 - Multimodal therapy
 - Trait theory
16. “Excuses are not accepted” is one of the key steps in which psychological theory:
- Psychoanalysis
 - Jungian psychology
 - Client centered therapy
 - Reality therapy
17. The act of converting of unwanted or dangerous feelings, thoughts or impulses into their opposite is an example of which type of defense mechanism:
- Repression
 - Sublimation
 - Reaction formation
 - Displacement
18. Which of the following is not one of Erikson’s Stages of Psychosocial Development:
- Autonomy versus shame and doubt
 - Initiative versus guilt
 - Productivity versus sloth
 - Integrity versus despair

19. Which theory states that altering maladaptive behaviour, learning the decision-making process and preventing problems are steps in the career decision making process:
- a. Career Choice Theory – John Krumboltz
 - b. Work Adjustment Theory - Rene Dawis, George England and Lloyd Lundquist
 - c. Career Anchors - Edgar Schein
 - d. Social Cognitive Career Theory - Robert Lent, Steven Brown and Gail Hackett
20. Which theory notes the following as the stages of development: Growth, exploration, establishment, maintenance and decline?
- a. Psycho-social theory of vocational development – Super
 - b. Career decision making – Ginzberg
 - c. Psychoanalytic theory – Roe
 - d. Personality type theory - Holland

Answers

1. Disability Issues - 1.1
2. Medical Model – 1.2
3. Pain – 1.4
4. Disability - 1.5
5. A plateau in recovery has been reached and it is not likely that there will be any further significant improvement in the work-related injury/disease. – 1.6
6. Physiatrist – 1.8
7. Canadian Association for the Deaf – 1.13
8. Only federally regulated activities – 1.14
9. Provincially regulated – 1.14
10. Classical Conditioning – 1.16
11. Negative Punishment – 1.16
12. Rational-emotive Behaviourial Therapy – 1.17
13. Maslow – 1.17
14. Good – 1.18
15. Gestalt psychology – 1.19
16. Reality therapy – 1.19
17. Reaction formation – 1.20
18. Productivity versus sloth – 1.20
19. Career Choice Theory – John Krumboltz 1.21
20. Psycho-social theory of vocational development – Super 1.22

Domain Two

Aspects of Disability

The VR professional must have a clear understanding of the wide range of disabling conditions and their implications for the assisting the client in their movement towards employment. This domain includes: work related injuries and illnesses, non-work related injuries and illnesses, congenital disabilities, physical disabilities and psychological disabilities.

A. Range of Disabling Conditions

2.1 Variety of disabling conditions:

Historically, the vocational rehabilitation professional's clients are those individuals who are experiencing some form of disabling condition. These disabling conditions can come in many forms:

- a. Congenital Disorders: these are disorders which are inherited and may have a significant impact on the individual's ability to successfully enter and/or maintain employment.
- b. Traumatic Injuries: These are injuries that the individual sustains at any point in their life experience. These could include such things as injuries sustain in car accident, sporting accidents, work related accidents, etc. Typically these disabilities occurred without warning and over a short period of time.
- c. Illness/Disease: There are instances where an individual has an illness or disease which creates a disability where a vocational rehabilitation professional's services could be needed. This includes such illnesses/diseases as multiple sclerosis, cancer, AIDS, heart condition, etc.
- d. Degenerative Diseases: A sub type of illnesses/diseases is degenerative diseases. There are instances where an individual has a disease which, over a period of time, increases their disability level. Diseases such as "degenerative disc disease" and some visual problems may take years to develop.
- e. Physical Disabilities: Historically, the vocational rehabilitation profession has provided services to individuals who have experienced a physical disability. Organic damage, no matter the cause, can lead to a disability and the need for VR services.
- f. Psychological Disability: Over the past number of years there has been an increasing emphasis on providing vocational rehabilitation services to those individuals who are

experiencing a psychological disability. This includes such things as: stress, depression, psychosis, post-traumatic stress disorder, etc.

- g. **Work Related Illnesses/Injuries:** Each province in Canada has a Worker's Compensation system to provide services to individuals who experience an illness or injury as a result of their job. These are no-fault systems that are solely paid for by those employers covered by the compensation system.
- h. **Preventative:** There are occasions when the individual is not experiencing a disability at the present time, but there is an indication they could have a disability in the future. For example a person may be diagnosed with a degenerative disorder that may have no present symptoms, but there is indication they will at some future time.

B. Physical Disabilities

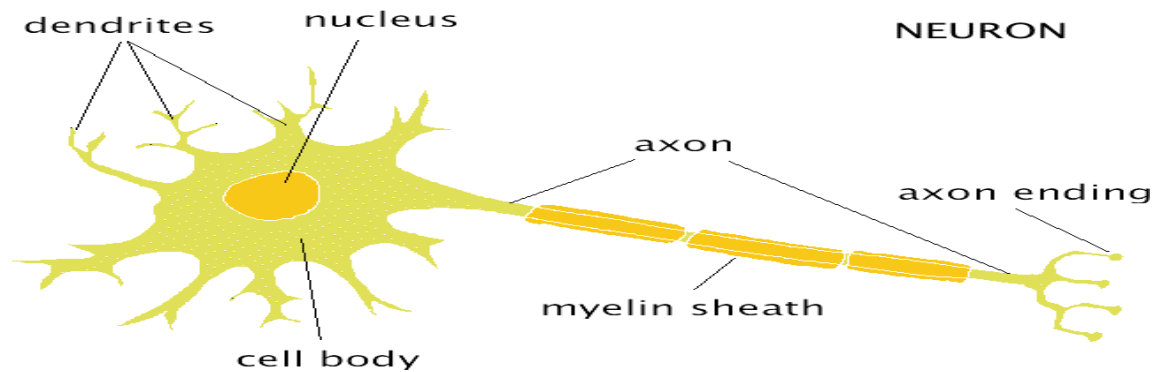
2.2 Nervous System

The human nervous system is a complex union composed of the brain, spinal cord and all associated nerves, ganglia, nuclei and sense organs. This system is responsible for mediating human behaviour.

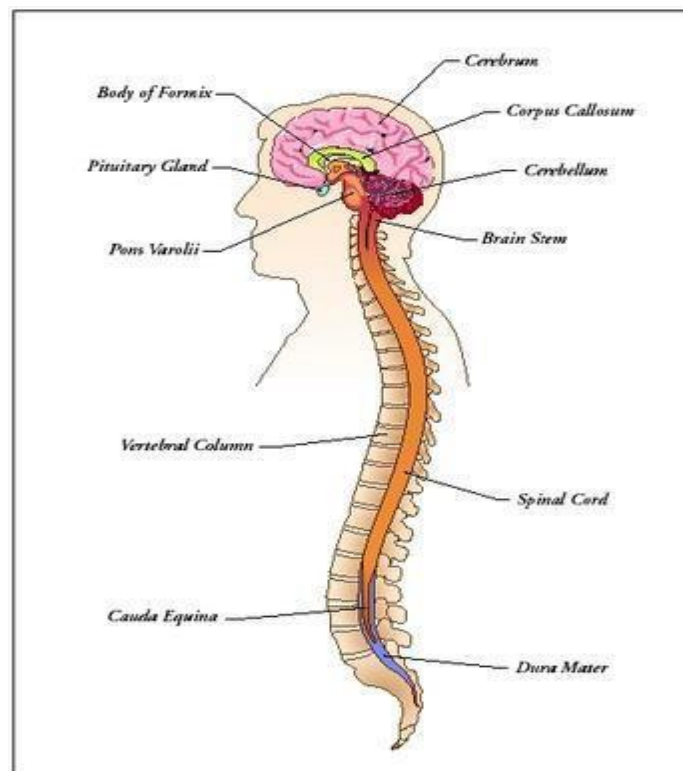
1. *Neuroanatomy*

Nerve cells are like the major roads and highways of a town that connect to other towns, major cities and finally other states. Neurons are a specific type of nerve cell (sort of like how interstates are a specific kind of highway that connects to other states). If we think of neuroanatomy in this way, we will begin to understand and appreciate this basic but yet very complex process that leads to purposeful behaviour.

The two divisions of a neuron are its nerve fibers and its cell body (soma). The center of the cell body is termed the nucleus. On one end of the cell body, you've got an axon (the long stringy thing) that branches out and sends out nerve impulses to other neurons, which the axon is connected to via a synapse (which is where neural transmission, a chemical process takes place). Dendrites are the fibers that receive these neural impulses.



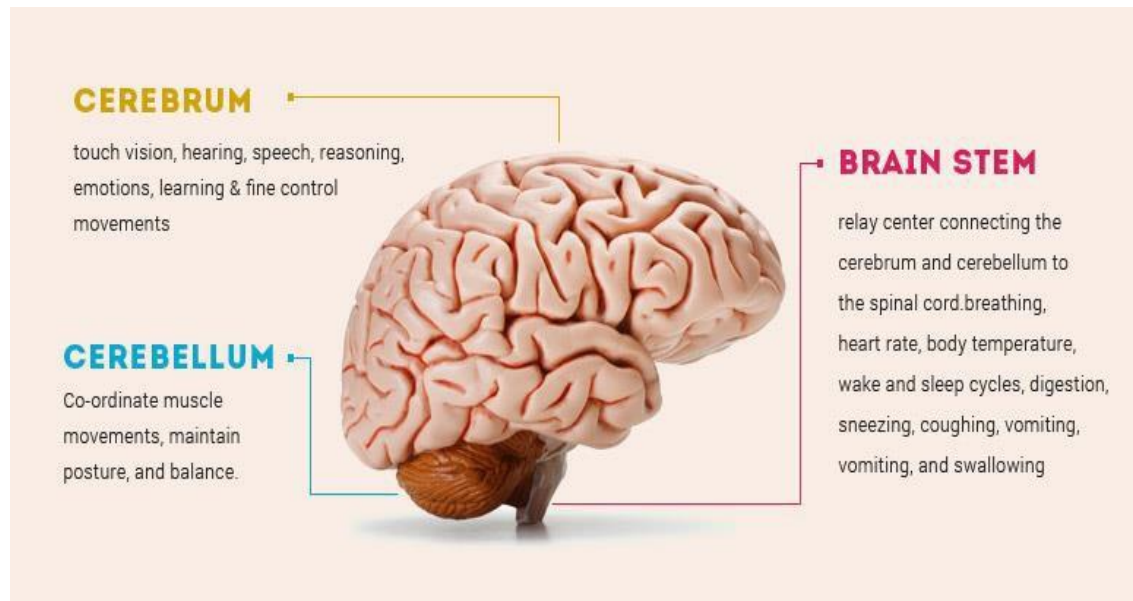
You can think of this in terms of an electrical current (although we know that this is a chemical process) traveling through an extension cord. Think of the dendrites as the prongs of the plug, which are connected to the bulk of the plug (which we can think of as the cell body), and then we have the cord itself (which we can think of as the axon) that plugs into the appliance (which we can think of as the dendrites attached to the body of another neuron). So that, the electrical current is transmitted to the appliance or cell body via dendrites at the synapse, which may then if need be, travel along that neuron's axon and transfer to another set of dendrites of a different neuron. This chemical transfer is facilitated by means of a chemical neurotransmitter, such as acetylcholine, which is primarily responsible for the muscle contractions that lead to movement⁴⁶.



2. The Brain

The brain is composed of the cerebrum, cerebellum, and brainstem.

- The cerebrum is the largest part of the brain and is composed of right and left hemispheres. It performs higher functions like interpreting touch, vision and hearing, as well as speech, reasoning, emotions, learning, and fine control of movement.
- The cerebellum is located under the cerebrum. Its function is to coordinate muscle movements, maintain posture, and balance.
- The brainstem includes the midbrain, pons, and medulla. It acts as a relay center connecting the cerebrum and cerebellum to the spinal cord. It performs many automatic functions such as breathing, heart rate, body temperature, wake and sleep cycles, digestion, sneezing, coughing, vomiting, and swallowing. Ten of the twelve cranial nerves originate in the brainstem.



Right brain – left brain: The right and left hemispheres of the brain are joined by a bundle of fibers called the corpus callosum that delivers messages from one side to the other. Each hemisphere controls the opposite side of the body. If a brain tumor is located on the right side of the brain, your left arm or leg may be weak or paralyzed.

Not all functions of the hemispheres are shared. In general, the left hemisphere controls speech, comprehension, arithmetic, and writing. The right hemisphere

controls perceptual skills such as creativity, spatial ability, artistic, and musical skills. The left hemisphere is dominant in hand use and language in about 92% of people.

Lobes of the brain: The cerebral hemispheres have distinct fissures, which divide the brain into lobes. Each hemisphere has 4 lobes: frontal, temporal, parietal, and occipital (Fig 3). Each lobe may be divided, once again, into areas that serve very specific functions. It's important to understand that each lobe of the brain does not function alone. There are very complex relationships between the lobes of the brain and between the right and left hemispheres.

Frontal lobe

- Personality, behaviour, emotions
- Judgment, planning, problem solving
- Speech: speaking and writing (Broca's area)
- Body movement (motor strip)
- Intelligence, concentration, self-awareness

Parietal lobe

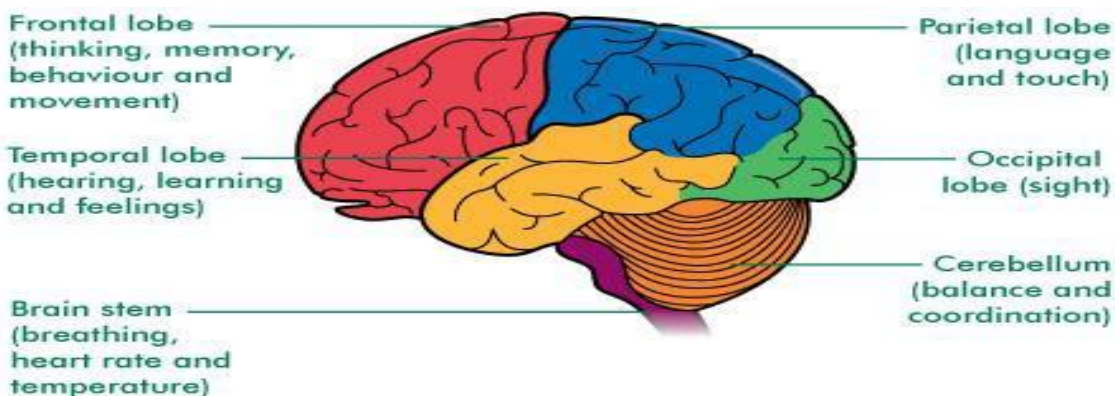
- Interprets language, words
- Sense of touch, pain, temperature (sensory strip)
- Interprets signals from vision, hearing, motor, sensory and memory
- Spatial and visual perception

Occipital lobe

- Interprets vision (color, light, movement)

Temporal lobe

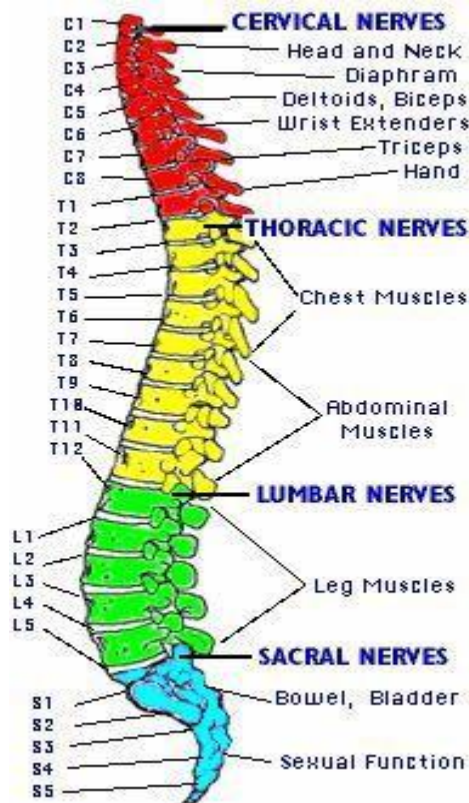
- Understanding language (Wernicke's area)
- Memory
- Hearing
- Sequencing and organization



3. Spinal Column

The spinal column (spinal cord) is made up of 32 to 33 vertebrae. These vertebrae are divided into five sections each with a certain number of vertebrae:

- Cervical (7) C1 - C7
- Thoracic (12) T1 - T12
- Lumbar (5) L1 - L5
- Sacrum/sacral (5) S1 - S5
- Coccyx/coccygeal (3 or 4) Coccyx (fused together)



Level of Injury:

Vertebrae are grouped into sections. The higher the injury on the spinal cord, the more dysfunction can occur.

- High-Cervical Nerves (C1 – C4) Most severe of the spinal cord injury levels. Paralysis in arms, hands, trunk and legs. Individual may not be able to breathe on his or her own, cough, or control bowel or bladder movements. Ability to speak is sometimes impaired or reduced.

When all four limbs are affected, this is called tetraplegia or quadriplegia. Requires complete assistance with activities of daily living, such as eating,

dressing, bathing, and getting in or out of bed. May be able to use powered wheelchairs with special controls to move around on their own. Will not be able to drive a car on their own. Requires 24-hour-a-day personal care.

- Low-Cervical Nerves (C5 – C8) Corresponding nerves control arms and hands. A person with this level of injury may be able to breathe on their own and speak normally.
 - C5 injury - Person can raise his or her arms and bend elbows. Likely to have some or total paralysis of wrists, hands, trunk and legs. Can speak and use diaphragm, but breathing will be weakened. Will need assistance with most activities of daily living, but once in a power wheelchair, can move from one place to another independently
 - C6 injury - Nerves affect wrist extension. Paralysis in hands, trunk and legs, typically. Should be able to bend wrists back. Can speak and use diaphragm, but breathing will be weakened. Can move in and out of wheelchair and bed with assistive equipment. May also be able to drive an adapted vehicle. Little or no voluntary control of bowel or bladder, but may be able to manage on their own with special equipment
 - C7 injury - Nerves control elbow extension and some finger extension. Most can straighten their arm and have normal movement of their shoulders. Can do most activities of daily living by themselves, but may need assistance with more difficult tasks. May also be able to drive an adapted vehicle. Little or no voluntary control of bowel or bladder, but may be able to manage on their own with special equipment
 - C8 injury - Nerves control some hand movement. Should be able to grasp and release objects. Can do most activities of daily living by themselves, but may need assistance with more difficult tasks. May also be able to drive an adapted vehicle. Little or no voluntary control of bowel or bladder, but may be able to manage on their own with special equipment
- Thoracic Nerves (T1 – T5) Corresponding nerves affect muscles, upper chest, mid-back and abdominal muscles. Arm and hand function is usually normal. Injuries usually affect the trunk and legs (also known as paraplegia). Most likely use a manual wheelchair. Can learn to drive a modified car. Can stand in a standing frame, while others may walk with braces.
- Thoracic Nerves (T6 – T12) Nerves affect muscles of the trunk (abdominal and back muscles) depending on the level of injury. Usually results in paraplegia. Normal upper-body movement. Fair to good ability to control and balance trunk while in the seated position. Should be able to cough productively (if abdominal muscles are intact). Little or no voluntary control of bowel or bladder but can manage on their own with special equipment. Most likely use a manual wheelchair. Can learn to drive a modified car. Some can stand in a standing frame, while others may walk with braces.

- Lumbar Nerves (L1 – L5) Injuries generally result in some loss of function in the hips and legs. Little or no voluntary control of bowel or bladder, but can manage on their own with special equipment. Depending on strength in the legs, may need a wheelchair and may also walk with braces. Sacral Nerves (S1 – S5) Injuries generally result in some loss of function in the hips and legs. Little or no voluntary control of bowel or bladder, but can manage on their own with special equipment. Most likely will be able to walk.
- Sacral Nerves (S1 – S5) Injuries generally result in some loss of function in the hips and legs. Little or no voluntary control of bowel or bladder, but can manage on their own with special equipment. Most likely will be able to walk.⁴⁷

4. *Peripheral Nervous System:*

The PNS consists of cranial nerves, spinal nerves, and billions of sensory and motor neurons. The primary function of the peripheral nervous system is to serve as a pathway of communication between the CNS and the rest of the body. While CNS organs have a protective covering of bone (brain-skull, spinal cord - spinal column), the nerves of the PNS are exposed and more vulnerable to injury⁴⁸.

There are two types of cells in the peripheral nervous system. These cells carry information to (sensory nervous cells) and from (motor nervous cells) the central nervous system. Cells of the sensory nervous system send information to the CNS from internal organs or from external stimuli. Motor nervous system cells carry information from the CNS to organs, muscles, and glands.

The motor nervous system is divided into the somatic nervous system and the autonomic nervous system. The somatic nervous system controls skeletal muscle, as well as external sensory organs, such as the skin. This system is said to be voluntary because the responses can be controlled consciously.

Reflex reactions of skeletal muscle, however, are an exception. These are involuntary reactions to external stimuli.

The autonomic nervous system controls involuntary muscles, such as smooth and cardiac muscle. This system is also called the involuntary nervous system. The autonomic nervous system can further be divided into parasympathetic, sympathetic, enteric divisions.

The parasympathetic division functions to inhibit or slow down autonomic activities such as heart rate, pupil constriction, and bladder contraction. The nerves of the sympathetic division often have an opposite effect when they are located within the same organs as parasympathetic nerves. Nerves of the sympathetic division

speed up heart rate, dilate pupils, and relax the bladder. The sympathetic system is also involved in the flight or fight response. This is a response to potential danger that results in accelerated heart rate and an increase in metabolic rate.

The enteric division of the autonomic nervous system controls the gastrointestinal system. It is composed of two sets of neural networks located within the walls of the digestive tract. These neurons control activities such as digestive motility and blood flow within the digestive system.

While the enteric nervous system can function independently, it also has connections with CNS allowing for the transfer of sensory information between the two systems.

5. *Cranial Nerves*

Cranial nerves are the nerves that emerge directly from the brain (including the brainstem), in contrast to spinal nerves (which emerge from segments of the spinal cord).⁴⁹ 10 of 12 of the cranial nerves originate in the brainstem. Cranial nerves relay information between the brain and parts of the body, primarily to and from regions of the head and neck.⁵⁰

A brief description of the 12 cranial nerves:

1. **Olfactory:** This is a type of sensory nerve that contributes in the sense of smell in human beings. These basically provide the specific cells that are termed as olfactory epithelium. It carries the information from the nasal epithelium to the olfactory center in brain.
2. **Optic:** This is a type of sensory nerve that transforms information about vision to the brain. To be specific this supplies information to the retina in the form of ganglion cells.
3. **Oculomotor:** This is a form of motor nerve that supplies to different centers along the midbrain. Its functions include superiorly uplifting the eyelid, superiorly rotating the eyeball, constriction of the pupil on the exposure to light and operating several eye muscles.
4. **Trochlear:** This motor nerve also supplies to the midbrain and performs the function of handling the eye muscles and turning the eye.
5. **Trigeminal:** This is a type of the largest cranial nerve in all and performs many sensory functions related to the nose, eyes, tongue and teeth. It basically is further divided in three branches that are ophthalmic, maxillary and mandibular nerve. This is a type of mixed nerve that performs sensory and motor functions in the brain.
6. **Abducens:** This is a type of motor nerve that supplies to the pons and performs the function of turning the eye laterally.
7. **Facial:** This motor nerve is responsible for different types of facial expressions. This also performs some functions of sensory nerve by supplying information

about touch on the face and senses of tongue in mouth. It is basically present over the brain stem.

8. **Vestibulocochlear:** This motor nerve is basically functional in providing information related to balance of head and sense of sound or hearing. It carries vestibular as well as cochlear information to the brain and is placed near the inner ear.
9. **Glossopharyngeal:** This is a sensory nerve which carries sensory information from the pharynx (initial portion of throat) and some portion of tongue and palate. The information sent is about temperature, pressure and other related facts.'

It also covers some portion of taste buds and salivary glands. The nerve also carries some motor functions such as helping in swallowing food

10. Vagus

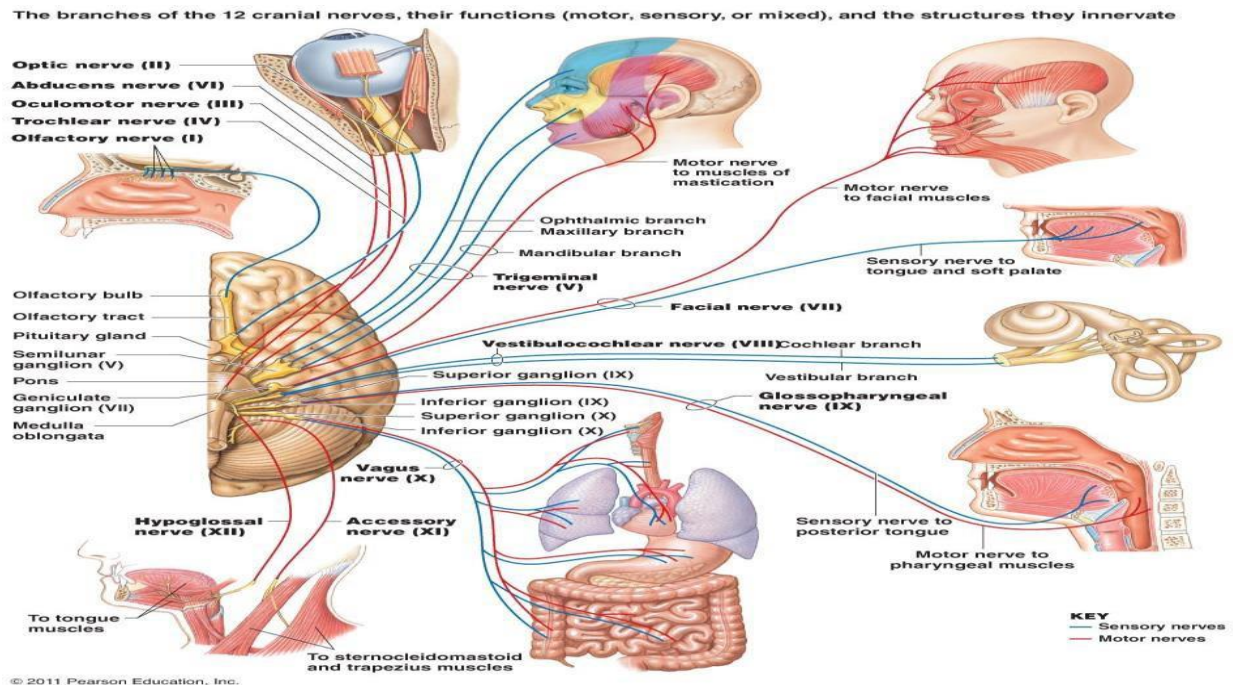
This is also a type of mixed nerve that carries both motor and sensory functions. This basically deals with the area of the pharynx, larynx, esophagus, trachea, bronchi, some portion of heart and palate. It works by constricting muscles of the above areas. In sensory part, it contributes in the tasting ability of the human being.

11. Spinal accessory

As the name intimates this motor nerve supplies information about the spinal cord, trapezius and other surrounding muscles. It also provides muscle movement of the shoulders and surrounding neck.

12. Hypoglossal

This is a typical motor nerve that deals with the muscles of tongue.⁵¹



2.3 Pain

Often the issue of pain is a key barrier in developing a successful return-to-work plan with an injured worker. There is not always a direct correlation between the physical damage of the workers' injuries and the amount of pain they feel. Many vocational rehabilitation professionals have cases where the individual's objective medical findings are apparently quite minor compared to the extent of the worker's subjective pain reports.

- *Acute pain* is caused by a very specific, identifiable incident that has occurred in the recent past (e.g., stubbing one's toe or straining muscles in the back). Pain warns the individual to cease or limit the action that could cause additional tissue damage. Acute pain is characterized by an identifiable cause, short duration, sudden onset, well-defined locus, decrease in severity and frequency with healing, and objective signs and symptoms sometimes accompanied by anxiety. In providing services to an injured worker, acute pain is typically not problematic. It is easily identifiable and time limited. As workers go through the rehabilitative process, their pain will abate.
- *Subacute pain (one to three months)* is somewhere between acute and chronic. It is more than acute but less than chronic pain.
- *Chronic pain* is long-lasting and can create numerous secondary problems. Chronic pain is characterized by a cause that is difficult to find, duration longer than several months, gradual onset and persistence, a locus that may or may not be well-defined, persistence beyond healing, feeling of exhaustion and uselessness, objective signs absent, and is often accompanied by depression and fatigue.
- *Respondent pain* is seen as a reflexive response to antecedent stimulus (tissue damage). The respondent pain may eventually evolve into operant and persisting pain if the environment offers pain contingent reinforcement.

2.4 Recovery from pain

The vocational rehabilitation professional must ensure interventions are appropriate for the workers' particular stage in the low back pain process.

Acute phase of low back pain: Immediately after the injury the first step in assisting a worker with low back pain/injury is to ensure the worker gets medical attention. The vocational rehabilitation professional should advise the worker that an accurate diagnosis may not be possible, due to the large number (300+) of muscles in the back, any one of which may be causing the injury. Nevertheless, treatment will likely be effective, even if a specific diagnosis is not made. The usual treatment is anti-inflammatory medications, ice, and physical therapy. Research has shown that 90% of

individuals with low back pain are pain-free within three months. Only 1 to 2% will require surgery.

Opinions regarding the effectiveness of rehabilitative treatment during the acute phase after an injury have changed. A number of years ago the general practice was to have injured workers rest and do nothing for the first number of weeks following an injury. When they were back to full functioning they were then brought back to work in their pre-accident occupation. The practice then moved to having the worker participate in an active rehabilitation program almost from the moment of injury.⁵² Recent studies suggest that early exercise instruction, physiotherapy and early activity and education programs are ineffective in improving longer-term outcomes.^{53,54,55}

Within the acute phase, two factors have a significant contribution in delaying a worker from returning to the workplace:

- *Clinical iatrogenesis*^{56,57}: Clinical iatrogenesis is a condition caused by medical personnel or procedures, including fears instilled by remarks or questions of health care professionals. Aggressive treatment of workers in the acute phase may increase the likelihood of the individual taking on sick-role' behaviours. Typically, the worker is fearful and anxious after sustaining a low back injury. Many questions regarding their present health and future come into their minds. Aggressive treatment reinforces these concerns. A number of early-intervention studies have noted this trend^{58,59,60}.
- *Inappropriate workplace response*^{61,62}: Research and experience is very clear in noting that if a workplace does not provide the injured worker with appropriate workplace accommodations, there is an increase in time away from the worksite and an increased risk in the worker developing a permanent disability^{63,64}. Organizations that do not actively provide modification of work duties run the risk of the worker being away from the workplace for additional weeks, months and perhaps even years if the individual develops chronic pain.

Most often there is very little the vocational rehabilitation professional can do to prevent clinical iatrogenesis. As was noted this condition is precipitated by the worker's interaction with the health care system. The worker should be provided with educational material about the injury and the healing process. It has been shown that if the care providers use a guidelines-based care protocol (e.g., decision aids, educational materials, academic detailing) when treating the worker, there is a potential reduction of 50% of time lost from work⁶⁵.

To ensure that the outcome is not compromised by an inappropriate workplace response, the vocational rehabilitation professional needs to put in place appropriate workplace interventions focused on prompt accommodations based on the worker's medical restrictions. Research has shown that if prompt accommodation occurs there is a potential reduction of 30% in lost time from work⁶⁶.

If the workers' medical restrictions preclude them from participating in any work tasks, the vocational rehabilitation professional should continue to maintain contact, ensure that they are receiving appropriate treatment and invite workers back to the worksite to maintain positive contact with co-workers, managers and events occurring at the workplace.

Subacute phase: During this phase there is a significant need for the vocational rehabilitation professional to be very actively involved in assisting the injured worker back onto the worksite^{67,68,69}. Research has suggested that effective disability management for workers experiencing low back pain has the following features:

- The type of care provided to the worker is less important than ensuring that prompt intervention is closely related to the workplace or is tied explicitly to the specific goal of return to meaningful and productive work.
- Appropriately modified work is offered according to the injured worker's clinically or functionally assessed capacity^{70,71,72}
- Sympathetic communication with the worker and non-adversarial handling of worker's compensation claims characterizes the interaction from the moment pain is first reported⁷³
- A mixture of approaches is used.⁷⁴

Workplace-based intervention would ideally include visits by the rehabilitation professionals to the worksite to gain a thorough understanding of the worker's work-related tasks. If that is not possible, the vocational rehabilitation professional should provide the treating professionals with a complete description of the physical demands of the injured worker's job. Treatment would then be based on providing rehabilitation that maximizes the likelihood of the individual being able to return to optimal functioning at the worksite. It is also recommended that the worker be reassessed clinically at 6 to 8 weeks following the onset of pain to rule out the possibility of rare but treatable conditions.⁷⁵

By promoting active return to work in an accommodated position within the worker's physical capabilities, there is a potential reduction of time lost from work of 35 to 50%.⁷⁶

Chronic phase: After approximately 12 weeks, the worker experiencing pain moves from the subacute to the chronic phase. What was an 'impairment' (i.e., any loss or abnormality of psychological, physiological or anatomical structure or function) becomes a 'disability' (i.e., any restriction or lack of ability to perform an activity in the manner or within the range considered normal for a human being). In turn this can create a 'handicap' (i.e., a disadvantage for a given individual, resulting from an impairment or disability that limits or prevents the fulfillment of a role that is normal for that individual.)

After an injury the worker may go through a number of steps to manage pain. The first is 'medical management' which occurs at the time of the injury and is used to take care of the immediate problem. This is followed by a period of convalescence during which the worker is given treatment to enhance the healing process. During this period, care should be given to any signs that healing is not occurring. Those workers who have not remained at work, will most likely return to the workplace by the end of the medical management or a period of convalescence. However, if the worker does not go back to work, 'functional management' will need to occur. Requiring the involvement of the injured worker, vocational rehabilitation professional, the workplace, and care providers, this progressive, dynamic, goal-oriented and often time-limited process enables an injured worker to identify and reach an optimal level of physical, mental, cognitive and social functioning.

Unfortunately, some workers with chronic pain remain in the medical management phase, which often includes treatment strategies, drug therapy, repeated radiological investigations and repeated consultations. When the medical model doesn't work, it creates a great deal of frustration for injured workers. They often have an expectation that surgery, another type of treatment or another medication will take away the pain. When surgery fails or they perceive that the physician has given up, injured workers may come to the conclusion that their medical doctors see their problems as 'not real' or 'all in their heads.'

For the vocational rehabilitation professional the movement of the worker to the chronic phase of pain presents very significant difficulties in assisting them back to work. One of the frustrations for all involved is the confusing array of therapeutic modalities offered in the community that promise success in treating individuals with chronic pain. Over the past ten years, many 'pain clinics' have opened, each claiming its treatment to be the most effective and efficient. Those programs that focus on pain-coping strategies and are multidisciplinary appear to be promising in their results. As programs can be very expensive, the vocational rehabilitation professional should research the effectiveness of the approaches used carefully.

In addition to the ongoing pain experienced during the chronic phase, the injured worker can experience psychological difficulties including depression, anxiety, despair, frustration and anger. For the worker in this chronic phase, it goes beyond pain to an experience of suffering.

One of the most beneficial methods of treating chronic pain is to have workers return to work early despite pain. If they can overcome the anxiety of the presence of pain, and can gain some assurance that they are not hurting themselves or worsening their condition, they can often manage employment, even if it is modified or partial. They gain a sense of self confidence and a reward for improving functions. To do this successfully, the treating physician needs to be familiar with the vocational rehabilitation process and be supportive of the initiatives to encourage return to work

as soon as medically possible. Workers should understand that they can expect to have some increase in pain and fatigue initially. The pain may later subside, but most importantly, the worker is maintaining maximum functional independence.⁷⁷

2.5 Examples of physical disabilities⁵:

Throughout the individual's career as a vocational rehabilitation professional they may encounter a wide variety of physical disabilities. The following is a listing of some of the disabilities that may be encountered.

- a. **Amyotrophic Lateral Sclerosis (ALS)** This is also known as Lou Gehrig's disease. This is a debilitating disease with varied etiology characterized by rapidly progressive weakness, muscle atrophy and fasciculations, muscle spasticity, difficulty speaking (dysarthria), difficulty swallowing (dysphagia), and difficulty breathing (dyspnea). ALS is the most common of the five motor neuron diseases.

The disorder causes muscle weakness and atrophy throughout the body caused by degeneration of the upper and lower motor neurons. Unable to function, the muscles weaken and atrophy. Affected individuals may ultimately lose the ability to initiate and control all voluntary movement, although bladder and bowel sphincters and the muscles responsible for eye movement are usually, but not always, spared until the terminal stages of the disease.⁷⁸

Possible Employment Issues

- Muscle weakness in hands, arms, legs or the muscles of speech, swallowing, or breathing
 - Twitching (fasciculation) and cramping of muscles, especially those in the hands and feet
 - Impairment of the use of the arms and legs
 - "Thick speech" and difficulty in projecting the voice in more advanced stages
 - Dealing with workplace stress
- b. **Attention Deficit Hyperactivity Disorder:** Attention deficit-hyperactivity disorder (AD/HD) is a neurobehavioural disorder with a persistent pattern of inattention and / or hyperactivity-impulsivity that interferes with functioning or development.

The common characteristics of AD/HD are impulsivity, inattention, and/or over-activity (DSM-V-TR, 2013). Failure to listen to instructions, inability to organize oneself and work tasks, fidgeting with hands and feet, talking too much, inability to stay on task, leaving projects, chores and work tasks unfinished, and having trouble paying attention to and

⁵ Examples of possible accommodations can be found in Appendix A

responding to details are the primary symptoms of AD/HD. Although individuals may have both inattention and hyperactivity symptoms, many individuals predominantly display one symptom more than another. Therefore, the DSM-IV-TR identifies three subtypes that can be diagnosed:

- AD/HD predominantly hyperactive-impulsive type: The major characteristics are fidgeting, talking excessively, interrupting others when talking, and impatience.
- AD/HD predominantly inattentive type: The major characteristics are distractibility, organization problems, failure to give close attention to details, difficulty processing information quickly and accurately, and difficulty following through with instructions.
- AD/HD combined type: The individual with combined type meets the criteria for both hyperactive-impulsive and inattentive type.

Possible Employment Issues

- Inattention means a person wanders off task, lacks persistence, has difficulty sustaining focus, and is disorganized; and these problems are not due to defiance or lack of comprehension.
 - Hyperactivity means a person seems to move about constantly, including in situations in which it is not appropriate; or excessively fidgets, taps, or talks. In adults, it may be extreme restlessness or wearing others out with constant activity.
 - Impulsivity means a person makes hasty actions that occur in the moment without first thinking about them and that may have high potential for harm; or a desire for immediate rewards or inability to delay gratification. An impulsive person may be socially intrusive and excessively interrupt others or make important decisions without considering the long-term consequences.
- c. **Bradyphrenia:** “Brady” means slower; “phrenia” means thinking—so slowed thinking processes. Bradyphrenia occurs in some people with Parkinson's disease. It appears to be related to damage to frontal cortex brain regions -- those regions of the brain that support thinking, reasoning, and planning. One of the ways bradyphrenia may impact communication is by making it difficult for a client to maintain topic, offer new information, or understand someone that talks very fast. As a result of bradyphrenia, incoming stimulus takes longer to be processed by the client and very often leads to communication breakdown.

Possible Employment Issues

See Parkinson's disease

- d. **Burns:** Burns are caused by excessive exposure to thermal, chemical, electrical or radioactive agents resulting in tissue damage. The effects of burns vary: they can be local, causing cell damage or death, or may cause primary shock occurring directly after an injury which can be both local and systemic and is seldom fatal. Or they can cause secondary shock following severe burns which often proves fatal. Severity of the burn is determined by size, depth or degree and location of the burn. Age of the individual and past medical history should be noted as well.

Classifications of burns are one through four depending upon the destruction of the tissue. One being superficial - four being the most critical. There is a different level of pain associated with each classification.

- **First-degree** means only epidermis is effected
- **Second-degree** means partial thickness burns to the epidermis and dermis
- **Third-degree** means full thickness burns to epidermis, dermis and all appendages
- **Fourth-degree** means burns extend through skin, subcutaneous tissue and into underlying muscle and bone.

Possible Employment Issues

- Fatigue
 - Susceptible to infection
 - Limits on how much they can lift
 - Limited exposure to extreme temperatures (avoiding extreme heat or prolonged periods of cold).
 - Social implication of scarring
- e. **Complex Regional Pain Disorder:** Complex regional pain syndrome (CRPS), formerly Reflex Sympathetic Dystrophy or Causalgia, is a chronic progressive disease characterized by severe pain, swelling, and changes in the skin. It often affects an arm or a leg and may spread to another part of the body and is associated with dysregulation of the autonomic nervous system resulting in multiple functional loss, impairment, and disability. Though treatment is often unsatisfactory, early multimodal therapy can cause dramatic improvement or remission of the syndrome in some clients⁷⁹. The International Association for the Study of Pain has proposed dividing CRPS into two types based on the presence of nerve lesion following the injury.
- Type I, formerly known as reflex sympathetic dystrophy (RSD), Sudeck's atrophy, reflex neurovascular dystrophy (RND), or algoneurodystrophy, does not have demonstrable nerve lesions.
 - Type II, formerly known as causalgia, has evidence of obvious nerve damage. It should be noted that most information commonly available about CRPS, including this Wikipedia source, relate information more accurately about Type I CRPS. It should be noted that Type II CRPS tends towards the more painful and difficult to control aspects of CRPS, and the three main types of CRPS listed in this article relate mainly to Type I, also. In Type II the "cause" of the syndrome is the known or

obvious injury, although the cause of the mechanisms of CRPS Type II are as unknown as the mechanisms of Type I.

Possible Employment Issues

- Limitations on activities of daily living
- Depression and anxiety
- Fatigue/weakness
- Muscle pain and stiffness

- f. **Diabetes Mellitus:** Diabetes is a disease in which blood glucose levels are above normal. Most of the food we eat is turned into glucose, or sugar, for our bodies to use for energy. The pancreas, an organ that lies near the stomach, makes a hormone called insulin to help glucose get into the cells of our bodies. When you have diabetes, your body either doesn't make enough insulin or can't use its own insulin as well as it should. This causes sugar to build up in your blood.

Diabetes can cause serious health complications including heart disease, blindness, kidney failure, and lower-extremity amputations.

Type 1 diabetes was previously called insulin-dependent diabetes mellitus (IDDM) or juvenile-onset diabetes. Type 1 diabetes develops when the body's immune system destroys pancreatic beta cells, the only cells in the body that make the hormone insulin that regulates blood glucose. This form of diabetes usually strikes children and young adults, although disease onset can occur at any age. Type 1 diabetes may account for 5% to 10% of all diagnosed cases of diabetes. Risk factors for type 1 diabetes may include autoimmune, genetic, and environmental factors.

Type 2 diabetes was previously called non-insulin-dependent diabetes mellitus (NIDDM) or adult-onset diabetes. Type 2 diabetes may account for about 90% to 95% of all diagnosed cases of diabetes. It usually begins as insulin resistance, a disorder in which the cells do not use insulin properly. As the need for insulin rises, the pancreas gradually loses its ability to produce insulin. Type 2 diabetes is associated with older age, obesity, family history of diabetes, history of gestational diabetes, impaired glucose metabolism, physical inactivity, and race/ethnicity. African Canadians, Hispanic/Latino Canadians, Indigenous, and some Asian Canadians and Native Hawaiians or Other Pacific Islanders are at particularly high risk for type 2 diabetes. Type 2 diabetes is increasingly being diagnosed in children and adolescents.

Hyperglycemia is a hallmark sign of diabetes (both type 1 diabetes and type 2 diabetes) and prediabetes.

Gestational diabetes is a form of glucose intolerance that is diagnosed in some women during pregnancy. Gestational diabetes occurs more frequently among African

Canadians, Hispanics/Latinos, and Indigenous. It is also more common among obese women and women with a family history of diabetes. During pregnancy, gestational diabetes requires treatment to normalize maternal blood glucose levels to avoid complications in the infant. After pregnancy, 5% to 10% of women with gestational diabetes are found to have type 2 diabetes. Women who have had gestational diabetes have a 20% to 50% chance of developing diabetes in the next 5-10 years.

Other specific types of diabetes result from specific genetic conditions (such as maturity-onset diabetes of youth), surgery, drugs, malnutrition, infections, and other illnesses. Such types of diabetes may account for 1% to 5% of all diagnosed cases of diabetes.

Possible Employment Issues

- Hypo/Hyperglycemia
- Neuropathy (Nerve damage)
- Fatigue or Weakness
- Vision Impairment
- Kidney Disease
- Cognitive Limitations
- Psychological Limitations

g. **Hearing issues/Deafness:** There are three types of hearing loss:

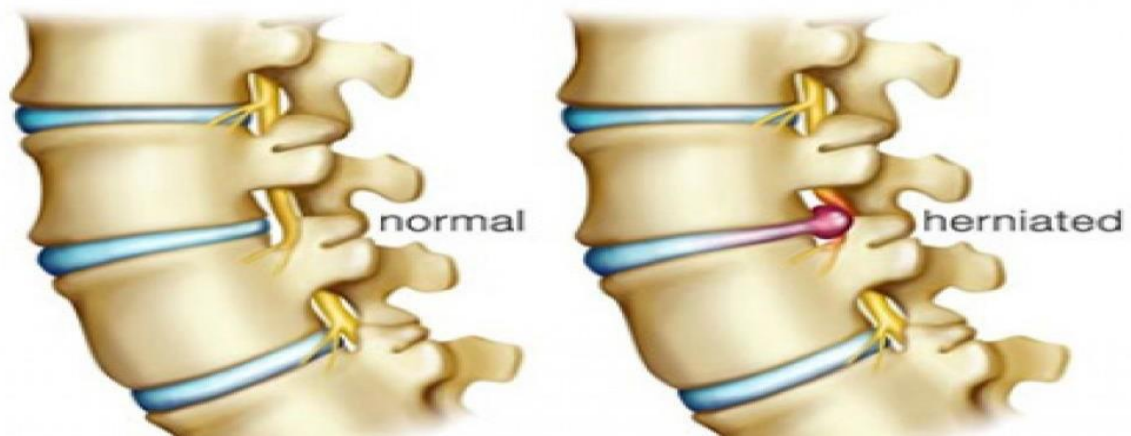
- **Sensorineural** hearing loss can result if there is some type of damage to the cilia in the cochlea or along the auditory nerve. Surgery cannot correct this type of loss. The most common treatment is the use of a hearing aid. Causes can include: genetic, noise, drugs damaging the ear (ototoxic), and aging. If a client has a profound hearing loss a cochlear implant may be recommended.
- **Conductive** hearing loss can result from an issue with the outer and/or middle ear such as middle ear infection, rupture (hole) in the tympanic membrane and/or cerumen production that impedes the movement of sound. Treatments may involve medicine and/or surgical procedures.
- A **mixed** hearing loss involves components of both sensorineural and conductive loss. If the conductive loss is treatable, this is done first. If hearing aids will help, then they are prescribed.

Possible Employment Issues

There are numerous accommodations that could be provided for an individual who has hearing difficulties. These include (but not limited to):

- Difficulty communicating face-to-face
- Difficulty communicating in groups, meetings, or training
- Difficulty communicating by telephone

- Difficulty communicating in the field
 - Safely operating or working around Vehicles
 - Difficulty responding to sounds in the environment
 - Difficulty wearing hearing protection
- h. **Herniated disc:** A Herniated Disc (also called a ruptured or slipped disc) occurs when the annulus (outer covering) of a fluid-filled intervertebral disc tears, resulting in a leak of the nucleus (or inner portion), which puts pressure on the exiting nerve root, causing pain. Causes of a herniated disc may include falls, sudden lifting and the spine going through a large amount of wear and tear (such as obesity, long-term heavy lifting or the aging processes).



Possible Employment Issues

- Fatigue/Weakness:
 - Gross Motor Impairment
- i. **HIV/AIDS:** HIV/AIDS is a disease of the human immune system caused by the human immunodeficiency virus (HIV). During the initial infection a person may experience a brief period of influenza-like illness. This is typically followed by a prolonged period without symptoms. As the illness progresses it interferes more and more with the immune system, making people much more likely to get infections, including opportunistic infections, and tumors that do not usually affect people with working immune systems.

Possible Employment Issues

- Fatigue/Weakness:
- Chronic Diarrhea:
- Decreased Cognitive Abilities: (Problems with concentration, memory, etc.)

- Vision Impairment: Reading information from computer screen (For those who benefit from magnification and other modifications)
- Vision Impairment: Reading information from computer screen (For those who do not benefit from magnification)
- Vision Impairment: Reading information from printed materials (For those who benefit from magnification and other modifications)
- Vision Impairment: Reading information from printed materials (For those who do not benefit from magnification)
- Sensitivity to Light:
- Respiratory Difficulties: (Problems breathing)
- Neurological Complications: (Problems with numbness in fingers, legs, feet or difficulties with seizures, headaches, noise, dizziness, mood swings and concentration)
- Skin Infections: (May include open sores, bruises, lesions and rashes)
- Psychological Implications: (Difficulties adjusting to having a disability, stress, etc.)
- Weight Loss:

j. **Multiple Sclerosis:** Multiple sclerosis is a chronic, progressive disease with onset commonly between 20 and 40 years of age. This disease is five times more common in temperate latitudes than in the tropics⁸⁰. The prevalence of MS is twice as high on the Prairie Provinces as compared to other regions of Canada. Although multiple sclerosis has been identified in the medical literature since the early 1800's, there is still no common understanding of the cause. It is thought to be an autoimmune disease in which the covering of the nerve fibers (myelin) is treated as foreign by the body and attacked. This results in lesions that delay or block the passage of nerve impulses. The variability and distributions of these lesions leads to an array of symptoms, varying from person to person.

There are a number of types of multiple sclerosis:

- Benign multiple sclerosis.
- Relapsing remitting multiple sclerosis.
- Secondary progressive multiple sclerosis.
- Primary progressive multiple sclerosis
- Progressive relapsing multiple sclerosis
- Malignant multiple sclerosis (Marburg variant)

Possible Employment Issues

- Cognitive Impairment:
- Fatigue/Weakness:
- Fine Motor Impairment:
- Gross Motor Impairment:

- Heat Sensitivity:
- Speech Impairment:
- Vision Impairment:

- k. **Parkinson's disease:** Parkinson's disease (also known as Parkinson disease, Parkinson's, idiopathic Parkinsonism, Primary Parkinsonism, PD, hypokinetic rigid syndrome/HRS, or paralysis agitans) is a degenerative disorder of the central nervous system. The motor symptoms of Parkinson's disease result from the death of dopamine-generating cells in the substantia nigra, a region of the midbrain; the cause of this cell death is unknown. Early in the course of the disease, the most obvious symptoms are movement-related; these include shaking, rigidity, slowness of movement and difficulty with walking and gait. Later, cognitive and behavioural problems may arise, with dementia commonly occurring in the advanced stages of the disease. Other symptoms include sensory, sleep and emotional problems. PD is more common in the elderly, with most cases occurring after the age of 50.

The main motor symptoms are collectively called Parkinsonism, or a "parkinsonian syndrome". Parkinson's disease is often defined as a parkinsonian syndrome that is idiopathic (having no known cause), although some atypical cases have a genetic origin. Many risk and protective factors have been investigated: the clearest evidence is for an increased risk of PD in people exposed to certain pesticides and a reduced risk in tobacco smokers. The pathology of the disease is characterized by the accumulation of a protein called alpha-synuclein into inclusions called Lewy bodies in neurons, and from insufficient formation and activity of dopamine produced in certain neurons within parts of the midbrain. Lewy bodies are the pathological hallmark of the idiopathic disorder, and the distribution of the Lewy bodies throughout the Parkinsonian brain varies from one individual to another. The anatomical distribution of the Lewy bodies is often directly related to the expression and degree of the clinical symptoms of each individual. Diagnosis of typical cases is mainly based on symptoms, with tests such as neuroimaging being used for confirmation.

Possible Employment Issues

- Cognitive slowing (also called bradyphrenia)
 - Change in organizational skills-
 - Stubbornness or inflexible behaviour
 - Changes in verbal fluency and word finding
- l. **Repetitive strain disorder** Repetitive strain injuries (RSIs) are "injuries of the musculoskeletal and nervous systems that may be caused by repetitive tasks, forceful exertions, vibrations, mechanical compression (pressing against hard surfaces), or sustained or awkward positions". RSI is also known as cumulative trauma disorders, repetitive stress injuries, repetitive motion injuries or disorders, musculoskeletal disorders, and [occupational] overuse syndromes.

Repetitive Strain Disorders (such as carpal tunnel syndrome, tennis elbow, thoracic outlet syndrome, etc.) result from a repeated motion of a specific body part. Often, a repeated movement results in friction, causing swelling or inflammation. An inflamed tissue puts pressure on surrounding nerves, resulting in a kink (impingement), distorting nerve signals below the inflamed area. At that point, sensory, motor, and reflex nerve responses may decrease in that area. Regular x-rays are frequently used for diagnoses, as well as cortisone injections and EMG (Electromyography, for complex impingement syndromes) - an invasive procedure performed by a neurologist.

When considering repetitive strain in a work setting, the key factors to consider are the body position when the task is performed, force exerted and repetition rate.

Possible Employment Issues

- Fatigue/weakness
- Fine motor impairment
- Gross motor impairment
- Temperature Sensitivity

- m. **Spinal cord injuries:** A spinal cord injury (SCI) refers to any injury to the spinal cord that is caused by trauma instead of disease.⁸¹ Depending on where the spinal cord and nerve roots are damaged, the symptoms can vary widely, from pain to paralysis to incontinence.^{82,83} Spinal cord injuries are described at various levels of "incomplete", which can vary from having no effect on the client to a "complete" injury which means a total loss of function. (See Competency 2.2 – Spinal Column)

Complications of paraplegia can include:

- Pressure sores (decubitus ulcers)
- Thrombosis.
- Depression.
- Bladder and bowel incontinence.
- Impotence.
- Circulation disorders.
- Autonomic dysreflexia.
- Loss of muscle tone.

Complications of quadriplegia can mean a loss or impairment in:

- Controlling bowel and bladder,
- Sexual function,
- Digestion,
- Breathing and other autonomic functions
- Numbness,
- Reduced sensation or burning neuropathic pain

Possible Employment Issues

- Standard Desk too low for Wheelchair Access
 - Pedestal desk center opening too narrow for wheelchair access
 - Holding a telephone receiver difficult due to limited hand or arm function
 - Using a standard keyboard/mouse with impaired hand or arm function
 - Managing papers difficult with limited hand function
 - Physical access into the facility
 - Physical access within facility
 - Bathroom access issues
 - Morning routine for personal care may necessitate changes in work schedules
- n. **Strokes (CVA):** Strokes (cerebrovascular accident or CVA) are the primary cause of adult disability, and occur when a disease of blood vessels causes acute brain damage. Men, the elderly, obese individuals, heavy drinkers, smokers, individuals with high cholesterol or with family history of stroke may be at a high risk for CVA.

There are two types of stroke; ischemic and hemorrhagic:

- A transient ischemic attack (TIA, or “mini stroke”) is the most common type of stroke. A TIA occurs when a clot blocking a cerebral artery interrupts blood flow to brain tissue (which causes tissue anoxia, resulting in damage of brain function). It takes as little as three to five minutes of loss of blood supply to the brain to cause death of nerve tissue, also known as necrosis. The oxygen deprivation in TIA, however, is not long enough for the cells to die, thus the damage is reversible.
- Ischemic strokes can be either thrombotic or embolic.
 - In a thrombotic ischemic stroke, material accumulates until it completely interrupts the blood supply, gradually occluding an artery.
 - An embolic ischemic stroke occurs when some material moving within the blood stream suddenly occludes an artery. This type of ischemic stroke may result in the sudden interruption of blood flow to the brain.

A hemorrhagic stroke is either a brain aneurysm burst or a weakened blood vessel leak. Blood spills into or around the brain and creates swelling and pressure, damaging cells and tissue in the brain. There are two types of hemorrhagic stroke called intracerebral and subarachnoid.

Stroke usually affects one side of the brain. Movement and sensation for one side of the body is controlled by the opposite side of the brain.

Some problems that happen after stroke are more common with stroke on one side of the brain than the other.

- The right side of the brain controls the ability to pay attention, recognize things you see, hear or touch, and be aware of your own body.
- In most people, the left side of the brain controls the ability to speak and understand language.

In some left-handed people, language is controlled by the right side of the brain and awareness by the left side of the brain.

There are some common outcomes of a right-side CVA including:

- Difficulties with left side of the body
- Anomia – inability to recognize faces or pictures of familiar people or objects
- Reduced attention span
- Denial
- Neglect
- Perseveration
- Visual/spatial problems

There are some common outcomes of a left-side CVA including:

- Difficulties with right side of body
- Aphasia (speech and language problems)
- Memory problems
- Problems with concepts and generalizations
- Development of a slow and cautious behavioural style

Possible Employment Issues

- Cognitive Impairment
 - Maintaining Concentration
 - Staying Organized and Meeting Deadlines
 - Handling Memory Deficits:
 - Handling Problem Solving Deficits
 - Working Effectively with Supervisors
 - Handling Stress and Emotions
 - Handling Change
 - Maintaining Stamina during the Workday
- Motor Limitations
 - Weakness or paralysis on one side of the body is common and can affect upper and/or lower extremities of the body
 - Balance and overall coordination make standing, climbing, sitting, and walking problematic
 - Ignoring or not being aware of the affected side of the body
 - Numbness or pain

- Dysphagia (trouble chewing/swallowing food) can prevent the person from getting basic nutrition and can cause aspiration (breathing in food)
 - Bowel and bladder incontinence and other activities of daily living including independent bathing, dressing, and eating
 - Fatigue and decreased stamina
 - Speech and Language Impairments
 - Communicating with the Person with the Speech or Language Impairment
 - Communicating One-on-One or in Group
 - Communicating on the Telephone
- o. **Traumatic (Acquired) Brain Injury:** Brain injury is often described as either 'traumatic brain injury' or 'acquired brain injury.' Some use these two terms interchangeably, but in general the term traumatic brain injury includes all incidents where there is a direct damage to the brain usually through some form of accident; whereas acquired brain injury includes these injuries plus other non-traumatic causes such as infection (e.g., meningitis, hepatic encephalopathy), heart attack, aneurysm, stroke, and tumor.

The ongoing effects of a brain injury are dependent on which part of the brain is damaged:

- Right hemisphere brain damage (RHD) is the result of injury to the right brain hemisphere. The right hemisphere of the brain coordinates tasks for perceptual skills, functional communication, which include problem solving, memory, and reasoning.
- The left half of the brain is responsible for verbal and logical functions including language (listening, reading, speaking, and writing), thought and memory involving words.
- The frontal lobe is located just behind the forehead. This part of the brain is responsible for such functions as: initiation, problem-solving, inhibition of behaviour, organization, mental flexibility, attention and concentration, planning, personality and emotional control.
- The cerebellum is located at the base of the brain. Its specific functions include balance, coordination of voluntary movement and skilled motor activity.
- The occipital lobe is towards the back of the head. This area controls vision.
- The parietal lobe is located near the back and top of the head. It has the specific function of controlling the sense of touch, visual perception, manipulation of objects and identification of size/shape/colors.
- The brain stem is located deep in the brain and leads directly to the spinal cord. The brain stem's functions include controlling breathing, heart rate, arousal and consciousness, sleep and wake cycles, attention and concentration, blood pressure, digestion, sense of balance, and body temperature.
- The temporal lobe is located on the side of the head above the ears. Its specific functions include memory, hearing, receptive language, organization and sequencing.

Possible Employment Issues

- Physical Limitations
- Visual Problems
- Maintaining Stamina During the Workday
- Maintaining Concentration
- Difficulty Staying Organized and Meeting Deadlines
- Memory Deficits
- Problem Solving Deficits
- Working Effectively with Supervisors
- Difficulty Handling Stress and Emotions
- Attendance Issues
- Issues of Change

- p. **Cancer:** Cancer is often seen as a single disease, but there are over 100 different types of cancers or neoplastic diseases.⁸⁴ The commonality is that all cancers are composed of malignant tumours characterized by unregulated and uncontrolled growth, creating new tumours in various parts of the body. About 63% of persons diagnosed with cancer survive at least five years. They may be disease-free, in remission or still undergoing cancer treatment. Survival rates vary according to the type and site of the cancer, stage of cancer at diagnosis, treatment protocols, additional illnesses, biological differences and behavioural characteristics of the individual.

There are a number of known causes of cancer: genetic factors, environmental hazards of both chemical (e.g., asbestos, coal tar) and physical agents (e.g., ionizing radiation, ultraviolet radiation), and social practices (e.g., smoking, alcohol consumption, diet).⁸⁵

Possible Employment Issues

- Fatigue/Weakness
- Medical Treatment Allowances
- Respiratory Difficulties
- Skin Irritations
- Stress
- Temperature Sensitivity

- q. **Cardiovascular disease:** The term *cardiovascular disease* takes in a number of clinical types including the following:
- *Valvular heart disease* often results from early rheumatic fever, causing damage to the heart valves. However, its effects may only be experienced in later adulthood.⁸⁶
 - *Myocardopathy* involves inflammation and weakness of the heart muscles. Often it is secondary to viral infection, exposure to chemical or toxic agents, alcoholism, diabetes or hypertension.⁸⁷

- *Angina pectoris* is due to an imbalance between oxygen supply and demand. It is characterized by chest discomfort, pain and pressure. It most often occurs as a result of physical exertion.⁸⁸
- *Hypertensive heart disease* is most often associated with high blood pressure. It can be the result of a primary condition with unknown associated conditions. It may also be secondary to kidney disease, vascular abnormalities or endocrine abnormalities.⁸⁹
- *Myocardial infarction* is usually known as a heart attack. This is the result of a cessation of blood flow to the myocardium, lasting more than 30 minutes. This occurs when a clot completely or partially obstructs the coronary artery. Myocardial infarction results in a damaged heart muscle often leading to congestive heart failure. When the coronary artery is not completely blocked but blood flow is restricted, the worker may develop angina, a discomfort in the chest, arms, or lower jaw that develops during physical exertion or emotional stress. Together, myocardial infarction and angina are called *coronary artery disease*.⁹⁰
- *Congestive heart failure* is usually the end stage for most gradually deteriorating cardiovascular diseases. This disease is characterized by enlarged heart chambers and thick muscle walls. Symptoms of this condition are shortness of breath (dyspnea), fluid retention (edema), fatigue and weakness.⁹¹
- *Arrhythmia* or *heart rhythm disorder* is an irregularity of the heart's electrical system that can cause the heart to beat too slowly (bradycardia) or too quickly (tachyarrhythmia). The heart beat may also be irregular.
- *Pulmonary vascular disease* is any condition that affects the blood vessels along the route between the heart and lungs. Blood travels from the heart, to the lungs, and back to the lungs. Any part of the heart-lung blood circuit can become damaged or blocked, leading to pulmonary vascular disease.

Possible Employment Issues

- Fatigue/Weakness
 - Respiratory Difficulties
 - Seizure Activity and Blackouts
 - Stress
 - Temperature Sensitivity
- r. **Asthma:** Asthma is a common long-term inflammatory disease of the airways of the lungs. It is characterized by variable and recurring symptoms, reversible airflow obstruction, and bronchospasm. Symptoms include episodes of wheezing, coughing, chest tightness, and shortness of breath. These episodes may occur a few times a day or a few times per week. Depending on the person, they may become worse at night or with exercise.

Asthma is thought to be caused by a combination of genetic and environmental factors. Environmental factors include exposure to air pollution and allergens. Other

potential triggers include medications such as aspirin and beta blockers. Diagnosis is usually based on the pattern of symptoms, response to therapy over time, and spirometry. Asthma is classified according to the frequency of symptoms, forced expiratory volume in one second (FEV1), and peak expiratory flow rate. It may also be classified as atopic or non-atopic, where atopy refers to a predisposition toward developing a type 1 hypersensitivity reaction.

There is no cure for asthma. Symptoms can be prevented by avoiding triggers, such as allergens and irritants, and by the use of inhaled corticosteroids. Long-acting beta agonists (LABA) or antileukotriene agents may be used in addition to inhaled corticosteroids if asthma symptoms remain uncontrolled. Treatment of rapidly worsening symptoms is usually with an inhaled short-acting beta-2 agonist such as salbutamol and corticosteroids taken by mouth. In very severe cases, intravenous corticosteroids, magnesium sulfate, and hospitalization may be required.

Possible Employment Issues

- Fatigue/Weakness
 - Avoiding Environmental Triggers
- s. **Fetal alcohol syndrome:** Fetal alcohol syndrome (FAS) is a pattern of mental and physical defects that can develop in a fetus in association with high levels of alcohol consumption during pregnancy. Current research also implicates other lifestyle choices made by the prospective mother.

Alcohol crosses the placental barrier and can stunt fetal growth or weight, create distinctive facial stigmata, damage neurons and brain structures, which can result in psychological or behavioural problems, and cause other physical damage.^{92,93} Surveys found that in the United States, 10–15% of pregnant women report having recently drunk alcohol, and up to 30% drink alcohol at some point during pregnancy.^{94,95}

The main effect of FAS is permanent central nervous system damage, especially to the brain. Developing brain cells and structures can be malformed or have development interrupted by prenatal alcohol exposure; this can create an array of primary cognitive and functional disabilities (including poor memory, attention deficits, impulsive behaviour, and poor cause-effect reasoning) as well as secondary disabilities (for example, predispositions to mental health problems and drug addiction).⁹⁶ Alcohol exposure presents a risk of fetal brain damage at any point during a pregnancy, since brain development is ongoing throughout pregnancy.⁹⁷

Physical indications of Fetal Alcohol Syndrome could include: smooth skin surface between the nose and upper lip, thin upper lip and small eye openings.

Possible Employment Issues

Limitations in Intellectual Abilities Reading:

- Writing
- Math
- Organization
- Task Completion
- Memory

Limitations in Motor Abilities

- Computer Use
- Telephone Use
- Handling Objects

Limitations in Social Abilities

- Emotional Support
- Interacting with Co-Workers
- Working Effectively with Supervisors

t. **Eating Disorders:**

- **Anorexia nervosa** is a serious, potentially life-threatening eating disorder characterized by restriction of energy intake (food consumption) and excessive weight loss. Symptoms include resistance to maintaining body weight at or above a minimally normal weight for age and height; intense fear of weight gain; disturbance in the experience of body weight or shape; undue influence of weight or shape on self-evaluation, or denial of the seriousness of low body weight; and loss of menstrual periods in girls and women post-puberty.

Anorexia nervosa typically appears in early to mid-adolescence and it has one of the highest death rates of any mental health condition.

- **Bulimia nervosa** is a serious, potentially life-threatening eating disorder characterized by a cycle of bingeing and compensatory behaviours designed to undo or compensate for the effects of binge eating. Its presence is indicated by regular intake of large amounts of food accompanied by a sense of loss of control over eating behaviour; regular use of inappropriate compensatory behaviours such as self-induced vomiting, laxative or diuretic abuse, fasting, and/or obsessive or compulsive exercise; and extreme concern with body weight and shape.

Bulimia nervosa affects 1-2% of adolescent and young adult women, and approximately 80% of bulimia nervosa patients are female.

Bulimia nervosa is frequently associated with symptoms of depression and changes in social adjustment.

- **Binge eating disorder (BED)** is a type of eating disorder not otherwise specified and is characterized by recurrent binge eating without the regular use of compensatory measures to counter the binge eating. It is characterized by frequent episodes of eating large quantities of food in short periods of time; feeling out of control over eating behaviour during the episode; and feeling depressed, guilty, or disgusted by the behaviour. Behavioural indicators of BED include eating when not hungry, eating alone because of embarrassment over quantities consumed and eating until uncomfortably full.

The prevalence of BED is estimated to be approximately 1-5% of the general population.

BED is often associated with symptoms of depression.

Possible Employment Issues

- Attendance
 - Maintaining Concentration
 - Managing Emotions
 - Fatigue
 - Stress
 - Malnutrition
- u. **Crohn disease:** Crohn's disease is an inflammatory bowel disease (IBD). It causes inflammation of your digestive tract, which can lead to abdominal pain, severe diarrhea, fatigue, weight loss and malnutrition. Inflammation caused by Crohn's disease can involve different areas of the digestive tract in different people.

The inflammation caused by Crohn's disease often spreads deep into the layers of affected bowel tissue. Crohn's disease can be both painful and debilitating, and sometimes may lead to life-threatening complications.

While there's no known cure for Crohn's disease, therapies can greatly reduce its signs and symptoms and even bring about long-term remission. With treatment, many people with Crohn's disease are able to function well⁹⁸.

Possible Employment Issues

- Need to use the restroom on a frequent basis
- Working while undergoing treatment
- Meeting the physical demands of the job
- Dealing with workplace stress

- v. **Raynaud's disease:** Raynaud syndrome, also known as Raynaud's phenomenon, is a medical condition in which spasm of arteries cause episodes of reduced blood flow. Typically the fingers, and less commonly the toes, are involved. Rarely, the nose, ears, or lips are affected. The episodes result in the affected part turning white and then blue⁹⁹. Often, there is numbness or pain. As blood flow returns, the area turns red and burns. The episodes typically last minutes, but can last up to several hours¹⁰⁰.

Episodes are often triggered by cold or emotional stress. There are two main types: primary Raynaud's, when the cause is unknown, and secondary Raynaud's, which occurs as a result of another condition. Secondary Raynaud's can occur due to a connective tissue disorder, such as scleroderma or lupus, injuries to the hands, smoking, thyroid problems, and certain medications, such as birth control pills. Diagnosis is typically based on the symptoms.¹⁰¹

The primary treatment is avoiding the cold. Other measures include the discontinuation of nicotine or stimulants use. Medications for treatment of cases that do not improve include calcium channel blockers and iloprost. Little evidence supports alternative medicine. Severe disease may rarely be complicated by skin sores or gangrene.

Possible Employment Issues

- Sensitivity to Cold Temperatures
- Fine Motor Impairment
- Stress Intolerance
- Concentration Issues
- Fatigue/Weakness

- w. **Epilepsy:** Epilepsy is a group of neurological disorders characterized by epileptic seizures¹⁰². Epileptic seizures are episodes that can vary from brief and nearly undetectable to long periods of vigorous shaking. These episodes can result in physical injuries including occasionally broken bones. In epilepsy, seizures tend to recur and as a rule, have no immediate underlying cause. Isolated seizures that are provoked by a specific cause such as poisoning are not deemed to represent epilepsy. People with epilepsy in some areas of the world experience varying degrees of social stigma due to their condition¹⁰³.

The cause of most cases of epilepsy is unknown. Some cases occur as the result of brain injury, stroke, brain tumors, infections of the brain, and birth defects, through a process known as epileptogenesis. Known genetic mutations are directly linked to a small proportion of cases. Epileptic seizures are the result of excessive and abnormal nerve cell activity in the cortex of the brain. The diagnosis involves ruling out other conditions that might cause similar symptoms such as fainting and determining if another cause of seizures is present such as alcohol withdrawal or electrolyte problems. This may be partly done by imaging the brain and performing blood tests. Epilepsy can often be confirmed with an electroencephalogram (EEG), but a normal test does not rule out the condition.

Epilepsy that occurs as a result of other issues may be preventable. Seizures are controllable with medication in about 70% of cases. Inexpensive options are often available. In those whose seizures do not respond to medication, then surgery, neurostimulation, or dietary changes may be considered. Not all cases of epilepsy are lifelong, and many people improve to the point that treatment is no longer needed.

There are 3 major groups of seizures.

1. **Generalized onset seizures:** These seizures affect both sides of the brain or groups of cells on both sides of the brain at the same time. This term was used before and still includes seizure types like tonic-clonic, absence, or atonic to name a few.
2. **Focal onset seizures:** The term focal is used instead of partial to be more accurate when talking about where seizures begin. Focal seizures can start in one area or group of cells in one side of the brain.
 - **Focal Onset Aware Seizures:** When a person is awake and aware during a seizure, it's called a focal aware seizure. This used to be called a simple partial seizure.
 - **Focal Onset Impaired Awareness:** When a person is confused or their awareness is affected in some way during a focal seizure, it's called a focal impaired awareness seizure. This used to be called a complex partial seizure.
3. **Unknown onset seizures:** When the beginning of a seizure is not known, it's now called an unknown onset seizure. A seizure could also be called an unknown onset if it's not witnessed or seen by anyone, for example when seizures happen at night or in a person who lives alone.
 - As more information is learned, an unknown onset seizure may later be diagnosed as a focal or generalized seizure.

Possible Employment Issues

- Cognitive Impairments Associated with Epilepsy
 - Memory
 - Time Management
 - Stress management

- Motor Impairments Associated with Seizures
 - Driving
 - Balancing/Climbing
 - Fatigue
 - Ensuring Safety in the Workplace:
 - Sensory Impairments Associated with Seizures
 - Photosensitivity
 - Seeing/Hearing/Communicating
- x. **Guillain-Barre syndrome:** Guillain-Barré syndrome, the body's immune system attacks part of the peripheral nervous system. The syndrome can affect the nerves that control muscle movement as well as those that transmit pain, temperature and touch sensations. This can result in muscle weakness and loss of sensation in the legs and/or arms. It is a rare condition, and while it is more common in adults and in males, people of all ages can be affected.
- Symptoms typically last a few weeks, with most individuals recovering without long-term, severe neurological complications. The first symptoms of Guillain-Barré syndrome include weakness or tingling sensations. They usually start in the legs, and can spread to the arms and face.

For some people, these symptoms can lead to paralysis of the legs, arms, or muscles in the face. In 20%–30 % of people, the chest muscles are affected, making it hard to breathe.

The ability to speak and swallow may become affected in severe cases of Guillain-Barré syndrome. These cases are considered life-threatening, and affected individuals should be treated in intensive-care units.

Most people recover fully from even the most severe cases of Guillain-Barré syndrome, although some continue to experience weakness. Even in the best of settings, 3%–5% of Guillain-Barré syndrome clients die from complications, which can include paralysis of the muscles that control breathing, blood infection, lung clots, or cardiac arrest¹⁰⁴.

Possible Employment Issues

- Managing fatigue or muscle weakness
 - Impairment of the use of the legs and feet
 - Impairment of the hands and fingers
- y. **Alzheimer's:** Alzheimer's disease (AD), also referred to simply as Alzheimer's, is a chronic neurodegenerative disease that usually starts slowly and worsens over time. It is the cause of 60% to 70% of cases of dementia¹⁰⁵. The most common early symptom is difficulty in remembering recent events (short-term memory loss). As the disease

advances, symptoms can include problems with language, disorientation (including easily getting lost), mood swings, loss of motivation, not managing self-care, and behavioural issues. As a person's condition declines, they often withdraw from family and society. Gradually, bodily functions are lost, ultimately leading to death¹⁰⁶. Although the speed of progression can vary, the average life expectancy following diagnosis is three to nine years.

The cause of Alzheimer's disease is poorly understood. About 70% of the risk is believed to be genetic with many genes usually involved. Other risk factors include a history of head injuries, depression, or hypertension. The disease process is associated with plaques and tangles in the brain. A probable diagnosis is based on the history of the illness and cognitive testing with medical imaging and blood tests to rule out other possible causes. Initial symptoms are often mistaken for normal ageing. Examination of brain tissue is needed for a definite diagnosis. Mental and physical exercise, and avoiding obesity may decrease the risk of AD; however, evidence to support these recommendations is not strong. There are no medications or supplements that decrease risk.

No treatments stop or reverse its progression, though some may temporarily improve symptoms. Affected people increasingly rely on others for assistance, often placing a burden on the caregiver; the pressures can include social, psychological, physical, and economic elements. Exercise programmes may be beneficial with respect to activities of daily living and can potentially improve outcomes. Treatment of behavioural problems or psychosis due to dementia with antipsychotics is common, but not usually recommended, as there is little benefit with an increased risk of early death.

Possible Employment Issues

- Memory
 - Time Management/Completing Tasks
 - Difficulty Performing Job Duties
- z. **Spondylosis:** Spondylosis is a broad term meaning degeneration of the spinal column from any cause. In the more narrow sense it refers to spinal osteoarthritis, the age-related wear and tear of the spinal column, which is the most common cause of spondylosis. The degenerative process in osteoarthritis chiefly affects the vertebral bodies, the neural foramina and the facet joints (facet syndrome). If severe, it may cause pressure on the spinal cord or nerve roots with subsequent sensory or motor disturbances such as pain, paresthesia, imbalance and muscle weakness in the limbs.

When the space between two adjacent vertebrae narrows, compression of a nerve root emerging from the spinal cord may result in radiculopathy (sensory and motor disturbances, such as severe pain in the neck, shoulder, arm, back, or leg, accompanied by muscle weakness). Less commonly, direct pressure on the spinal cord (typically in the

cervical spine) may result in myelopathy, characterized by global weakness, gait dysfunction, loss of balance, and loss of bowel or bladder control. The client may experience shocks (paresthesia) in hands and legs because of nerve compression and lack of blood flow. If vertebrae of the neck are involved it is labeled cervical spondylosis. Lower back spondylosis is labeled lumbar spondylosis.

Possible Employment Issues

- Activities of Daily Living
- Fatigue/Weakness
- Fine Motor Impairment
- Gross Motor Impairment
- Photosensitivity
- Skin Irritations
- Sleep Disorder
- Stress

aa. **Visual impairment:** Visual impairment, also known as vision impairment or vision loss, is a decreased ability to see to a degree that causes problems not fixable by usual means, such as glasses. Some also include those who have a decreased ability to see because they do not have access to glasses or contact lenses.¹⁰⁷ Visual impairment is often defined as a best corrected visual acuity of worse than either 20/40 or 20/60. The term blindness is defined as 20/200 in the better eye with corrective lens. Visual impairment may cause people difficulties with normal daily activities such as driving, reading, socializing, and walking.

The most common causes of visual impairment globally are uncorrected refractive errors (43%), cataracts (33%), and glaucoma (2%). Refractive errors include near sighted, far sighted, presbyopia, and astigmatism. Cataracts are the most common cause of blindness. Other disorders that may cause visual problems include age related macular degeneration, diabetic retinopathy, corneal clouding, childhood blindness, and a number of infections. Visual impairment can also be caused by problems in the brain due to stroke, premature birth, or trauma among others. These cases are known as cortical visual impairment. Screening for vision problems in children may improve future vision and educational achievement. Screening adults without symptoms is of uncertain benefit. Diagnosis is by an eye exam.¹⁰⁸

Possible Employment Issues

- Reading Printed Materials
- Accessing Computer Information
- Writing Notes and Completing Forms
- Accessing a Telephone

- Working with Money
- Reading from Instrument or Control Board
- Repairing, Constructing, Assembling Pieces/Parts
- Mobility
- Driving
- Working with Light Sensitivity
- Distinguishing Colors
- Depth perception (the ability which object is closer or further away)

bb. Cystic Fibrosis

Cystic fibrosis (CF) is an inherited (genetic) disease in which excess mucus clogs the lungs, prevents food from being digested, and damages the reproductive system. It is the most common life-threatening genetically inherited disease affecting Caucasians. The incidence of CF occurs in about 1 in 3,600 live Caucasian births in Canada.

In CF, an abnormal protein called CFTR is produced. This protein changes the way chloride (a component of salt, which is also called sodium chloride) moves in and out of cells. This affects the balance between salt and water in the body, making the mucus that lines the lungs, pancreas, and other organs thicker and stickier.

CF affects all the body's *exocrine* glands. These glands create chemicals necessary for proper functioning of the body. The pancreas, for example, is an exocrine gland that provides digestive enzymes for the stomach. The sweat glands provide liquid to cool the skin. In CF, some glands produce abnormal substances. The sweat glands, for example, release high levels of salt. Other glands, like the pancreas, become plugged with mucus. Because it affects so many organs in our body, CF is usually diagnosed early in childhood.

CF causes the body to produce large amounts of thick mucus. This affects the lungs as well as the digestive and reproductive systems. Symptoms of CF may appear at birth or years later, and range from mild to severe.

Enzymes produced by the pancreas are necessary to digest food in the stomach. In people with CF, large amounts of mucus block the pancreas and prevent enzymes from being released. This causes digestive problems. Even if they eat a normal diet, children with CF may be smaller than others of the same age. Since food is not digested correctly, it leaves the body as waste in the stools. The stools are often large and have a foul smell.

As a child grows older, CF may cause other symptoms. Some develop diabetes and need insulin treatment, and others suffer liver damage. Many children with CF live well into adulthood. On average, people with CF in North America live to the age of 37. With improving treatments and health care, this age will continue to increase gradually. For

the minority who have a healthy pancreas, the prognosis is far better. Good lung function is also a promising sign. Men tend to survive slightly longer than women.

C. International Classification of Functioning (ICF)⁶

The International Classification of Functioning, Disability and Health, known more commonly as ICF, provides a standard language and framework for the description of health and health-related states. It is a classification of health and health-related domains -- domains that help us to describe changes in body function and structure, what a person with a health condition can do in a standard environment (their level of capacity), as well as what they actually do in their usual environment (their level of performance). These domains are classified from body, individual and societal perspectives by means of two lists: a list of body functions and structure, and a list of domains of activity and participation. In ICF, the term functioning refers to all body functions, activities and participation, while disability is similarly an umbrella term for impairments, activity limitations and participation restrictions. ICF also lists environmental factors that interact with all these components.

ICF is WHO's framework for health and disability. It is the conceptual basis for the definition, measurement and policy formulations for health and disability. It is a universal classification of disability and health for use in health and health related sectors. ICF therefore looks like a simple health classification, but it can be used for a number of purposes. The most important is as a planning and policy tool for decision-makers.

ICF is named as it is because of its stress is on health and functioning, rather than on disability. Previously, disability began where health ended; once you were disabled, you were in a separate category. We want to get away from this kind of thinking. We want to make ICF a tool for measuring functioning in society, no matter what the reason for one's impairments. So it becomes a much more versatile tool with a much broader area of use than a traditional classification of health and disability. This is a radical shift. From emphasizing people's disabilities, we now focus on their level of health. ICF puts the notions of 'health' and 'disability' in a new light. It acknowledges that every human being can experience a decrement in health and thereby experience some disability. This is not something that happens to only a minority of humanity. ICF thus 'mainstreams' the experience of disability and recognises it as a universal human experience. By shifting the focus from cause to impact it places all health conditions on an equal footing allowing them to be compared using a common metric – the ruler of health and disability.

In ICF disability and functioning are viewed as outcomes of interactions between health conditions (diseases, disorders and injuries) and contextual factors. Among contextual factors are external environmental factors (for example, social attitudes, architectural characteristics, legal and social structures, as well as climate, terrain and so forth); and internal personal factors, which

⁶ For more information on the ICF refer to the WHO website: <http://www.who.int/classifications/icf/en/>

include gender, age, coping styles, social background, education, profession, past and current experience, overall behaviour pattern, character and other factors that influence how disability is experienced by the individual.

D. Psychological/Cognitive Disabilities

2.6 Diagnostic and Statistical Manual of Mental Disorders (DSM)

The **Diagnostic and Statistical Manual of Mental Disorders**, commonly abbreviated as the *DSM*, is a book published by the American Psychiatric Association providing standardized criteria to the diagnosis of mental health conditions. The *DSM* is used widely by mental health practitioners in Canada to aid in diagnosing clients. For many decades, there was immense concern that psychiatric diagnoses were based upon the whims of psychiatric professionals and were not scientifically valid. Different practitioners might give the same client completely different diagnoses, which in turn would result in different standards and courses of treatment. The *DSM* is an attempt to correct for this potential problem.

Originally published in 1952 based upon data from psychiatric hospitals and practicing mental health clinicians, the *DSM* has undergone several revisions. The current incarnation of the *DSM* is the *DSM-5*, which was finalized December 1, 2012 and released in May 2013. It replaced the *DSM-IV*, which was published in 1994 and revised in 2000.

The *DSM-5* is organized into three sections, with 20 chapters that address specific disorders. The chapters are arranged based on common features among disorders. The *DSM-5* dispensed with the multi-axial system used in the *DSM-IV*.

- Section I provides an introduction and information regarding organizational features of the text, revisions, field trials, and public, professional, and expert review.
- Section II includes diagnostic criteria and codes. Disorders are coded based on the International Classification of Diseases, 9th edition, Clinical Modification (ICD-9-CM) and the *DSM-5* includes coding to reflect the changes that will take effect on October 1st, 2014 with the adoption of the ICD-10-CM.
- Section III addresses assessment measures, cultural formulations, a glossary, and conditions that warrant further study, such as Internet gaming disorder, suicidal behaviour disorder, and neurobehavioural disorder due to prenatal alcohol exposure (ND-PAE).

2.7 Personality Disorders

In the course of the individual's career, the vocational rehabilitation professional will likely provide services to clients who have been diagnosed with a personality disorder. There are four core features which are common to all personality disorders:

1. *Distorted thinking patterns:*

People with personality disorders tend to exhibit distortions in the way they interpret and think about the world, and in the way they think about themselves. Not surprisingly, people with personality disorders think about things quite differently than people with healthy personalities. They may have thinking patterns that are very extreme and somewhat distorted. These dysfunctional patterns are most evident when someone attempts to understand their interactions with others. Examples of these problematic interpretations of the self-in-the-world include:

- extreme black-or-white thinking patterns;
- patterns of idealizing then devaluing other people or themselves;
- patterns of distrustful, suspicious thoughts;
- patterns that frequently include unusual or odd beliefs that are contrary to cultural standards; or,
- patterns of thoughts that include perceptual distortions and bodily illusions

2. *Problematic emotional responses:*

People with personality disorders exhibit characteristic, emotional response patterns that can become problematic. Generally, each of the personality disorders has an emotional response pattern that is associated with that particular disorder. This inflexible pattern of emotional response often creates difficulty. Some personality disorders are characterized by emotional sensitivity and a tendency to experience feelings with great intensity. Other personality disorders are characterized by little or no emotional response, regardless of the circumstance or situation. Yet another set of disorders are characterized by bouncing back and forth between these two extremes: from being overwhelmed with intense emotions one moment, to feeling numb and disconnected in the next.

Some theorists understand this aspect of personality disorders as a problem of emotional regulation; some disorders are characterized by a tendency to under-regulate emotions, whereas others tend to over-regulate emotions. This differs from a healthy personality where we expect a full range of emotional intensity from controlled to fully expressive. This range is dictated by the situation and circumstance. Of course, people with healthy personalities will occasionally get overwhelmed with emotions, or can feel emotionally detached at times. Similar to the distorted thinking patterns we discussed earlier, the problem for people with personality disorders is the extreme degree and persistence of their dys-regulated affect.

In addition, people with healthy personalities tend to understand when it is beneficial to express a particular emotion, and when it is best to restrict its expression. In other words, people with healthy personalities have learned that there are times when it is wise and appropriate to fully express a particular emotion. At other times it is best to regulate or restrict its expression, or to dampen down its intensity. Having decided just

how much emotion is appropriate to display, they then display only the appropriate amount, knowing just how to do that. As we have emphasized previously, a key feature of healthy personalities is flexibility. Healthy personalities have a flexible range of affective responses that properly consider the time, place, and circumstance.

Unfortunately, persons with personality disorders are not nearly as flexible. Depending upon the type of personality disorder, affective (emotional) features can range from being very constricted, indifferent, cold, and experiencing little pleasure in life; to rapidly changing and wildly fluctuating emotions, often expressed with great intensity and dramatic flair. In some personality disorders this lack of flexibility surrounding emotional expression leads to problems with chronic anger and irritability, problems with extreme anxiety, or a complete lack of empathy.

3. *Over or under regulated impulse control*

People with personality disorders tend to exhibit problems with impulse control. These problems can manifest as either over-controlled or under-controlled impulses. (Under-controlled impulse control is commonly called a "lack of impulse control"). In the same manner that people with personality disorders may have problems with over or under controlled affective (emotional) regulation, they also tend to have problems regulating their impulses. Here, too, we can think of impulse regulation along a continuum ranging from over-control to under-control, with healthy personalities falling somewhere in the middle between these two extreme poles.

Consider the issue of self-control and the need for a healthy *balance* between over-control and under-control. On the one hand, we need to control our impulses and to consider the consequences of acting upon an impulse. Having considered the consequences, we then decide how to act accordingly. We determine whether to allow ourselves to indulge the impulse, or whether to inhibit it. The inhibition of certain impulses enables us to behave in ways that are both responsible and socially acceptable. Therefore, in some circumstances the inhibition of our impulses serves to promote our success in both relationships and in the workplace. Two areas of particular concern are aggressive and sexual impulses. If we were to act on our every aggressive or sexual impulse, we would easily get ourselves into a great deal of trouble. On the other hand, the over-control of impulses leads to its own set of problems. A certain amount of carefully considered risk-taking is necessary to reap the benefits of creative expression, rewarding relationships, and successful problem-solving. Some amount of risk-taking is part of the excitement, fun, and spontaneity associated with an enjoyable life. With too much impulse control, we end up feeling restricted, bored, and dull; with too little we can get ourselves into a great deal of trouble. Clearly, a balance between these two extreme poles of over- and under-control would represent a healthy personality.

The challenge to strike the right balance of impulse control affects everyone from time-to-time, including people with healthy personalities. We all have had occasions where

we behaved irresponsibly, or unwisely chose to act upon an impulse. At other times, we may have been too controlled, failing to take a risk that would have ultimately benefitted us. Once again, *flexibility* enables healthy personalities to achieve the proper balance of impulse control *most of the time*. People with personality disorders are distinguished by the rigidity of their pattern of over- or under-control, and the severity and persistence of their impulse control problems. Rigid and persistent over-control of impulse can manifest itself as inhibition, reluctance to do anything that involves any type of uncertainty or risk, reluctance to start new things or try new activities, and over-conscientiousness or scrupulousness. Rigid and persistent under-control can manifest itself as recklessness and a disregard for rights and needs of other people. This pattern can lead to troublesome or dangerous problems such as drug use, dangerous or risky sexual liaisons, over-spending, assault, or self-injury.

4. *Interpersonal difficulties:*

Problems with interpersonal relationships are common to all personality disorders. Experts consider these interpersonal difficulties to be the most significant and defining feature that all personality disorders share.

Quite logically, the three defining features described above (i.e., problems with thinking, emotional regulation, and impulse regulation) cause significant interpersonal difficulties. These problematic thoughts, feelings, and behaviours converge to create a very negative impact on people's ability to fulfill social roles, and their ability to form and maintain healthy and rewarding relationships.

Previously, we suggested two core features of personality disorder, affective (emotional) regulation and impulse regulation, could be understood along a single continuum of regulation. At one pole of this regulation continuum is extreme over-regulation (of emotion and/or impulsivity). At the other pole is extreme under-regulation (of emotion and/or impulsivity). In other words, there is a single dimension of regulation ranging from very high to very low, with personality disorders falling at each end of the continuum, and healthy personalities falling somewhere in the middle of these two extremes.

However, the interpersonal problems associated with personality disorders are a bit different. Instead of a single dimension, some experts believe that two dimensions are necessary to properly describe these interpersonal problems. These two dimensions are called the *need for power* and the *need for relationship* and are understood to be at right angles to one another (orthogonal), just like the X and Y axes on a graph. On the vertical Y axis is the need-for-power dimension ranging from high need-for-power (dominance) to low need-for-power (submission). On the X axis is the need-for-relationship dimension ranging from high need for relationship (affiliation) to low need for relationship (detachment).

Most of the personality disorders can be placed into one of the four quadrants that are created by the intersecting lines of these X and Y axes. Some personality disorders, such as the Borderline Disorder, are considered to bounce back and forth between two quadrants. In contrast, healthy personalities exhibit a full range of interpersonal approaches and will generally adjust their manner of relating to others based on the person, the type of relationship, the situation, and the circumstances. Thus, they can comfortably interact in each of the four quadrants and modify their interpersonal style as needed. For instance, it's probably best to interact on the slightly deferential, submissive side of things when we interact with our boss, but probably best to operate on the more dominant side when parenting our children. Once again we see that healthy personalities are distinguished by *flexibility*; in this case, interpersonal flexibility.

Before a diagnosis is made, a person must demonstrate significant and enduring difficulties in at least two of those four areas. Furthermore, personality disorders are *not* usually *diagnosed in children* because of the requirement that personality disorders represent enduring problems across time.

The ten personality disorders can be grouped into three clusters based on descriptive similarities within each cluster. These clusters are:

Cluster A (the "odd, eccentric" cluster);
Cluster B (the "dramatic, emotional, erratic" cluster); and,
Cluster C (the "anxious, fearful" cluster).

Cluster A: Paranoid, Schizoid, and Schizotypal Personality Disorders.

Cluster A is called the *odd, eccentric* cluster. It includes Paranoid Personality Disorder, Schizoid Personality Disorder, and Schizotypal Personality Disorders. The common features of the personality disorders in this cluster are social awkwardness and social withdrawal. These disorders are *dominated by distorted thinking*.

- ***Paranoid personality disorder:*** Paranoid Personality Disorder, as described by the DSM, is the pervasive, persistent and inappropriate mistrust of others. The motives of others are interpreted as malevolent without evidence. The symptoms must begin in early adulthood and be present in a variety of contexts as indicated by at least four of seven possible criteria listed in the manual. Further, this should not be diagnosed exclusively in the presence of a psychotic disorder. These folk tend to be aloof, emotionally distant, grandiose, ridged, sarcastic, contentious and litigious. They are generally unable to accept criticism and usually blame others when criticized.

Early theorists believed the Paranoid Personality developed as a reaction formation against homosexual impulses. The resulting rage was thought to be projected onto others. While much of this theory has been refuted, projection is still considered an

important component of paranoia and in this disorder. Humiliation as a child or excessive parental rage are two possible etiological factors that may create this condition. However, there is also evidence that suggests a genetic component. It is likely, as with many disorders, that both factors play a part in the development of Paranoid Personality Disorder.

- **Schizoid personality disorder:** Schizoid Personality Disorder as defined by the DSM is characterized by profound difficulties in relating to others and a tendency toward constricted emotional expression in interpersonal situations. Individuals afflicted with this disorder appear to have no desire for relationships and are socially isolated. Unlike many other disorders that may produce social isolation (e.g., depression), these individuals do not generally see their lack of social involvement as part of the problem. The diagnosis requires pervasive detachment from interpersonal relationships, restricted range of emotional expression and at least four of seven possible criteria that describe isolation, lack of social desire and emotional detachment/constriction.

Early editions of the DSM had significant differences in the description of Schizoid Personality. The disorder was broadly described in early editions and it has more recently been divided into Schizoid, Schizotypal and Avoidant Personality Disorders. Early clinicians and theorists used terms like "shut-in personality" and "autistic personality" to describe this disorder.

Individuals with Schizoid Personality Disorder do not generally seek out counselling or psychiatric help. However, they may seek out treatment for associated problems such as depression. They are very difficult to treat because they see no benefit in developing a relationship with others and are very resistant to the idea that their way of relating is a problem.

- **Schizotypal:** Schizotypal Personality Disorder as described by the DSM is a pervasive pattern of discomfort and social ineptitude that includes cognitive and/or perceptual distortions and odd or eccentric behaviour. Of course, this begins in early adulthood and is present in a variety of settings as with all the personality disorders. The DSM lists nine criteria, five of which must be present for the diagnosis. The disorder cannot be present "exclusively" in the course of Schizophrenia, however, it may be present before the onset of Schizophrenia. In this case, Schizotypal Personality Disorder (Premorbid) would be the diagnosis. Individuals afflicted with this disorder tend to have similar features of social isolation as in Schizoid Personality Disorder. They may have paranoid features similar to Paranoid Personality Disorder. However, neither Paranoid nor Schizoid Personality type has the marked peculiar behaviour or the cognitive/perceptual problems present in Schizotypal Personality Disorder. A common feature of Schizotypal Personality is ideas of reference. Research suggests that Schizotypal Personality is a "schizophrenia spectrum" disorder. Relatives of schizophrenics have

a higher incidence of Schizotypal Personality and vice versa. It may be that Schizotypal Personality is a trait-like variant of Schizophrenia. Another possibility is that the Schizotypal Personality constitutes the core features of Schizophrenia that may or may not become floridly psychotic. In fact, the ICD-10 classifies Schizotypal Personality with Schizophrenia, rather than with the other personality disorders.

Cluster B is called the dramatic, emotional, and erratic cluster.

It includes:

- Borderline Personality Disorder
- Narcissistic Personality Disorder
- Histrionic Personality Disorder
- Antisocial Personality Disorder

Disorders in this cluster share problems with impulse control and emotional regulation.

- ***Borderline personality disorder:*** Borderline Personality Disorder is one of the most studied personality disorders. It is also one of the most casually used "diagnoses" when clinicians refer to their "difficult" clients. Very angry clients may receive the diagnosis without full consideration of the diagnostic criteria. The diagnosis is often applied loosely to a variety of different contexts and closely related clinical conditions. Originally the term "borderline" developed out of early clinical work in an attempt to classify a condition that was not either "neurotic" or "psychotic", but somewhere in-between.

According to the DSM, Borderline Personality is characterized by problems in relationships, self-image, affects and impulsivity. The most significant area of impairment is related to problems in capacity for attachment and very maladaptive behaviours related to separation. When in a relatively stable and safe relationship, the depressive features are evident. When a disruption occurs in their sense of safety and nurturance, these individuals often decompensate and may experience psychotic-like symptoms such as hallucinations or depersonalization. Rage and sometimes-violent behaviour may result. At this times, the underlying depression may be replaced with impulsive acting out (often substance abuse, sexual promiscuity or suicidal gestures). Further, the once idealized nurturing figure may become a hated persecutor in their mind. This polar shift in perception is called splitting.

These clients can be very challenging for a clinician but also may respond quite strongly to the nurturing qualities of their therapist. The idealization that they receive from these clients is often quite gratifying for the vocational rehabilitation professional. However, where there is idealization, there is often devaluation. Minor mistakes can turn the perfect idealized vocational rehabilitation professional into a demonic monster. Vacations can develop into crises and threats of suicide.

- ***Narcissistic personality disorder:*** Narcissistic Personality Disorder, as described by the DSM, is a pervasive pattern of grandiosity in fantasy or behaviour as well as a need for admiration and a lack of empathy that begins in early adulthood. This occurs in a variety of contexts and has at least five indicators out of the nine that are listed in the DSM. These individuals tend to devalue others for their imperfections. At times, they may idealize others whom they feel meets their criteria for perfection only to be disappointed when the idealized figure ultimately fails or lets them down in some way. Grandiosity is the most useful feature in differentiating Narcissistic Personality Disorder from Histrionic, Antisocial or Borderline Personality. Excessive pride, a lack of emotional expression may distinguish Narcissistic from Histrionic Personality. A fairly stable sense of self, lack of self-destructive and impulsive behaviour and abandonment concerns may distinguish Narcissistic from Borderline Personality.

These individuals are often extremely vulnerable to fluctuations in self-esteem, rage and depression if slighted or if they feel they have been rejected or defeated in some way. Depression is often the reason for seeking clinical assistance after some disappointment has occurred. While individuals with Narcissistic Personality Disorder may be quite arrogant, others may hide their sense of superiority behind humility and self-sacrifice.

- ***Histrionic personality disorder:*** In the past called Hysterical Personality, the label was changed to Histrionic Personality Disorder for the DSM-III and was originally developed out of the work of Sigmund Freud and Pierre Janet. (Both believed sexual seduction played a part in the development of "hysteria". However, Freud moved away from the idea that actual seduction occurred in early life as he elaborated his theory of libidinal drive. Janet, who is not often heard about, maintained that early trauma had lasting effect on hysterical individuals.) In any case, the folks developing the DSM were beginning to move away from theoretical to diagnostic terms that are more neutral. Since the DSM follows a descriptive and categorical approach to diagnosis, Histrionic Personality Disorder was seen as a better description of the emotional lability and attention seeking behaviours of these individuals. The DSM has a list of eight "symptoms" for Histrionic Personality Disorder, at least five of which must be met for the diagnosis. These individuals focus on attention from others and often have quite emotional and dramatic presentations. They present an "exaggeration of femininity", almost to the point of absurdity in some cases. These clients will most likely present clinically with depression or somatic concerns. It is also likely that clinicians will see these individuals due to relationship problems. These individuals are not "reflective" and generally do not function well in close intimate relationships. Rather, they seek to be "fetching companions." Underlying the construction of the "extreme" woman is a very poor self-image and a desire to gratify others (mainly men) through seductive means. Seduction has become the way of connection and relating.

- ***Antisocial Personality Disorder:*** Antisocial personality disorder, sometimes called sociopathy, is a mental disorder in which a person consistently shows no regard for right and wrong and

ignores the rights and feelings of others. People with antisocial personality disorder tend to antagonize, manipulate or treat others harshly or with callous indifference. They show no guilt or remorse for their behavior.

Individuals with antisocial personality disorder often violate the law, becoming criminals. They may lie, behave violently or impulsively, and have problems with drug and alcohol use. Because of these characteristics, people with this disorder typically can't fulfill responsibilities related to family, work or school.

Cluster C is called the anxious, fearful cluster.

It includes;

- Avoidant,
- Dependent, and
- Obsessive-Compulsive Personality Disorders.

These three personality disorders share a high level of anxiety.

- ***Avoidant personality disorder***: is characterized by a pervasive pattern of social inhibition, feelings of inadequacy, and a hypersensitivity to negative evaluation. People with this disorder are intensely afraid that others will ridicule them, reject them, or criticize them. This leads them to avoid social situations and to avoid interactions with others. This further limits their ability to develop social skills. People with Avoidant Personality Disorders often have a very limited social world with a small circle of confidants. Their social life is otherwise rather limited.

Their way of thinking about and interpreting the world revolves around the thought that they are not good enough, and that others don't like them. They think of themselves as unappealing and socially inept. These types of thoughts create feelings of intense anxiety in social situations, along with a fear of being ridiculed, criticized, and rejected. The intensity of this fearful anxiety, and the discomfort it creates, compels them to avoid interpersonal situations. They might avoid parties or social events, and may have difficulty giving presentations at work or speaking up in meetings. Others might perceive them as distant or shy. They likely come across as stiff and restricted. All this will likely interfere with their ability to make friends, or to move ahead professionally.

- ***Dependent personality disorder:*** Dependent Personality Disorder, as described by the DSM, is a pervasive and excessive need to be cared for by another person that leads to clinging and fears of separation. This begins in early adulthood and is present in a variety of contexts. The disorder requires the presence of five out of eight possible criteria that describe problems such as: self-directed behaviour; decision-making; excessive reliance on others for nurturing; support in the face of fears of inability to care for oneself. These people are generally fairly functional and appear to be able to care for themselves. However, they continue to rely excessively on others. An individual afflicted with this pattern of functioning seeks out powerful others to make decisions and guide them through life. These folks may jump quickly into new relationships when one ends, without much concern for the appropriateness of the relationship. These individuals often seek out or end up with controlling and abusive partners. While women in abusive relationships may have Dependent Personality Disorder, the clinician must be cautious not to diagnose this disorder erroneously. Firstly, women are encouraged in this culture toward dependence on others. Further, abuse may create "learned" dependence. Often women who might otherwise be relatively independent in healthy relationships become highly dependent due to ongoing abuse and restrictive control.

Cultural issues must also be considered. Some cultures value dependence on the family much longer than would be considered healthy in the Canadian culture. Therapists must be careful not to be excessively biased by their own cultural viewpoints when conducting cross-cultural counselling. One must always consider the context in which the individual is embedded.

Borderlines may have similar dependency needs, but are likely to be enraged rather than clingy when threatened with abandonment. Further, they would undoubtedly be frightened to allow someone so much control over their life. While both Avoidant and Dependent Personalities need excessive reassurance and have low self-esteem, Dependents seek out rather than avoid or withdraw from relationships, as is characteristic of Avoidant Personality Disorder.

- ***Obsessive compulsive personality disorder:*** Obsessive Compulsive Personality Disorder is a pervasive pattern of preoccupation with orderliness, perfectionism and mental/interpersonal control. For this control they tend to sacrifice flexibility, openness and efficiency. This begins in early adulthood, is present in a variety of contexts and is indicated by four criteria from a list of eight. These symptoms interfere with normal functioning and create significant distress. They are ultimately unproductive, paying more attention to the details of orderliness while sacrificing task completion. These individuals tend to work very hard, but do so at the expense of leisure or pleasurable activities. These individuals live by the words "I should...". Relationships and emotions are characterized by control. Warm expression and intimacy are seldom a part of their

experience or interpersonal relationships. They may have difficulties in being rid of old or worn out objects because they may be needed in the future.

Obsessive Compulsive Personality Disorder differs from Obsessive Compulsive Disorder (OCD) in that OCD involves rituals and repetitive thoughts rather than personality characteristics. Further, OCD is "ego-dystonic" while Obsessive Compulsive Personality Disorder is "ego-syntonic". The two disorders may be co-morbid.

2.7 Other Common Disorders:

- **Substance related disorders:** Although substance-related disorders may be most commonly thought of as the result of drug or alcohol abuse, dysfunction stemming from toxin exposure or the side effects of a medication is included as well. The use of alcohol, amphetamines, caffeine, cannabis, cocaine, hallucinogens, inhalants, nicotine, opiates, phencyclidines, sedatives or anxiolytics can be the foundation of a specific substance-related disorder. In addition, a classification of "unknown" or "other" exists when precise determination cannot be made.

Alcohol abuse is defined as a maladaptive pattern of alcohol abuse leading to clinically significant impairment or distress, as manifested by one or more of the following, occurring within a 12-month period:

- Recurrent alcohol use resulting in failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; or neglect of children or household).
- Recurrent alcohol use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine).
- Recurrent alcohol-related legal problems (e.g., arrests for alcohol-related disorderly conduct).
- Continued alcohol use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the alcohol (e.g., arguments with spouse about consequences of intoxication or physical fights).

Substance Abuse and Substance Dependence: With likely symptoms including failure to meet role obligations, lack of friends, legal problems, inability to keep a job, difficulty in parenting and continued use of a substance in spite of negative consequences, Substance Abuse implies a continued pattern of using alcohol or drugs. Although it is usually coupled with adverse consequences, the client continues this pattern of substance use. Maladaptive behaviours result.

Substance Abuse lacks the component of dependence, an important consideration in diagnosis. To apply the classification of Substance Dependence, the same symptoms are present as for Substance Abuse, but with greater duration and intensity. The client may

describe tolerance, withdrawal or both. Since tolerance indicates the body's adjustment to a substance, the client may make statements such as, "I need more to get just as high," or "I am less drunk than other people using the same amount." If the client attempts to stop substance use, symptoms of withdrawal are experienced. These manifestations include physical symptoms such as sleep disorders, motoric responses and mood changes. Clients may complain of tiredness, inability to concentrate, agitation, depression, irritability or moodiness. Inability to sleep or difficulty awakening may also be present.

- **Schizophrenia:** Schizophrenia is a mental disorder characterized by abnormal social behaviour and failure to understand reality. Common symptoms include false beliefs, unclear or confused thinking, hearing voices that others do not, reduced social engagement and emotional expression, and a lack of motivation. People with schizophrenia often have additional mental health problems such as anxiety, depressive, or substance-use disorders. Symptoms typically come on gradually, begin in young adulthood, and last a long time.
- **Anxiety disorder:** When the diagnosis is any type of anxiety disorder, a physical examination is generally indicated. Including Generalized Anxiety Disorder, Panic Disorder, Phobias (simple, Agoraphobia and social), Obsessive-Compulsive Disorder and PTSD, anxiety disorders respond well to cognitive-behavioural interventions and behaviour therapy, particularly in vivo desensitization. Objectives of treatment include reduction of anxiety and improved management of stress. With the lessening of anxiety, related behaviours and somatic symptoms also diminish. Development of socialization skills and giving a sense of mastery are additional goals.
- **Generalized Anxiety Disorder:** Generalized anxiety disorder (GAD) is an anxiety disorder that is characterized by excessive, uncontrollable and often irrational worry about everyday things that is disproportionate to the actual source of worry. In the case of this disorder, symptoms must last at least 6 months.¹⁰⁹ This excessive worry often interferes with daily functioning, as individuals suffering GAD typically anticipate disaster, and are overly concerned about everyday matters such as health issues, money, death, family problems, friend problems, relationship problems or work difficulties.
- **Panic disorder:** Individuals diagnosed with Panic Disorder suffer from panic attacks involving intense fear such as dying or losing control, doubled with a variety of physical symptoms. Panic attacks may be abrupt and peak within 10 minutes; they may last only a few minutes or they may last for hours.

Symptoms are often perceived as medical in nature and can also include:

- Pounding heart
- Chest pains
- Trembling

- Choking
 - Abdominal pain or distress (nausea)
 - Sweating
 - Dizziness
 - Confusion
 - Dread
 - A desire to flee
- **Obsessive-compulsive disorder (OCD):** A person with this disorder will have obsessions and compulsions that occupy much of their time or cause significant distress or impairment. The obsessions or compulsions will attempt to be ignored, suppressed or eliminated. With this disorder, the person does realize their obsessions or compulsions are excessive and are created by their own minds. Obsessive-Compulsive Disorder is chronic and tends to occur mostly with women.

Obsessions are repetitive ideas, images or impulses that intrude into the individual's thinking. They are unwanted, distressful and are sometimes frightening and violent. An example of a frightening obsession is the impulse to jump in front of a car or the concern that he/she may attack a spouse or child. An individual may ruminate endlessly about locking the door or turning off the stove. Compulsions are often obsessions made manifest. Common compulsions include counting, hand washing and cleaning.

Compulsions may become ritualized to the extent that they take up huge amounts of time. These rituals are often based on magical thinking (e.g., clapping my hands 50 times will prevent my mother from dying).

- **Posttraumatic stress disorder:** Posttraumatic Stress Disorder is a condition that sometimes develops in the aftermath of a specific stressful, traumatic event. The disorder exceeds 1 month and involves recurring memories of the trauma. Other symptoms included are emotional withdrawal, intrusive memories, emotional numbing and increased physiological arousal. Examples of traumas include (but are not limited to) abductions, rapes, incest and combat experiences.

PTSD was first "discovered" and classified due to symptoms presented by Vietnam veterans. Similar patterns of symptoms were in the past called "shell shock". People with this disorder often become emotionally numb and try to avoid anything that will trigger unwanted memories. People with Posttraumatic Stress Disorder often have difficulty sleeping, aggressive behaviour and anxiety attacks.

- **Mood disorders:** The diagnostic cluster of mood disorders: Major Depression, Dysthymia, Atypical Depression, Bipolar Disorder I & II and Cyclothymic Disorder, respond well to cognitive-behavioural, interpersonal and related interventions. Within the larger objective of overall adjustment, mood stabilization, alleviation of depression

and mania, enhancement of coping skills, improvement in relationships and the prevention of relapse are vital treatment objectives.

- **Depression:** Depression is one of the most prevalent conditions causing disability in the workplace. Depression should not be confused with 'sadness'. Most individuals, including the vocational rehabilitation professional, feel sad or blue for a short time especially if something bad happens to them but that mood is limited. Clinical depression means that the symptoms associated with depression (e.g., despondent mood, sadness, loss of interest in the things previously enjoyed) are so severe and persistent that they interfere with work, relationships, and physical health. The brain in a depressed individual no longer shuts off the depressed affect or may turn it on for no reason.

People who are depressed often feel hopeless because the symptoms that initially triggered their stress reaction have persisted despite their personal efforts to change them. In addition to a depressed mood, the worker may exhibit a number of other signs and symptoms including poor sleep, appetite disturbances, hopelessness and worthlessness, suicidal thoughts, lack of interest or pleasure and lack of concentration.

In providing services to individuals who have been off work due to depression there are measures which may prove useful in the return to work process:

- The Patient Health Questionnaire
 - Beck Depression Inventory and
 - The client's identification of readiness
- **Major depressive disorder:** Major Depressive Disorder is major depressive episodes without a history of manic, mixed or hypomanic episodes. This disorder is two times more likely in adolescent and adult females than in males. In the preadolescent period, this disorder affects boys and girls equally. Major Depressive Disorder causes the person to feel unmotivated, sad, listless and emotionally drained. Behavioural manifestations may vary from profound psychomotor retardation and withdrawal, to agitation and irritability.

These symptoms have a profound impact on activities of daily living. A person suffering from this disorder may find it difficult to work, sleep, eat and function from day-to-day. Approximately 25% of the cases include a "presumed" precipitating factor. It appears there is a precipitant in 50% of the elderly population. A thought disorder is sometime present like Major Depression with psychotic features. Delusions are often mood congruent. Hallucinations are rare and when present, usually paranoid or self-deprecating in nature. In the elderly, depression is often called Pseudodementia because it often "looks like" Dementia (e.g., psychomotor retardation, confusion, memory impairment).

Classical psychoanalytic theory postulates that depressed clients have suffered a real or imagined loss of an ambivalently loved object. The person reacts with rage that is turned inward. Cognitive theory suggests a cognitive triad of distorted perceptions. This theory holds that a person's negative interpretation of his own life causes self-deprecating thoughts that lead to depression. Biological theories focus on several neurotransmitters, particularly Norepinephrine (NE) and Serotonin (5 HT). It is suggested that lower levels of one or more of these neurotransmitters causes Depression. Some of the evidence for these theories comes from the action of antidepressants. (They increase levels of neurotransmitters and thereby reduce depressive symptoms; hence it must be lower levels of these chemicals that "create" the depression.) While some tests that measure neurotransmitter levels show lowered presence in depressed clients, the results are inconsistent.

- **Dysthymic disorder:** Dysthymic Disorder is a form of Depression that is not as debilitating as Major Depressive Disorder. Dysthymic Disorder is sometimes called, Neurotic Depression (or Minor Depression). The implication is that Dysthymia is the result of psychological or social factors that create a depressive reaction as opposed to Major Depression that is endogenous and neurochemically based. While there is empirical evidence that suggests a familial pattern to Major Depression and therefore a genetic component, the line of differentiation is not so clear. This disorder is more common in women than men and is considered chronic depression that is continual in nature. Diagnostic criteria for Dysthymia include a course that lasts for 2 years or more. Only about 6% of the population will suffer from Dysthymic Disorder.

Factors that predispose one to Dysthymic Disorder include: A major loss in childhood (often an important caretaking person), a recent loss, chronic stress, the presence of a personality disorder with compulsive or dependent features and alcohol or drug abuse.

Often those persons who suffer from a major depressive disturbance will have a clearing of the more severe symptoms and chronically suffer from a "residue" of Dysthymic Disorder. This is called "Double Depression". Dysthymia must be differentiated from Adjustment Disorder that usually results after a clearly identifiable stressor and resolves after the stress disappears.

- **Bipolar disorder:** Bipolar Disorder is a major mood disorder including moderate or severe depression that alternates with very high levels of happiness and physical activity most of the time. Mania, at some time severe enough to compromise functioning, is required for Bipolar I Disorder. 90% of clients have periods of depression. A "manic episode" usually develops over several days and 20% of manics have hallucinations and/or delusions.

Severe Mania may be indistinguishable from an organic Delirium. A person with this disorder usually has a difficult time concentrating, needs very little sleep and may have inflated self-esteem. Often people with this disorder have also had at least one major depressive episode. A client with Bipolar Disorder may have severe depression but may present with mild depressive symptoms. Attacks are often separated by months or years, but cycling between depression and mania may occur over days or weeks. Pure Mania (Unipolar Mania) is rare, but may occur.

Bipolar II Disorder is diagnosed when a client has Major Depression but also experiences a Hypomanic Episode (usually around the time of the depression) but never develops a full manic episode. 5 to 10% of first-degree relatives with Bipolar Disorder develop the illness. Bipolar Disorder is considered a genetic disorder due to 70% concordance for identical twins. There is some evidence to suggest an abnormality on chromosome 11, but this is not clear at this time.

In individuals with this disorder, the first manic episode usually occurs before age thirty. Onset is usually rapid and resolves within 2 to 4 months. In addition, one or more periods of depression have usually already occurred. Suicide is a major risk during depressive episodes. Legal difficulties or substance abuse are major risks during manic episodes.

- **Conversion disorder:** Conversion disorder (CD) is a diagnostic category used in some psychiatric classification systems (type of somatoform disorder). It is sometimes applied to patients who present with neurological symptoms, such as numbness, blindness, paralysis, or fits, which are not consistent with a well-established organic cause, which cause significant distress, and can be traced back to a psychological trigger. It is thought that these symptoms arise in response to stressful situations affecting a patient's mental health or an ongoing mental health condition such as depression.
- **ADHA: Attention deficit hyperactivity disorder (ADHD)** is a mental disorder of the neurodevelopmental type. It is characterized by problems paying attention, excessive activity, or difficulty controlling behaviour which is not appropriate for a person's age. The symptoms appear before a person is twelve years old, are present for more than six months, and cause problems in at least two settings (such as school, home, or recreational activities). In children, problems paying attention may result in poor school performance. Although it causes impairment, particularly in modern society, many children with ADHD have a good attention span for tasks they find interesting.

Adults with ADHD are diagnosed under the same criteria as children, including that their signs must have been present by the age of six to twelve. Questioning parents or guardians as to how the person behaved and developed as a child may form part of the assessment; a family history of ADHD also adds weight to a diagnosis. While the core

symptoms of ADHD are similar in children and adults they often present differently in adults than in children, for example excessive physical activity seen in children may present as feelings of restlessness and constant mental activity in adults.

Some ADHD symptoms in adults differ from those seen in children. While children with ADHD may climb and run about excessively, adults may experience an inability to relax, or they talk excessively in social situations. Adults with ADHD may start relationships impulsively, display sensation-seeking behaviour, and be short-tempered. Addictive behaviour such as substance abuse and gambling are common. The DSM-V criteria do specifically deal with adults, unlike those in DSM-IV, which were criticized for not being appropriate for adults; those who presented differently may lead to the claim that they outgrew the diagnosis.

- **Specific Learning Disorder:** This refers to a number of disorders which may affect the acquisition, organization, retention, understanding or use of verbal or nonverbal information. These disorders affect learning in individuals who otherwise demonstrate at least average abilities essential for thinking and/or reasoning.

Learning disabilities result from impairments in one or more processes related to perceiving, thinking, remembering or learning. Learning disabilities range in severity and may interfere with the acquisition and use of oral language, reading, written language, and mathematics. Learning disabilities may also involve difficulties with organizational skills, social perception, social interaction and perspective taking.

Although learning disabilities occur in very young children, the disorders are usually not recognized until the child reaches school age. Learning disabilities are a lifelong condition; they are not outgrown or cured, though many people develop coping techniques through special education, tutoring, medication, therapy, personal development, or adaptation of learning skills.

Learning disabilities can be divided into three broad categories with more specific disorders included in each (NCLD, 2015). The specific disorders are described below.

- **Dyslexia** is the term associated with specific learning disabilities in reading. Although features of a learning disability in reading vary from person to person, common characteristics include the difficulty with individual sounds in words, and difficulties with word decoding, fluency, rate of reading, rhyming, spelling, vocabulary, comprehension and written expression. Dyslexia is the most prevalent and well-recognized of the subtypes of specific learning disabilities. Symptoms may include reversing letter sequences; slow or poor recall of facts; trouble summarizing and awkward pencil grip.

- **Dyscalculia** is the term associated with specific learning disabilities in math. Although features of a learning disability in math vary from person to person, common characteristics include difficulty with counting, learning number facts and doing math calculations, difficulty with measurement, telling time, counting money, estimating number quantities, mental math and problem-solving strategies.
- **Dysgraphia** is the term associated with specific learning disabilities in writing. This term is used to capture both the physical act of writing and the quality of written expression. Dysgraphia can manifest in difficulties with spelling, putting thoughts on paper, and poor handwriting, including difficulty in forming letters or writing within a defined space, organizing thoughts on paper, keeping track of thoughts already written down, and difficulty with syntax, structure, and grammar.
- **Tourette:** Tourette syndrome is a chronic movement disorder diagnosed by the presence of frequent motor and vocal tics. It begins between 2 and 15 years of age, and is marked by a fluctuating course. Typically, symptoms change slowly, with old tics disappearing and new tics replacing, or being added to pre-existing tics. The tics commonly decrease during concentration or sleep, and increase with anxiety or tension. Tics can be suppressed, making it difficult at times for physicians to make the diagnosis. A child who only has tics when he takes medication, like Ritalin or Dexedrine, is not given the diagnosis of Tourette syndrome. Some children have only one or two motor tics, or one vocal tic. These children may have other problems similar to children with Tourette syndrome, but are given a diagnosis of Chronic Motor Tic Disorder, or Chronic Vocal Tic Disorder.

Tics are involuntary movements or vocalizations that are brief, sudden, frequent, unexpected, repetitive, purposeless, inappropriate, often irresistible and of variable intensity. Motor and vocal tics may be simple or complex.

- Simple Motor Tics are rapid, darting, "meaningless" movements such as eye blinking, facial grimacing, head or nose-twitching, shoulder shrugging, abdominal tensing, frowning or rapid jerking of any body part.
- Complex Motor Tics are slower, more "purposeful" appearing movements that are never-the-less involuntary and typically non-productive. These include hopping, clapping, touching objects, touching one's self or others, throwing motions, arranging, gyrating, bending, self-biting, rolling the eyes to the ceiling, holding funny expressions, sticking out the tongue, kissing, pinching, hitting, writing the same word over and over, or tearing paper or books. Echopraxia (repeating the actions of another) and copropraxia (obscene gestures) are additional examples of complex motor tics.

- Simple Vocal Tics are fast "meaningless" sounds such as whistling, sniffing, coughing, throat-clearing, barking, grunting, screeching, gurgling, hissing, sucking, and innumerable sounds such as uh-uh, ee-ee, and ah.
- Complex Vocal Tics are more recognizable, although inappropriate words, phrases or statements that are typically used repeatedly. Examples include "Shut-up", "Stop that", "I'm going to do better, right?" "Now you've seen it all right, oh boy." Counting rituals or repeating a phrase until it is "just right" are additional examples. The most well-known complex vocal tic is coprolalia, an outburst of obscene language. It probably occurs in less than one third of individuals with Tourette syndrome, with a peak during adolescence. An outburst of obscene language must be inappropriate to the situation and impulsive to qualify as a tic. It will typically have a "driven" quality as well.
- Sensory Tics have also been described. These can be sensations of pressure, tickle, warmth, cold or other abnormal sensations in the skin, bones, muscles or joints. Sometimes odd sensations are the cause of motor tics.¹¹⁰

2.9 Stress:

Over the past number of years the number of stress-related incidents have risen significantly. Stress management can be complicated and confusing because there are different types of stress — acute stress, episodic acute stress, and chronic stress — each with its own characteristics, symptoms, duration and treatment approaches.

- **Acute stress:** Acute stress is the most common form of stress. It comes from demands and pressures of the recent past and anticipated demands and pressures of the near future. Acute stress is thrilling and exciting in small doses, but too much is exhausting. A fast run down a challenging ski slope, for example, is exhilarating early in the day. That same ski run late in the day is taxing and wearing. Skiing beyond your limits can lead to falls and broken bones. By the same token, overdoing on short-term stress can lead to psychological distress, tension headaches, upset stomach and other symptoms.

Fortunately, acute stress symptoms are recognized by most people. It's a laundry list of what has gone awry in their lives: the auto accident that crumpled the car fender, the loss of an important contract, a deadline they're rushing to meet, and their child's occasional problems at school and so on.

Because it is short term, acute stress doesn't have enough time to do the extensive damage associated with long-term stress. The most common symptoms are:

- Emotional distress — some combination of anger or irritability, anxiety and depression, the three stress emotions.

- Muscular problems including tension headache, back pain, jaw pain and the muscular tensions that lead to pulled muscles and tendon and ligament problems.
- Stomach, gut and bowel problems such as heartburn, acid stomach, flatulence, diarrhea, constipation and irritable bowel syndrome.
- Transient over arousal leads to elevation in blood pressure, rapid heartbeat, sweaty palms, heart palpitations, dizziness, migraine headaches, cold hands or feet, shortness of breath and chest pain.

Acute stress can crop up in anyone's life, and it is highly treatable and manageable.

- ***Episodic acute stress:*** There are those, however, who suffer acute stress frequently, whose lives are so disordered that they are studies in chaos and crisis. They're always in a rush, but always late. If something can go wrong, it does. They take on too much, have too many irons in the fire, and can't organize the slew of self-inflicted demands and pressures clamoring for their attention. They seem perpetually in the clutches of acute stress.

It is common for people with acute stress reactions to be over aroused, short-tempered, irritable, anxious and tense. Often, they describe themselves as having "a lot of nervous energy." Always in a hurry, they tend to be abrupt, and sometimes their irritability comes across as hostility. Interpersonal relationships deteriorate rapidly when others respond with real hostility. The workplace becomes a very stressful place for them.

The cardiac prone, "Type A" personality described by cardiologists, Meyer Friedman and Ray Rosenman, is similar to an extreme case of episodic acute stress. Type A's have an "excessive competitive drive, aggressiveness, impatience, and a harrying sense of time urgency." In addition there is a "free-floating, but well-rationalized form of hostility, and almost always a deep-seated insecurity." Such personality characteristics would seem to create frequent episodes of acute stress for the Type A individual. Friedman and Rosenman found Type A's to be much more likely to develop coronary heart disease than Type B's, who show an opposite pattern of behaviour.

Another form of episodic acute stress comes from ceaseless worry. "Worry warts" see disaster around every corner and pessimistically forecast catastrophe in every situation. The world is a dangerous, unrewarding, punitive place where something awful is always about to happen. These "awfulizers" also tend to be over aroused and tense, but are more anxious and depressed than angry and hostile.

The symptoms of episodic acute stress are the symptoms of extended over arousal: persistent tension headaches, migraines, hypertension, chest pain and heart disease.

Treating episodic acute stress requires intervention on a number of levels, generally requiring professional help, which may take many months.

Often, lifestyle and personality issues are so ingrained and habitual with these individuals that they see nothing wrong with the way they conduct their lives. They blame their woes on other people and external events. Frequently, they see their lifestyle, their patterns of interacting with others, and their ways of perceiving the world as part and parcel of who and what they are.

Sufferers can be fiercely resistant to change. Only the promise of relief from pain and discomfort of their symptoms can keep them in treatment and on track in their recovery program.

- **Chronic stress:** While acute stress can be thrilling and exciting, chronic stress is not. This is the grinding stress that wears people away day after day, year after year. Chronic stress destroys bodies, minds and lives. It wreaks havoc through long-term attrition. It's the stress of poverty, of dysfunctional families, of being trapped in an unhappy marriage or in a despised job or career. It's the stress that the never-ending "troubles" have brought to the people of Northern Ireland, the tensions of the Middle East have brought to the Arab and Jew, and the endless ethnic rivalries that have been brought to the people of Eastern Europe and the former Soviet Union.

Chronic stress comes when a person never sees a way out of a miserable situation. It's the stress of unrelenting demands and pressures for seemingly interminable periods of time. With no hope, the individual gives up searching for solutions.

Some chronic stresses stem from traumatic, early childhood experiences that become internalized and remain forever painful and present. Some experiences profoundly affect personality. A view of the world, or a belief system, is created that causes unending stress for the individual (e.g., the world is a threatening place, people will find out you are a pretender, you must be perfect at all times). When personality or deep-seated convictions and beliefs must be reformulated, recovery requires active self-examination, often with professional help.

The worst aspect of chronic stress is that people get used to it. They forget it's there. People are immediately aware of acute stress because it is new; they ignore chronic stress because it is old, familiar, and sometimes, almost comfortable.

Chronic stress kills through suicide, violence, heart attack, stroke and, perhaps, even cancer. People wear down to a final, fatal breakdown. Because physical and mental resources are depleted through long-term attrition, the symptoms of chronic stress are difficult to treat and may require extended medical as well as behavioural treatment and stress management.

E. Rehabilitation Process:

Medical rehabilitation is a term used to describe a treatment plan whose focus is on maximizing functional abilities to promote physical and mental health. It can concentrate on the physical or cognitive aspects of recovery from an illness, disease, condition or injury. It typically employs the use of a multi-disciplinary team of health professionals to promote overall health.

After the onset of an illness or injury many vocational rehabilitation clients undergo medical rehabilitation. This involves a number of steps:

2.8 Diagnosis

Utilizing a variety of tools a diagnosis of a medical condition typically is undertaken by a medical doctor. General components, which are present in a diagnostic procedure in most of the various available methods includes complementing the already known information with further data gathering, which may include questions of the medical history (potentially from other people close to the patient as well), physical examination and various diagnostic tests.

A diagnostic test is any kind of medical test performed to aid in the diagnosis or detection of disease. Diagnostic tests can also be used to provide prognostic information on people with established disease.

Processing of the answers, findings or other results. Consultations with other providers and specialists in the field may be sought.

- **Blood tests:** Some of the most common blood tests are:
 - *A complete blood count (CBC):* The CBC is one of the most common blood tests. It's often done as part of a routine checkup. The CBC can help detect blood diseases and disorders, such as anemia, infections, clotting problems, blood cancers, and immune system disorders.
 - *Blood chemistry tests/basic metabolic panel:* The basic metabolic panel (BMP) is a group of tests that measures different chemicals in the blood. These tests usually are done on the fluid (plasma) part of blood. The BMP can give doctors information about muscles (including the heart), bones, and organs (such as the kidneys and liver). The BMP includes blood glucose, calcium, electrolyte, and kidney function tests. Some of these tests requires the individual to fast (not eat any food) before the test, and others don't.
 - *Blood enzyme tests:* Enzymes help control chemical reactions in the body. There are many blood enzyme tests including: tropomin, creatine kinase, etc.
 - *Blood clotting tests:* Blood clotting tests sometimes are called a coagulation panel. These tests check proteins in your blood that affect the blood clotting process. Abnormal test results might suggest that an individual is at risk of bleeding or developing clots in your blood vessels. Blood clotting tests also are used to monitor

people who are taking medicines to lower the risk of blood clots. Warfarin and heparin are two examples of such medicines.

- **X-ray:** X-rays are a form of electromagnetic radiation, just like visible light. In a health care setting, a machine sends individual x-ray particles through the body. A computer or special film is used to record the images that are created. Structures that are dense (such as bone) will block most of the x-ray particles, and will appear white. Metal and contrast media (special dye used to highlight areas of the body) will also appear white. Structures containing air will be black, and muscle, fat, and fluid will appear as shades of gray.
- **Magnetic resonance imaging (MRI):** Magnetic resonance imaging (MRI), nuclear magnetic resonance imaging (NMRI), or magnetic resonance tomography (MRT) is a medical imaging technique used in radiology to visualize internal structures of the body in detail. MRI makes use of the property of nuclear magnetic resonance (NMR) to image nuclei of atoms inside the body.

An MRI scanner is a device in which the patient lies within a large, powerful magnet where the magnetic field is used to align the magnetization of some atomic nuclei in the body, and radio frequency fields to systematically alter the alignment of this magnetization. This causes the nuclei to produce a rotating magnetic field detectable by the scanner—and this information is recorded to construct an image of the scanned area of the body. Magnetic field gradients cause nuclei at different locations to rotate at different speeds. By using gradients in different directions 2D images or 3D volumes can be obtained in any arbitrary orientation.

MRI provides good contrast between the different soft tissues of the body, which makes it especially useful in imaging the brain, muscles, the heart, and cancers compared with other medical imaging techniques such as computed tomography (CT) or X-rays. Unlike CT scans or traditional X-rays, MRI does not use ionizing radiation.

- **Computerized Tomography Scan (CT Scan):** Computerized (or computed) tomography, and often formerly referred to as computerized axial tomography (CAT) scan, is an X-ray procedure that combines many X-ray images with the aid of a computer to generate cross-sectional views and, if needed, three-dimensional images of the internal organs and structures of the body. Computerized tomography is more commonly known by its abbreviated names, CT scan or CAT scan. A CT scan is used to define normal and abnormal structures in the body and/or assist in procedures by helping to accurately guide the placement of instruments or treatments.

A large donut-shaped X-ray machine or scanner takes X-ray images at many different angles around the body. These images are processed by a computer to produce cross-sectional pictures of the body. In each of these pictures the body is seen as an X-ray "slice" of the body, which is recorded on a film. This recorded image is called a tomogram.

"Computerized axial tomography" refers to the recorded tomogram "sections" at different levels of the body.

Imagine the body as a loaf of bread and you are looking at one end of the loaf. As you remove each slice of bread, you can see the entire surface of that slice from the crust to the center. The body is seen on CT scan slices in a similar fashion from the skin to the central part of the body being examined. When these levels are further "added" together, a three-dimensional picture of an organ or abnormal body structure can be obtained.

- **Single-photon emission computerized tomography (SPECT Scan):** A single-photon emission computerized tomography (SPECT) scan lets the medical practitioner analyze the function of internal organs. A SPECT scan is a type of nuclear imaging test, which means it uses a radioactive substance and a special camera to create 3-D pictures.

While imaging tests such as X-rays can show what the structures inside the body look like, a SPECT scan produces images that show how the organs work. For instance, a SPECT scan can show how blood flows to a heart or what areas of a brain are more active or less active.

- **Electroencephalogram (EEG):** When the neurons of the human brain process information, they do so by changing the flow of electrical currents across their membranes. These changing currents generate electric and magnetic fields that can be recorded from the surface of the scalp. The electric fields are measured by attaching small electrodes to the scalp.

The potentials between different electrodes are then amplified and recorded as the electroencephalogram; (EEG), which means the writing out of the electrical activity of the brain (that which is inside the head). The human EEG was first recorded in the 1920s by a German psychiatrist named Hans Berger.

The tiny magnetic fields that are generated by the neurons of the brain can be measured with very specialized detectors that became available in the 1970s. These are called superconducting quantum-interference devices; or SQUIDS. These devices are based upon the idea that the resistance of a conductor becomes very low when it is cooled by liquid helium to within a few degrees of absolute zero. These superconducting devices can then pick up the very tiny currents that are induced by the magnetic fields. A set of these detectors (usually mounted in a helmet) brought close to the human scalp, can record the magnetoencephalogram or MEG.

- **Electrocardiogram (ECG/EKG):** The electrocardiogram (ECG or EKG⁷) is a non-invasive test that is used to reflect underlying heart conditions by measuring the electrical activity of the heart. By positioning leads (electrical sensing devices) on the body in standardized

⁷ The reason this test is occasionally called an "EKG" is to assure that it is not confused with the close sounding "EEG".

locations, information about many heart conditions can be learned by looking for characteristic patterns on the ECG.

ECG leads are attached to the body while the patient lies flat on a bed or table. Leads are attached to each extremity (four total) and to six pre-defined positions on the front of the chest. A small amount of gel is applied to the skin, which allows the electrical impulses of the heart to be more easily transmitted to the ECG leads. The leads are attached by small suction cups, Velcro straps, or by small adhesive patches attached loosely to the skin. The test takes about five minutes and is painless. In some instances, men may require the shaving of a small amount of chest hair to obtain optimal contact between the leads and the skin.

An ECG can detect a number of things including:

- The underlying rate and rhythm mechanism of the heart.
- The orientation of the heart (how it is placed) in the chest cavity.
- Evidence of increased thickness (hypertrophy) of the heart muscle.
- Evidence of damage to the various parts of the heart muscle.
- Evidence of acutely impaired blood flow to the heart muscle.
- Patterns of abnormal electric activity that may predispose the patient to abnormal cardiac rhythm disturbances.

2.9 Medication

Many, if not most, clients that the typical vocational rehabilitation professional sees will be on some type of medication for symptoms related to their disability. The VR Professional needs to be aware of the side effects of these medications as they may have a significant impact on the vocational rehabilitation process. There are numerous compendiums and websites which list medications and their various side-effects.

Some of the most common medications and their side-effects, used by vocational rehabilitation clients are:

- **OxyContin** (oxycodone) is an opioid pain reliever similar to morphine. An opioid is sometimes called a narcotic. OxyContin is used to treat moderate to severe pain that is expected to last for an extended period of time. OxyContin is used for around-the-clock treatment of pain. Common side-effects include: physical addiction, constipation; dizziness; drowsiness; dry mouth; headache; nausea; sweating; vomiting; and weakness.
- **Paxil (paroxetine)** is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors (SSRIs). Paxil affects chemicals in the brain that may become unbalanced. Paxil is used to treat depression, obsessive-compulsive disorder, anxiety disorders, post-traumatic stress disorder (PTSD), and premenstrual dysphoric disorder (PMDD). Common side-effects include: Anxiety; blurred vision; constipation; decreased

sexual desire or ability; diarrhea; dizziness; drowsiness; dry mouth; gas; increased sweating; increased urination; loss of appetite; nausea; nervousness; numbness or tingling of the skin; stomach upset; trouble sleeping; weakness; and yawning

- **Lipitor (atorvastatin)** belongs to a group of drugs called HMG CoA reductase inhibitors, or "statins." Lipitor reduces levels of "bad" cholesterol (low-density lipoprotein, or LDL) and triglycerides in the blood, while increasing levels of "good" cholesterol (high-density lipoprotein, or HDL). Lipitor is used to treat high cholesterol, and to lower the risk of stroke, heart attack, or other heart complications in people with type 2 diabetes, coronary heart disease, or other risk factors. Common side-effects include: Diarrhea; joint pain; mild sore throat; nausea; runny or stuffy nose; and stomach upset
- **Vicodin** contains a combination of acetaminophen and hydrocodone. Hydrocodone is in a group of drugs called opioid pain relievers. An opioid is sometimes called a narcotic. Acetaminophen is a less potent pain reliever that increases the effects of hydrocodone. Vicodin is used to relieve moderate to severe pain. Common side-effects include: Blurred vision; constipation; difficulty breathing; dizziness; drowsiness; flushing; lightheadedness; mental/mood changes; nausea and vomiting
- **Norvasc (amlodipine)** belongs to a group of drugs called calcium channel blockers. Norvasc relaxes (widens) blood vessels and improves blood flow. Norvasc is used to treat high blood pressure (hypertension) or chest pain (angina) and other conditions caused by coronary artery disease. This medication is for use in adults and children who are at least 6 years old. Common side-effects include: Dizziness; drowsiness; fatigue; flushing; headache; muscle cramps; nausea; stomach pain and weakness
- **Omeprazole** belongs to a group of drugs called proton pump inhibitors. It decreases the amount of acid produced in the stomach. Omeprazole is used to treat symptoms of gastroesophageal reflux disease (GERD) and other conditions caused by excess stomach acid. It is also used to promote healing of erosive esophagitis (damage to your esophagus caused by stomach acid). Omeprazole may also be given together with antibiotics to treat gastric ulcer caused by infection with helicobacter pylori (*H. pylori*). Common side effects include: Diarrhea; gas; headache; nausea; stomach pain and vomiting
- **Xanax (alprazolam)** belongs to a group of drugs called benzodiazepines. It works by slowing down the movement of chemicals in the brain that may become unbalanced. This results in a reduction in nervous tension (anxiety). Xanax is used to treat anxiety disorders, panic disorders, and anxiety caused by depression. Common side-effects include: Changes in appetite; constipation; decreased sexual desire or ability; diarrhea; dizziness; drowsiness; dry mouth; light-headedness; nausea; tiredness and weight changes
- **Diazepam (Valium)** belongs to the class of medications called *benzodiazepines*. It is used for the short-term relief of symptoms of excessive anxiety or alcohol withdrawal (such as

agitation). It is also used for the reduction of muscle spasms. It works by slowing down the nerves in the brain (i.e., central nervous system). The injectable form of this medication is used to control prolonged seizures. Side effects could include: clumsiness or unsteadiness, dizziness, drowsiness or slurred speech.

- **Sertraline** (Zoloft) belongs to a class of medications known as *selective serotonin reuptake inhibitors* (SSRIs). It is used to treat depression, panic disorder, and obsessive-compulsive disorder (OCD). It modifies brain chemistry, which helps to elevate mood, reduce panic attacks, and treat OCD. Side effects could include: decreased sexual desire or ability, diarrhea, dizziness, drowsiness, dry mouth, headache, heartburn, increased sweating, loss of appetite, nausea, nervousness, sleep disturbance and tremor (shakiness).
- **Risperidone**: Risperidone is used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions) in adults and teenagers 13 years of age and older. It is also used to treat episodes of mania (frenzied, abnormally excited, or irritated mood) or mixed episodes (symptoms of mania and depression that happen together) in adults and in teenagers and children 10 years of age and older with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). Risperidone is also used to treat behaviour problems such as aggression, self-injury, and sudden mood changes in teenagers and children 5 to 16 years of age who have autism (a condition that causes repetitive behaviour, difficulty interacting with others, and problems with communication). Risperidone is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain.

This is not an exhaustive list of common medications used by vocational rehabilitation clients; rather it is only a small sampling for illustrative purpose. As can be seen, even in this short list, each of these common medications could have an impact on a client finding and maintaining employment. The vocational rehabilitation professionals needs to keep in mind not only the client's disability but also the limitations which are created by medication.

2.10 Rehabilitation Terminology

The rehabilitation process varies widely, dependent on the underlying issue. The vocational rehabilitation professional may encounter a number of terms related to the rehabilitation process. The following is a listing of some of the more common terms that may be encountered:

- **Angioplasty**
 - a minimally invasive endovascular procedure to widen narrowed or obstructive arteries or veins
 - typically used to treat arterial atherosclerosis

- also known as balloon angioplasty (because a balloon catheter is used for the procedure) or percutaneous transluminal angioplasty (PTA)
- **ASIA Impairment Scale (American Spinal Injury Association)**
 - This is a method to define the extent of spinal cord injury (SCI)
 - A = Complete: No sensory or motor function is preserved in sacral segments S4-S5
 - B = Incomplete: Sensory, but not motor, function is preserved below the neurologic level and extends through sacral segments S4-S5
 - C = Incomplete: Motor function is preserved below the neurologic level, and most key muscles below the neurologic level have a muscle grade of less than 3
 - D = Incomplete: Motor function is preserved below the neurologic level, and most key muscles below the neurologic level have a muscle grade that is greater than or equal to 3
 - E = Normal: Sensory and motor functions are normal
- **Assistive Technology**
 - an umbrella term that includes assistive, adaptive and rehabilitative devices for people with disabilities
 - used to mitigate the effects of disabilities and promote greater independent functioning
- **Audiology**
 - a branch of science that concerns hearing, balance and related disorders
 - audiologists treat those with hearing loss and proactively prevent related damage
- **Comorbidity**
 - the presence of one or more additional diseases or disorders co-occurring with a primary disease or disorder
- **Ergonomics**
 - Ergonomics is about interactions between people and their physical and organizational environments. When people's workplace conditions and job demands match their capabilities, safety and productivity improve. Ergonomics can reduce the risk of strains and sprains and other related musculoskeletal injuries (MSIs). A professional that specializes in this field is an “ergonomist”.
- **Idiopathic**
 - a disease or illness that is not connected to any particular cause
 - arising spontaneously or from an obscure or unknown cause
 - peculiar to the individual

- **Massage Therapy**
 - a scientific manipulation of the soft tissues of the body in order to normalize those tissues
 - involves manual techniques that include applying fixed or movable pressure, holding and/or causing movement of or to the body
- **Maximum Medical Improvement/Medical Plateau**
 - at point at which a person reaches a state where his or her condition cannot be improved with any further treatment or interventions
 - full recovery where the healing process is complete
- **Nerve Conduction Velocity**
 - the speed at which an electrochemical impulse spreads down a neural pathway
 - conduction velocities can be affected by many factors including age, sex, and various medical conditions
- **Neuro-ophthalmology**
 - a combination of neurology and ophthalmology designed to deal with complex systemic diseases that manifest in the visual system
 - used in any afferent visual system disorders that include optic neuropathy, brain tumors, strokes, and so on
- **Neuropsychological Assessment**
 - the assessment of cognition and behaviour
 - used to determine the effects of brain injury, dementia, or other neuropathological processes
 - focus is on orientation, new learning, memory, intelligence, language, visuoperception, executive functions, and so on
- **Neuropsychology**
 - the study of the structure and function of the brain as it relates to specific psychological processes and behaviour
 - concerned with the diagnosis and treatment of behavioural and cognitive effects of neurological disorders
- **Occupational Therapy**
 - the use of assessment and intervention to develop, recover, or maintain meaningful activities or occupations
 - typically directed towards people with mental health problems, injuries, or impairments

- **Occupational Health Psychology**
 - Occupational health psychology (OHP) is an interdisciplinary area of psychology that is concerned with the health and safety of workers. OHP addresses a number of major topic areas including the impact of occupational stressors on physical and mental health, the impact of involuntary unemployment on physical and mental health, work-family balance, workplace violence and other forms of mistreatment, accidents and safety, and interventions designed to improve/protect worker health.
- **Orthotics**
 - a specialty in the medical field concerned with the design, manufacture and application of externally applied devices (orthoses)
 - used to modify the structural and functional characteristics of the neuromuscular and skeletal system
- **Physiatrist**
 - Physical Medicine and Rehabilitation (PM&R) physician who treats a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles and tendons
 - a physiatrist can also diagnose and treat pain
 - treatment focuses on function
- **Physical Therapy (Physiotherapy)**
 - a branch of medicine that uses mechanical force and movements, manual therapy, exercise therapy, and electrotherapy (rather than drugs)
 - used to correct the disabling consequences of impairments and promote mobility and function
 - in terms of injuries, studies conclude that the timing is critical; faster initiation of physiotherapy post-injury can result in faster recovery rates, increased functionality, and decreased disability
- **Prosthesis**
 - an artificial device that replaces a missing body part
 - intended to restore the normal functions of the missing body part
 - prosthetics are created with CAD (Computer-Aided Design) in order to help creators visualize the device in 3-D form
- **Radiology**
 - medical imaging to diagnose and treat diseases within the body
 - includes x-ray, radiography, ultrasound, computed tomography (CT), positron emission tomography (PET), and magnetic resonance imaging (MRI)
- **Reflexive Response**
 - an involuntary and nearly instantaneous movement in response to a stimulus

- does not involve conscious thought
- **Residual Functional Capacity**
 - concerns an individual's remaining physical and mental capacity to perform work (or activities of daily living) on a regular and continuing basis after an impairment is experienced (and in some cases, treated)
 - focuses on functioning level of exertion and limiting restrictions
- **Respondent Pain**
 - a conditioned response to a stimulus; in this case, pain
 - concerns the development of chronic pain
 - the hypothesis is that the responses to acute pain (muscle tension, etc) evolve into chronic pain through a process of classical conditioning to stimuli like certain environments and body positions
 - such conditioning can elicit a fear of pain
- **Rheumatology**
 - a sub-specialty of internal medicine concerning the diagnosis and treatment of rheumatic diseases (e.g., gout, arthritis, lupus, etc.)
 - focuses on clinical problems with joints, soft tissues, autoimmune diseases, vasculitides, and heritable connective tissue disorders
 - because many such clinical problems are now known to be disorders of the immune system, rheumatology involves the study of immunology
- **Speech-Language Pathology**
 - a field of expertise that specializes in the evaluation, diagnosis, and treatment of communication disorders, cognitive-communication disorders, voice disorders, and swallowing disorders
 - concerned with a broad scope of speech, language, swallowing and voice issues involved in communication
- **Threshold of Pain**
 - the point along a curve of increasing perception of an external stimulus at which point pain begins to be felt
 - a completely subjective phenomenon concerning the experience of a person in response to an external stimulus
- **Work Conditioning**
 - an intensive, goal-oriented conditioning program designed to restore neuromuscular and musculoskeletal function, including strength, power, endurance, joint mobility, range of motion (ROM), motor control, cardiovascular endurance and functional abilities
 - primary objective is to restore functional capacity to work

Review:

1. These disorders are inherited and may have a significant impact on the individual's ability to successfully enter and/or maintain employment?
 - a. Traumatic injuries
 - b. Degenerative injuries
 - c. Congenital disorders
 - d. Physical disabilities
2. The fibers that receive neural impulses are called:
 - a. Dendrites
 - b. Synapses
 - c. Neurons
 - d. Soma
3. The bundle of nerves that join the right and left hemisphere of the brain is called:
 - a. Medulla
 - b. Corpus Callosum
 - c. Cerebellum
 - d. Pons
4. A client has normal function of his arms and hands. Due to their spinal cord injury there has been an effect on their trunk and legs. They have been diagnosed with "paraplegia". At what level was the client's spine likely injured?
 - a. C1 - C4
 - b. S1 – S5
 - c. T1 - T5
 - d. L1 – L5
5. The parasympathetic division of the autonomic nervous system functions to:
 - a. Inhibit or slow down autonomic activities such as heart rate, pupil constriction and bladder contraction.
 - b. Control skeletal muscles, as well as external sensory organs, such as the skin.
 - c. Speed up heart rate, dilate pupils and relax the bladder.
 - d. Carry information from the central nervous system to organs, muscles and glands
6. This cranial nerve is basically functional in providing information related to balance of head and sense of sound or hearing.
 - a. Oculomotor
 - b. Trochlear

- c. Vestibulocochlear
 - d. Trigeminal
7. Which of the following is a condition caused by medical personnel or procedures, including fears instilled by remarks or questions of health care professionals?
- a. Clinical iatrogenesis
 - b. Clinical atrophy
 - c. Clinical symbiosis
 - d. Clinical protocol
8. What is the typical timeframe for individuals moving from subacute to chronic phase of pain?
- a. 2 weeks
 - b. 7 weeks
 - c. 26 weeks
 - d. 12 weeks
9. This disorder is a chronic progressive disease characterized by severe pain, swelling and changes in the skin?
- a. Complex Regional Pain Disorder
 - b. Parasympathetic Pain Disorder
 - c. Chronic Pain Disorder
 - d. Simple Generalized Pain Disorder
10. Bradyphrenia sometimes occurs in people with:
- a. Cancer
 - b. Heart disease
 - c. Diabetes mellitus
 - d. Parkinson's disease
11. Interpretation of vision (colour, light, movement) is controlled by what part of the brain?
- a. Cerebellum
 - b. Occipital lobe
 - c. Brain stem
 - d. Frontal lobe
12. This disease can lead to abdominal pain, severe diarrhea, fatigue, weight loss and malnutrition:
- a. Crohn disease
 - b. Tourette syndrome
 - c. Bradyphrenia

- d. Parkinson's disease
13. An anxiety disorder which is characterized by excessive, uncontrollable and often irrational worry about everyday things that is disproportionate to the actual source of worry.
- a. Panic disorder
 - b. Obsessive-compulsive disorder
 - c. Generalized anxiety disorder
 - d. Posttraumatic stress disorder
14. This disorder is characterized by profound difficulties in relating to others and a tendency toward constricted emotional expression in interpersonal situations:
- a. Paranoid personality disorder
 - b. Schizoid personality disorder
 - c. Dysthymic disorder
 - d. Narcissistic personality disorder
15. According to the DSM, "retardation" occurs for individuals with an measured IQ of:
- a. 100 or below
 - b. 50 or below
 - c. 85 or below
 - d. 70 or below
16. The disorder that is characterised by major mood changes between depression and mania:
- a. Schizophrenia
 - b. Bipolar
 - c. Paranoia
 - d. Dysthymic
17. A non-invasive test that is used to reflect underlying heart conditions by measuring the electrical activity of the heart is a (an):
- a. Electroencephalogram (EEG)
 - b. Electrocardiogram (ECG)
 - c. Single-proton computerized tomography scan (SPECT)
 - d. Magnetic resonance imaging (MRI)
18. An example of an antidepressant drug is:
- a. Lipitor
 - b. Vicodin
 - c. Paxil
 - d. Omeprazole

19. The ASIA Impairment Scale is a method to define the extent of:
- a. Spinal cord injury
 - b. Heart muscle tissue injury
 - c. Vision loss
 - d. Hearing loss
20. A client receives a diagnosis that their disability is “idiopathic”. This means:
- a. The disability arises due to a virus
 - b. The disability not connected to any particular cause
 - c. The disability is due to an tissue damage
 - d. The disability arises due to a bacteria

Answers

1. Congenital disorder - 2.1
2. Dendrites – 2.2
3. Corpus Callosum – 2.2
4. T1 – T5 – 2.2
5. Inhibit or slow down autonomic activities such as heart rate, pupil constriction and bladder contraction - 2.2
6. Vestibulocochlea - 2.2
7. Clinical iatrogenesis – 2.4
8. 12 Weeks – 2.4
9. Complex Regional Pain Disorder – 2.5
10. Parkinson's Disease – 2.5
11. Occipital lobe – 2.5
12. Crohn Disease – 2.5
13. Generalized Anxiety Disorder – 2.7
14. Schizoid Personality Disorder – 2.7
15. 70 or below – 2.7
16. Bipolar – 2.7
17. Electrocardiogram (ECG) – 2.8
18. Paxil – 2.9
19. Spinal Cord Injury – 2.10
20. The disability is not connected to any specific cause – 2.10

Domain Three

Vocational Interviewing and Counselling

The biopsychosocial model of disability provides the most effective understanding of the effects of a disability on the individual. It takes into consideration not only the biological/medical issues, but also the social and psychological impact of the disability on the individual. For a vocational rehabilitation program to be effective, it also has to recognize and provide services to the person, rather than focus just on the biological aspects of their disability.

A. Roles and Function of the Vocational Rehabilitation Professional

3.1 Roles and function of the Vocational Rehabilitation Professional:

The role and function of the Canadian vocational rehabilitation professional has changed significantly in the past fifty years. With the introduction of the Canadian Human Rights Act, and the requirement of evidence-based service delivery there has been a change from economic- return philosophy to disability rights philosophy. Throughout the early part of the twentieth century and continuing even into the 1970's employment of individuals with disabilities was seen more as a relief of economic costs and increasing income. Whereas with the rise of the disability rights movement there came an understanding that the ability to pursue employment is not only an economic issue but a human rights issue. This has meant inclusion, opportunity, independence, rehabilitation, empowerment and quality of life for individuals with disabilities.

Both vocational rehabilitation professionals and clients generally accept the notion that the goals of the vocational rehabilitation process can be better achieved when there is maximum client involvement in the development, implementation, and use of vocational rehabilitation services. The concept of client informed choice is intended to maximize the involvement of clients in their vocational rehabilitation programs. Vocational rehabilitation professionals assist clients in exercising informed choice throughout the vocational rehabilitation process by (a) providing clients with information pertaining to various options (e.g., job development service providers, vocational evaluation service providers, plan development, etc.), (b) providing recommendations and professional opinions, and (c) providing clients with information concerning the policies and procedures on service provision.

Muthard and Salamone¹¹¹ conducted the first study investigating the roles and functions of Vocational Rehabilitation Professionals. Their results suggested that these

Professionals divide their time equally among three areas including: (a) counselling and guidance; (b) clerical work, planning, recording, and placement; and (c) professional growth, public relations, reporting, resource development, travel, and supervisory administrative duties.

Leahy et al.¹¹² conducted a recent roles and functions study, which involved a survey of a large random sample of certified rehabilitation Vocational Rehabilitation Professionals. This study examined the perceived importance of major job functions and knowledge domains that underlie contemporary rehabilitation counselling practice and credentialing. Results revealed seven major job functions as central to the professional practice of vocational rehabilitation counselling in today's practice environment including: (a) vocational counselling and consultation, (b) counselling interventions, (c) community-based rehabilitation service activities, (d) case management, (e) applied research, (f) assessment, and (g) professional advocacy.

The vocational counselling and consultation function was composed of four sub-factors including: (a) job development and placement, (b) career counselling, (c) employer consultation, and (d) vocational planning and assessment. The tasks associated with counselling interventions were organized into three sub-factors including (a) providing individual, group, and family counselling; (b) building client-Vocational Rehabilitation Professional working relationships; and (c) helping clients cope with specific psychosocial issues related to disabilities. The community-based rehabilitation service function represents activities that involve such tasks as (a) researching resources and funding available in the community for clients, (b) advocating for clients and their families, (c) benefits counselling, (d) and marketing rehabilitation services to the community. The case management function involves activities such as: (a) obtaining written reports regarding client progress, (b) developing rapport/referral network with physicians and other rehabilitation health professionals, (c) reporting to referral sources regarding progress of cases, and (d) making financial decisions for caseload management. The applied research function focuses primarily on applying research skills to professional practice (e.g., reviewing clinical rehabilitation literature on a given topic or case problem). The assessment function represents assessment activities such as selecting and administering standardized tests and conducting ecological assessment. Finally, the professional advocacy function involves applying disability-related policy and legislation to daily rehabilitation practices.

On a daily basis, the most frequently performed tasks fall under the functional domains of case management, professional advocacy, and counselling, followed by vocational consultation, assessment, utilization of community-based services and applied research.

3.2 Knowledge and skills of a Vocational Rehabilitation Professional

Rubin and Roessler¹¹³ proposed that in order for persons with disabilities to be effectively served, vocational rehabilitation professionals must operate as "sophisticated

professionals” who possess multiple skills and knowledge domains and have the ability to integrate a multifaceted service delivery system. Leahy et al.¹¹⁴ identified six knowledge and skill domains perceived by vocational rehabilitation professionals as important for contemporary VR counselling practice including: (a) career counselling, assessment and consultation; (b) counselling theories, techniques, and applications; (c) rehabilitation services and resources; (d) case and caseload management; (e) healthcare and disability systems; and (f) medical, functional, and environmental implications of disability.

The career counselling, assessment and consultation services domain represents knowledge in vocational consultation and employer services, job development/job placement, and career counselling and assessment techniques. The counselling theories, techniques, and applications domain represents knowledge in mental health counselling, group and family counselling, individual counselling, psychosocial and multicultural counselling, and professional issues. The rehabilitation services and resources domain represents knowledge related to supported employment and school to work transition, independent living, benefits counselling, healthcare and rehabilitation systems, and other community resources. The case and caseload management domain represents knowledge related to principles of caseload management, clinical problem-solving skills, case recording and documentation, interdisciplinary teamwork, and conflict resolution strategies. The healthcare and disability systems domain represents knowledge required to perform rehabilitation case management functions in integrated disability management systems. The medical, functional and environmental implications of disability domain represent knowledge related to medical and functional limitations of disabilities and their vocational implications.

Leahy’s study also highlighted the renewed emphasis on the need for clinical counselling skills. The implications for Canada are a move away from “vocational rehabilitation mechanics” and towards true vocational rehabilitation professional, where the individual with a disability becomes the focus of the service and not the program. Historically, organizations have employed individuals, with minimal education and training, to move clients through their program. The current focus is shifting towards professionally skilled individuals who can adapt and change the services depending on the needs of the individual with the disability

3.3 Difference between vocational guidance and counselling:

In the history of vocational rehabilitation, counselling and guidance have been thrown together as if they were one and the same thing. Only recently has the profession acknowledged the difference and the importance of these two processes. Corthwell¹¹⁵ wrote:

Guidance is informed advice. Guidance is the giving of information, and in the case of career guidance, the sharing of information relative to careers. Guidance is guiding. Conversely, counselling is a structured process of intervention with the objective of

helping the individual define his/her thoughts and feelings, in the case of career counselling, about possible occupations.

The meanings of the words “counselling” and “guidance” in the vocational rehabilitation system have never been clear. Frequently “counselling” and “guidance” were viewed as though they were one thing. The fact is that counselling and guidance are two different activities. Examples of guidance include: referring clients for aptitude, achievement, interest, personality and intelligence tests; directing clients to computer-based vocational exploration systems and helping them to use and interpret the products of those systems; helping clients explore opportunities at universities, community colleges and community service providers and referral for vocational evaluation and interpretation plus application of results. Counselling, on the other hand, includes activities such as: assisting a client through a process that promotes identification, exploration and articulation of personal needs and desires; assisting a client to identify, clarify and articulate likes and dislikes and assisting a client to identify and articulate fears. “The assistive process becomes career counselling when it includes exploring how those needs, desires, likes, dislikes, fears, etc., pertain to possible career choices.”¹¹⁶

In the past, the field of vocational rehabilitation counselling has used the term vocational counselling for what is now understood to be vocational guidance. Now, the term career counselling is preferred in the field to talk about the process of helping a client to explore values, interests, feeling, goals and emotional barriers related to discovering and entering a suitable career.

For the majority of vocational rehabilitation clients, career guidance will be appropriate and sufficient where guidance will consist of the exploration of aptitudes, interests, abilities, etc. utilizing psychometric instruments coupled with information about occupations and occupational requirements. For some clients, career guidance alone will not suffice. Some individuals require a more structured and thorough examination of their values and interests and a comparison of those values and interests with the realities of their current situation. Examples of people who can benefit from career counselling include individuals with self-image problems, unrealistic goals, undetermined vocational goals, unspecified vocational goals and perhaps unresolved grief associated with the acquisition of a disability that has created the need to change career paths. It is important to remember that even if the vocational rehabilitation professional’s assessment is that career counselling is needed, the decision to participate in career counselling must be one jointly agreed upon by both the client and the VR Professional.

B. Interviewing Skills

Typically, the first direct contact between a client and the vocational rehabilitation professional occurs during the intake interview. Depending on the organization this interview is sometimes called the initial vocational assessment or intake interview.

The purpose of the intake interview is to gather information about the client. The skill of information gathering requires the vocational rehabilitation professional to have good communication skills.

Most communication has a purpose although people in social situations rarely think about whether their goal is information, entertainment or support. In a workplace, communication may have to do with establishing the rapport that is necessary for teamwork, passing on the organizational culture, or carrying out the work of the organization. While an interview is more formal than a chat on the way in the door in the morning, many interviews are more commonly thought of as one-to-one meetings and they are often unceremonious.

In assisting clients one of the most important skills to possess is the ability to communicate effectively and to respond to the worker's needs. There are a number of important characteristics of effective communication:

- Listening
- Questioning
- Presenting and responding
- Non-verbal communication

3.4 Listening

For various reasons, most people tend to place more emphasis in communication on what they say as opposed to what they hear. There are several types of listening including:

- Inactive listening in which words go in one and out the other ear—the listener does not work to understand
- Selective listening in which the listener filters the message—paying attention only to specific parts of the message—perhaps those that reinforce his or her position
- Reflective listening in which an individual listens for the key points while screening for his or her own prejudices and emotions. The listener encourages, prompts, paraphrases or summarizes (but doesn't parrot) what was said—focussing on both content and feeling—in order to move the conversation forward.

There are a number of common barriers to listening:

- Since people can take in information more quickly than they can speak, it is easy to begin thinking about the first part of a communication while missing the latter part.
- Concentration can be improved by mentally summarizing points or identifying the key parts of a statement, without analyzing it.
- Sometimes the person listening is focussed on their own personal agenda and interests and does not really take in what is being said or they pay attention only to the parts of the message that relate to their own interests. If you become aware that an earlier

concern (perhaps a project deadline or a need to make a decision about a purchase) is impeding your communication, shift your focus away from yourself and concentrate on the person speaking with you and their issues.

- Emotional noise is a term for feelings that distract you from the present communication. (Someone might be anxious about a child's school exam, or irritated because they were unfairly blamed for a problem.) Self-talk can help you deal with this issue and put it aside while you are communicating. ("I have helped my son with his school work as much as I could and my worrying is not going to have any effect on his exam performance.")
- Often, people evaluate or criticize the speaker rather than listening to the message. ("Her grammar is really bad," or "He really doesn't have the expertise to deal with this issue.") Again, the answer is to focus on the message rather than the messenger.
- Sometimes people become overloaded with information and are unable to take in information. Be sensitive to this when planning how much to cover in a meeting with a returning employee and in monitoring their responses.
- External noise refers to things that are happening in the environment that may draw attention away from what is being discussed. If two people are having an argument outside a meeting room, it's probably better to stop, open the door and suggest they move somewhere else. If someone stops you in a busy hallway and wants to discuss a personal problem, you may want to ask them to go with you to a more tranquil place.

3.5 Questioning:

It is possible to be a very good listener and at the same time fail to receive important or useful information. We hear and understand what the person we are with is saying. We may even pay attention to body language to see if there are any discrepancies between the verbal and the nonverbal communication. However, we fail to grasp the whole picture because we don't ask for more information. Questions such as "Are there any possible downsides to this?" or "How did you feel when that happened?" can sometimes provide the one extra piece of information that will enable a listener to see the whole picture. Questions are also a good way to ensure that you listen more than you talk. Generally, open questions provide more information about a client's situation than closed questions. Closed questions—questions that basically need a yes or no answer—can be useful in some situations, such as when you need a commitment or confirmation.

Open versus closed questions:

A closed question is one that is likely to be answered with a simple yes or no. Examples might be:

- Does your back ache?
- Do you enjoy working with your hands?
- Have you applied for social assistance?

An open question is one that requires an explanation or description. It generally yields more information about the client's situation.

- Where and when do you feel pain or discomfort?
- What kinds of work situations do you enjoy?
- How are you dealing with this situation?
- What kinds of work situations do you enjoy?
- How are you dealing with this situation?

Types of Questions

Questions fulfill a number of functions. You can ask questions to obtain a better idea of what happened or what point a person is trying to make.

- Can you tell me more about?
- What would that look like if put into practice?
- How did it go?
- The last time we talked, you were about to How did it work out?
- Can you give me a specific example of?
- What happened first?
- What did you do then?
- Is there anything we've missed?
- How did you react when?
- When does the problem occur? In what environment? In what situations?
- Are there any other symptoms?

You can also ask people questions to clarify their own thinking or feelings.

- What would happen if?
- How did you feel then ... ?
- How would you feel if?
- What would be the benefits of?
- What would be the consequences of?
- What does all this mean to you personally?
- What would be the difference between and?
- How would that compare with?

Questions can also help people identify potential solutions.

- Is there anything else you could try?
- Are there any other possibilities?
- What has worked for you before?
- Are there any clues there to?
- Well, I understand you can't, but if you could, what would that look like?
- What kinds of things are holding you back?
- What would you like more information on?

- What kind of information would you need to answer that question?

Generally questions can be helpful in communications but there are times when questions can be problematic. These include:

- Bombardment—asking bursts of questions without leaving time for consideration or full answers—the other person feels that they are being grilled
- Multiple questions—asking a question that actually consists of several questions—so that the other person isn't sure which one to answer and may feel confused
- Rhetorical questions—asking people questions that don't allow them a point of view (You couldn't disagree with that, right?)
- Blaming questions—questions that assume blame (e.g. Why weren't you wearing the safety gloves? What would make you think you could lift that?)
- Culturally inappropriate questions.

3.6 Presenting and responding:

In addition to asking good questions, other speaking skills can enhance understanding including choice of words, paraphrasing to ensure understanding, and summarizing to move a discussion forward.

Empowering words: The words that are used in communication can have a powerful effect. Denotative language conveys content. Connotative language conveys feelings. Some words empower people and others suggest that they are helpless. For example, using words such as afflicted or suffering implies that the person is a victim of circumstances that they have no control over. Simply stating that they are wheelchair-bound indicates instead that they are experiencing a situation that may be unpleasant but that they have other characteristics that are just as important in living a full life.

Think about the difference between these pairs of phrases.

- He is afflicted with muscular dystrophy. He has muscular dystrophy.
- She is the victim of a work-related injury. She experienced a work-related injury.
- He is deaf. He is hearing impaired.
- Tell me about your problem. Tell me about your situation?

Be descriptive rather than evaluative. Rather than saying "You're not approaching this with a positive attitude," try "It sounds like you are concerned about (and note the problem) and you're looking for strategies to decrease the likelihood that this will happen?" And later, "What are the things that you look forward to in returning to work?" Rather than telling someone "You aren't lifting properly," try "When you lift (and explain specifically what the person is doing and why that might exacerbate a back injury)." In particular, avoid global statements. Rather than "You're always late," say, "In the last two weeks, you punched in late four times."

“I” statements can be effective when a conversation has an emotional content. Statements such as “You are too lazy to put your equipment away and we’re all angry because we have to waste our time looking for things,” might be better phrased as “I feel a bit irritated when I have to spend time looking for a tool because someone hasn’t put it away. It would be easier for me if everyone would replace equipment once they’ve finished using it. I know that it is tempting for people to leave a tool out when they think that they’re going to be using it again shortly, but if I need the equipment in the interim and have to go looking for it, it doubles the time I have to take to complete an activity.” This kind of statement provides logical information about why you want the change.

Whether “I” statements are effective in the workplace depends on the context. It may irritate you that someone is always late but that may not be the issue. If you are the supervisor and being on time is an expectation for everyone in the department, then the employee has an obligation to be on time and that has nothing to do with how anyone feels about it.

Paraphrasing: Paraphrasing is a tool used to ensure that you have actually understood what the person said.

A worker who had suffered a back injury might say, “I’m really worried about going back to work. My back is still very sore and I’m not sure whether I can lift heavy boxes all day.” The individual assisting the worker could paraphrase this statement in the following way:

1. Stem: It sounds like you’re concerned that you might re-injure
2. Essence: your back or delay your recovery
3. Key words: if you lift heavy boxes all day.
4. Check accuracy: Is that what you’re worried about?

Paraphrasing a statement and then asking a question allows you to gain a clearer idea of the problems.

1. You’re worried? (Checks feelings and concerns)
2. Back still sore? (Checks current physical condition)
3. Lift boxes? (Probes for specific aspects of the job that might need to be restricted)
4. All day? (Questions whether the length of time is a concern and whether an accommodation such as a reduced work day might be helpful)

Summarizing: Summarizing can be used to remind yourself and the other person about how far you have moved in your thinking, to clarify points, and to ensure that there is agreement as you move forward.

Non-verbal communication: Non-verbal communication is important because it carries almost all of the emotional content of messages—some researchers say roughly 93 percent. When you are interviewing injured workers or their supervisor, non-verbal communication will be a major source of the information they use to interpret your attitudes and feelings. It also reinforces, contradicts or substitutes for verbal messages.

Examples of non-verbal communication might be pointing as well as providing verbal directions; telling someone that you have time to help them while looking nervously at your watch; or using hand motions to help someone park a car. There are several types of non-verbal communication including:

- Movement and gestures
- Eye contact
- Facial expression (e.g., smiles, lifted eyebrows, wrinkled brow)
- Vocal cues (e.g., tone of voice, loudness or softness, and silence)
- Use of space
- Touch
- Appearance and dress.

Attending is a term for actions (mostly non-verbal) that indicate that one person is paying attention to another, that they value the other and want to hear what they have to say. Attending might involve smiling or leaning forward or engaging in eye contact. It is possible to demonstrate attending behaviours without actually listening and some people who are good listeners may be unexpressive in their body language.

Non-verbal communication may be ambiguous and open to culturally based interpretation. For example, frequent eye-contact can indicate a high interest in what the person is saying, liking or love for that person, a desire to dominate or influence, or even the fact that there is nothing else in the environment to look at. On the other hand, ongoing eye contact is considered rude in some cultures.

People who are very persuasive will often intentionally or unintentionally mirror the behaviour of the people with whom they are interacting, including their posture, gestures, tone and speed of talking. While genuineness is an important part of being an effective helper, it is useful to at least be aware of the other person's non-verbal behaviour. For example, energetic, upbeat body language may make it more difficult for someone who is depressed or in pain to relate to you. A more relaxed or less assertive demeanour may allow a relationship to develop more easily.

Environmental Influences: The environment in which vocational rehabilitation counselling and/or interviewing takes place can have a significant impact on the outcome. There are a number of considerations which should be taken into consideration:

- Perhaps one of the most important environment factors the VR professional must take into consideration is to ensure the privacy of all conversations. Meetings that are held in public areas or in coffee shops may provide a more “comfortable” atmosphere, but can breach client confidentiality.

- First impressions are the most important. The VR professional should attempt to make a good first impression. Typically, this means making the client comfortable.
- There should be an attempt to optimize furniture placement to promote open communication. Sitting behind a desk during a counselling/interviewing session may feel more comfortable to the VR professional but it can not only separate the VR from the individuals physically but also emotionally.
 - Ensuring privacy of all conversations
 - Providing positive first impressions
 - Optimizing furniture placement to promote open communication
 - Providing a comfortable environment
 - Minimizing distractions
 - Support of significant others

3.7 Identifying the need

Presenting Problems: A holistic approach to vocational rehabilitation means that the helping individual needs to be sensitive to the ongoing needs of the client. There are occasions when the individual will be very clear regarding his/her needs. For example they may say such things as:

- I'm having financial difficulties.
- I don't know how to apply for benefits.
- I'm feeling a lot of pain in the morning
- My spouse and I are always arguing.
- I think my drinking is getting out of control.
- I don't think my supervisor wants me to come back to work.

In each of these instances the "presenting problem" may create difficulties in the work-entry or return to work process. For example:

- I'm having financial difficulties
 - This may cause a situation where the worker returns to work too early after an injury and is in danger of reinjuring themselves.
 - This may cause the individual entering the work force for the first time to obtain a job that does not match their skills and/or interests.
- I don't know how to apply for benefits.
 - If the worker doesn't know how to apply for benefits, this could create a significant financial hardship on the individual and their family. This could increase the stress on the worker and in turn exacerbate their physical impairment.
- I'm feeling a lot of pain in the morning
 - This may be an indication of an unidentified physical condition which may impede the rehabilitation process.
- My spouse and I are always arguing.

- Family support is one of the key indicators of a successful job entry or return to work. If the worker and their spouse are arguing this may take their focus off the rehabilitation process and impede the healing process.
- I think my drinking is getting out of control.
 - If a worker makes this statement, this should raise a “red flag” as it could negate anything that is being done in the job-entry or return to work process.
- I don’t think my supervisor wants me to come back to work.
 - If a worker believes that he/she is not welcome back to work they may resist any attempts at the return to work process.

Even though most of the above presenting problems are not directly related to work or the worksite, in order to enhance the possibility of job entry or return to work they need to be addressed.

Underlying Problems: There are occasions when, for a variety of reasons, the client may not directly address problems they are experiencing in their rehabilitation or return to work process. This could be due to such things as:

- Embarrassment
- Inability to articulate problem
- Secondary issues
- Anger

Underlying problems can be very difficult to ascertain but could have significant implications for the success of any return to work plan. For example:

- A client knows they have a problem with their prescription drugs but may be too embarrassed to talk about it.
- A client is feeling hopeless and doesn’t want to leave the home. They know something is wrong but are unsure what it is.
- A worker has been on short term disability for 100 days. The organizations long term disability plan starts at 120 days. They are concerned that if they participate in the return to work program their acceptance into the LTD plan will be jeopardized.
- A worker believes that the supervisor was to blame for the injury which occurred at the workplace. They do not want to return to work and have to report to that supervisor.

One of the significant underlying problems which needs to be recognized is “work adjustment”. A worker who has experienced a disabling condition may experience:

- Being off work an extended period of time and not use to the discipline required by the work setting (e.g. being at a certain place at a certain time, taking directions from a supervisor, etc.).
- Unsure of their present skills and abilities. After a period of time away from work the individual may start to question their abilities to carry out the tasks assigned to their job.

- Unsure of changes in the work place. It is common for work places to change their procedures and processes over time. If the worker is away from work for an extended period of time there could be extensive changes which could in turn cause apprehension.
- A feeling of “not fitting in”. This is one area that is seldom recognized but can have significant impact on a return to work. Social interactions between co-workers change over time and a returning worker may find themselves left out. For example, a worker may have regularly taken their coffee breaks with a particular group of co-workers prior to leaving the workplace. If they are away for an extended period of time these groups could have added new individuals or take their breaks at different times. This may leave the client feeling that they don’t quite fit in anymore.

Adjusting back into the workplace is more than just being physically able to do tasks but also feeling comfortable. There needs to be recognition that problems do not stop when the workers returns to the workplace, but can continue to create difficulties.

Building Rapport and Trust: In order to be able to address these underlying problems the client must feel comfortable enough to be open. This means building rapport and trust with the individual.

Prior to engaging in the interpersonal communication process, there are basic requirements which will influence the worker’s ability to express him/herself, and to make decisions regarding the relationship. These aspects refer to the setting, which in the initial meetings can cause a significant impact in the client's perception towards the vocational rehabilitation representative. In a nutshell, the helper should observe the following:

- Comfort: a comfortable setting improves worker expression of feelings.
- Security/Privacy: providing the worker with security during a session.
- Noise control: ensuring that noise does not affect communication.
- Supportive environment: a space in which the worker can share in their own pace.

Rules of Engagement: There are certain ‘rules of engagement’ which dictate the likelihood of a helping relationship being constructive, and these rules apply to any context. For example, if you have just been introduced to someone at a social event, you should initially avoid asking personal questions as that is perceived to be intrusive. These rules are inherited by particular social groups, and following them is the basis for creating a positive profile and developing a receptive attitude from other group members.

In the vocational rehabilitation setting, there is much more necessity in applying such rules. The client is there for a specific purpose, which requires a particular approach to the situation. The worker is also likely to be “uneasy” or unsure about what to expect, which increases the ‘risk’ of making a bad impression or not developing good rapport.

In order to encourage the worker to engage in a formal relationship, the helper must first avoid the common pitfalls which can make communication difficult. The first and foremost issue to consider in this scenario is the elusive impact of 'first impressions' in the eyes of an individual. Trust and rapport are emotional keywords in the worker's subconscious, and once they have been negatively 'red-flagged' for any reason; it is very unlikely that relationship will move forward. So what can make this occur?

Dodging the Pitfall: The standard communication pitfalls found in any relationship cover most potential problems of the first couple of meetings. They relate to a range of conscious and subconscious thinking patterns which could create communication gaps between the client and Vocational rehabilitation representative.

These patterns are based on the each individual's education, relationships, attitudes, motivational targets, self-confidence levels and a range of other factors. Because the initial stages of a relationship tend to be open and unpredictable, a good strategy to move forward is engaging in prevention: aiming to reduce the probability of communication pitfalls. To prevent this, the individual must be aware of the common mistakes, or negative patterns, of good communication:

- Judging: Criticizing, name-calling, diagnosing and praising evaluatively
- Sending Solutions: Ordering, threatening, moralizing, and advising
- Avoiding the Other's Concerns: Diverting, logically arguing and reassuring

The probable outcome of avoiding such pitfalls is establishing grounds for a productive relationship through good rapport and developing a certain level of trust and openness.

Providing Service

One of the key roles in any vocational rehabilitation program is the provision of "case management" services. This type of service indicates a couple of concepts:

1. Effective vocational rehabilitation programs utilize a biopsychosocial model. That is, there is a concern about the whole person and not just the physical injury. Facilitating the individual back to work requires recognition that psychological and social barriers to return to work are as significant as biological barriers.
2. As the client's needs can extend beyond just the disability there is a need to utilize an interdisciplinary team.
3. There needs to be a coordination of services both inside and outside of the organization.

The first step in coordinating a plan is for the vocational rehabilitation professional to determine what resources (e.g. personnel, finances, equipment, etc.) that would be need to assure the success of the plan.

Depending on the worker's needs, internal and external resources are necessary to overcome barriers to return-to-work. These resources include:

- Internally – supervisors, health and safety professionals, human resource professionals, benefit advisors or administrators, Employee Assistance Programs, occupational health professionals.
- Externally – ergonomist, community resources and funding agencies, insurance carriers, legal professionals, vocational rehabilitation professionals, healthcare professionals, service providers.

In enhancing the possibility of a successful completion of a return-to-work plan the vocational rehabilitation professional needs to be able to engage resources outside of the workplace. This would include third party insurers, such as the workers compensation system and/or LTD provider. It would also include other providers such as counselling services, assistive equipment, etc.

In order to ensure that all stakeholders are “on the same page” regular communication needs to take place. This could be formal communication such as a “team meeting” or ongoing informal conversations. In order to ensure consistency the vocational rehabilitation professional needs to document these conversations.

Collaborative Relationship with Medical Providers

In order to provide effective service to clients in a return to work process, the vocational rehabilitation professional should be aware of the medical practitioners in his/her community. For some, for example those living in a large city, it would be impossible to know every medical practitioner. However, the vocational rehabilitation professional should research to find those practitioners who provide the best services to their patients.

There are various professionals which could be involved with a client. A partial listing would include:

- General Practitioner - A physician whose practice is not oriented to a specific medical specialty but instead covers a variety of medical problems in patients of all ages.
- Specialists – This could include such medical practices as cardiologist (heart), endocrinologist (glands/hormones), gastroenterologist (digestion), neurologist (nervous system), oncologist (cancer), etc.
- Physiatrist – A medical doctor specializing in physical medicine and rehabilitation.
- Psychiatrist – A medical doctor specializing in emotional and mental health difficulties.

- Psychologist – A non-medical doctor (holds a PhD) specializing in emotional and mental health difficulties. Also performs cognitive and neuropsychological assessments.
- Physiotherapist – A therapist who treats injury or dysfunction with exercises and other physical treatments of the disorder.
- Occupational Therapist - The role of an occupational therapist is to work with a client to help them achieve a fulfilled and satisfied state in life through the use of "purposeful activity or interventions designed to achieve functional outcomes which promote health, prevent injury or disability and which develop, improve, sustain or restore the highest possible level of independence."
- Rheumatologist - A rheumatologist is an internist or pediatrician who received further training in the diagnosis (detection) and treatment of musculoskeletal disease and systemic autoimmune conditions commonly referred to as rheumatic diseases. These diseases can affect the joints, muscles, and bones causing pain, swelling, stiffness, and deformity.
- Massage Therapist – An individual who practices therapeutic massage.
- Kinesiologist - An individual who specializes in understanding anatomically and mechanically how the human body moves.
- Chiropractor – An individual who specializes in the hands on or hand-held instrumental movement of the bone structure of the body to improve the function of the joints and/or nervous system.

It is important for the Vocational Rehabilitation Program to make itself known to the health care community. This is typically done in a number of ways including:

- Information package sent to health care provider with the client. This information package contains an outline of the Vocational rehabilitation Program, the process used, the availability of transitional/modified work and contact person.
- General mail out of program information to health care community (e.g. brochures, newsletters, etc.).
- Individual and group invitation to attend the worksite to learn about the Vocational rehabilitation Program.

The Vocational Rehabilitation Program should always attempt to improve the quality of service to clients. One effective method is for vocational rehabilitation professional to hold education sessions for the health care community. In addition to providing information to this group of professionals it also gives an opportunity to seek their input and feedback regarding the Program and the processes.

A common concern with many Vocational Rehabilitation Programs is the lack of coordination with the health care community. One of the roles and responsibilities of the vocational rehabilitation professional is to build relationships between the program and community providers. This relationship should be written into a standardized

protocol. By having a protocol everyone understands their roles and responsibilities in providing service to the client.

An assessment and evaluation of community service providers should be undertaken on a regular basis. This evaluation should consider such things as: effectiveness of service (did they do what they were expected to do), responsiveness of service (did they see clients in a timely manner), cost effectiveness (did the benefits of the service support the associated costs) and worker's satisfaction. This will inform the vocational rehabilitation professional as to the relationship between the Program and the healthcare providers.

The vocational rehabilitation professional needs to work as a team member in carrying out his/her roles and responsibilities. This is especially true in working with external health care providers. It is important for all to work together for the common goal of returning the disabled to work in a safe and timely manner. The vocational rehabilitation professional needs to be responsive and work cooperatively with the others on the team.

Collaborative Relationship with “Psycho-social” Providers

As has been emphasized a client's needs may (and in many instances will) extend beyond just the physical. In order to be effective the vocational rehabilitation professional will need to work with an interdisciplinary team which extends beyond the medical needs of the worker. As needs, which could create barriers to return to work, are identified there needs to be a process in place to provide support and assistance. Typically, these services will be undertaken by community third party providers. These providers could include:

- Employee Assistance Program
- Marriage vocational rehabilitation professionals
- Substance abuse vocational rehabilitation professionals
- Budget/Financial vocational rehabilitation professionals
- Support groups
- Cultural groups

3.8 Initial assessment documentation

The International Labour Organization's Convention 159⁸ provides a listing of elements which should be in an initial vocational assessment:

- An interview with a vocational guidance officer
- Examination of record of work experience

⁸ The ILO is the oldest and one of the largest departments of the United Nations

- Examination of scholastic or other records relating to education or training received
- Medical examination for vocational guidance purposes
- Appropriate tests of capacity and aptitude and, where desirable, other psychological tests
- Ascertainment of personal and family circumstances
- Ascertainment of aptitudes and development of abilities by appropriate work experiences and trial and other similar means
- Technical trade tests, either verbal or otherwise, in all cases where such seem necessary
- Analysis of physical capacity in relation to occupational requirements and the possibility of improving that capacity
- Provision of information concerning employment and training opportunities related to the qualifications, physical capacities, aptitudes, preferences and experience of the person concerned and to the needs of the employment market.¹¹⁷

C. Vocational Counselling

3.9 Stages of Helping

A number of texts in counseling and helping describe a three stage model of working with clients to improve their life situations.

Hill and O'Brien call the three stages exploration, insight and action. Shebib describes the three stages as problem exploration, goal setting and problem solving. Egan¹¹⁸ defines them as:

- Outlining the current state of affairs or assessment— “finding out, or rather learning, what’s wrong, what resources are not being used, what opportunities lie fallow.”
- Determining the preferred scenario by helping the client answer the questions “What do you want and what do you have to do to get what you want?”
- Helping clients work for what they need and want by developing goals and strategies.

This three stage approach is useful in considering the activities of a vocational rehabilitation professional, although a VRP who is exploring work options for a welder who has lost part of an arm in an accident will not be dealing with issues in quite the same way as a therapist who is helping someone to improve their family relationships. In a return to work setting these stages roughly translate into:

- Exploration
- Goal setting and planning
- Action and implementation.

In the exploration stage the vocational rehabilitation professional develops a relationship with the client, finds out about the client's situation, and helps to identify concerns that need to be addressed and problems that require solutions.

During the goal setting and planning stage the elements of the vocational rehabilitation plan are clarified. This involves examining possibilities and determining priorities.

The action or implementation stage involves putting the plan into action, monitoring the plan, and making adaptations or changes if necessary.

Some situations are relatively straightforward. A client with a back injury may simply require a few changes to the work station, elimination of some tasks for a period of time, assistance in developing a plan to enhance back strength as rehabilitation continues, or referral to a massage therapist or acupuncture. In other circumstances, more time and thought will have to be expended—for example, if the client cannot return to the previous job, needs a variety of home and work supports, or must deal with chronic pain or depression.

Vocational rehabilitation professionals approach clients from a perspective that is similar to other professional helpers.

- They suspend judgement and accept the feelings and thoughts of a client who is entering or re-entering the work force. In some cases such individuals may feel that they have been treated unfairly; they may exaggerate or minimize their condition; or they may feel hopeless.
- They try to view the world from the perspective of their client, figuratively to walk in their shoes.
- They demonstrate unconditional positive regard for the person they are trying to assist. While it is important to use the communication skills of attending, this sense of caring must be genuine. Such caring and commitment can be developed by understanding the experience of the client and by focusing on their strengths and positive characteristics. Helpers do not need to "like" clients in the same way that you like or choose to spend time with close friends. Rather, helpers have a responsibility to understand and assist clients and to feel compassion and caring for the human beings underneath the exterior presentations. ... Even though helpers may not have experienced the same life events as their clients, they have surely experienced many of the same emotions and, thus, can empathize with their feelings even if they disagree with their behaviours.
- They put the needs of the client who has incurred an injury or illness first, and are clear about how, in doing this, they can also fulfill their responsibilities to the organization that is employing them.

Worth keeping in mind when working with clients who might be considered difficult, is that almost every quality has a positive and negative side. One side of the coin might be stubbornness with the other side being perseverance. Openness to all possible solutions may

be paired with a tendency not to close on any one solution. The effective helper can assist the client in identifying and harnessing the positive aspects of any quality.

3.10 Vocational Rehabilitation Counselling Intervention

One of the main roles of the vocational rehabilitation professional is to provide vocational, work adjustment and other forms of counselling to their client. It is recognized that the VRP does not typically provide therapeutic counselling as this would be outside of their scope of practice. However, the skills needed in vocational rehabilitation counselling are similar to those found in other helping professionals.

There are numerous counselling interventions which the vocational rehabilitation professional can provide. Two of the most common are a cognitive-behavioural approach and motivational interviewing.

Cognitive- behavioural approach

A cognitive-behavioural approach that emphasizes changing distorted thinking has been found to be very successful in counselling. It is useful for the VRP to recognize the impact that various beliefs may have on the vocational rehabilitation plan and to be prepared to deal with these beliefs.

For example, a client may not want to return to his job because he believes that returning to work is possible only when he is 100 percent free of medical restrictions. In such a situation, the VRP must be prepared to help the client analyse this belief and identify other criteria that would be important in a safe and productive return to work. Another example could be someone who had difficulty learning a new skill. Although the problem may be that the person lacked a foundation of basic skills that were necessary before more complex skills could be acquired, many people in this situation might assume that they were incapable of learning and could never learn the skills required for a new job.

Distorted thinking can affect communication at any level in the vocational rehabilitation process—at the client level, supervisor level, physician level, and labour-management relations level. In communicating, the goal is not to point out to people where they are going wrong but rather to have them explore their own thinking and identify preconceived ideas by empathetically and respectfully using questions and paraphrasing.

Several authors have elaborated on various styles of distorted thinking (Beck, 1979; Burns, 1999; McKay, Davis & Fanning, 1981; Schafer, 1987), including the following cognitive distortions:

- **Filtering**
An individual takes the negative details and magnifies them while filtering out all the positive aspects of a situation. Example: "I would enjoy returning to work if I didn't have to work with Fred."
- **Polarized Thinking**
Things are black or white, good or bad. The person has to be perfect or they are a failure. There is no middle ground. Example: "Either my supervisor is for me or against me."
- **Mind Reading**
Without their saying so, client with an injury or illness knows what people are feeling and why they act the way they do. She especially know how they are feeling about her. Example: "The doctor jokes with me a lot, but I know he really dislikes me because I'm on worker's compensation."
- **Catastrophizing**
The person expects disaster, starting his thinking with "What if..." He exaggerates the negative aspects of the situation. Example: "I haven't been back to work for two months. I know they are going to fire me."
- **Should Statements**
The individual has a list of ironclad rules about how she and others should act. Those who break the rules anger her and she feels guilty if she violate the rules. For example, the belief might be "He should come back to work only when he's at 100%."
- **Personalizing**
The returning client thinks that everything people do or say is some kind of reaction towards him. He also compare himself to others, trying to determine who is smarter, better looking, etc. "Most of my coworkers are smarter than I am."
- **Blaming**
The person hold others responsible for her pain, or conversely take the opposite track and blame herself for every problem. "It's my supervisor's fault that I'm out with this bad back."
- **Being Right**
The individual continually tries to prove that his opinions and actions are correct. Being wrong is unthinkable, and he will go to any lengths to show that he is right. "I really don't care what my boss said. They caused my injury and they should pay for my misery."
- **Fallacy of Change**
The client expects that other people will change to suit her if she just pressures or cajoles them enough. She needs to change people because her hopes and happiness seem to depend entirely on them. "If my company had a health club, I would never have been injured."
- **Overgeneralization**
The person see a single negative event as a never-ending pattern of defeat. If something bad happens once, he expects it to happen over and over again. "Ever since my supervisor screamed at me, I can't trust management."

Motivational interviewing

Motivational Interviewing recognizes and accepts the fact that clients who need to make changes in their lives approach counseling at different levels of readiness to change their behaviour. During counseling, some clients may have thought about making a behaviour change, but may not yet have taken steps to make that change themselves. Alternatively, other clients may be actively trying to change their behaviour and may have been doing so unsuccessfully for years.

For a vocational rehabilitation professional to succeed at motivational interviewing⁹, they should first establish four basic interaction skills. These skills include: the ability to ask open-ended questions, the ability to provide affirmations, the capacity for reflective listening, and the ability to periodically provide summary statements to the client. These skills are used strategically, while focusing on a variety of topics, such as looking back, reflecting on a typical day, the importance of change, looking forward, and examining one's confidence about behaviour changes.

Motivational interviewing is non-judgmental, non-confrontational and non-adversarial. The approach attempts to increase the client's awareness of the potential problems caused, consequences experienced, and risks faced as a result of the behaviour in question. Alternatively, or in addition, vocational rehabilitation professional may help clients envision a better future, and become increasingly motivated to achieve it. Either way, the strategy seeks to help clients think differently about their behaviour and ultimately to consider what might be gained through change. Motivational interviewing focuses on the present, and entails working with a client to access motivation to change a particular behaviour that is not consistent with a client's personal value or goal. Warmth, genuine empathy, and acceptance are necessary to foster therapeutic gain (Rogers, 1961) within motivational interviewing. Another central concept is that ambivalence about decisions is resolved by conscious and unconscious weighing of pros and cons of change vs. not changing (Ajzen, 1980).

The main goals of motivational interviewing are to engage clients, elicit change talk, and evoke client motivation to make positive changes. For example, change talk can be elicited by asking the client questions, such as "How might you like things to be different?" or "How does _____ interfere with things that you would like to do?" Change may occur quickly or may take considerable time, depending on the client. Knowledge alone is usually not sufficient to motivate change within a client, and challenges in maintaining change should be thought of as the rule, not the exception.

Ultimately, practitioners must recognize that motivational interviewing involves collaboration not confrontation, evocation not education, autonomy rather than authority, and exploration instead of explanation. Effective processes for positive change focus on goals that are small, important to the client, specific, realistic, and oriented in the present and/or future.

While there are as many variations in technique as there are clinical encounters, the spirit of the method, however, is more enduring and can be characterized in a few key points:
Motivation to change is elicited from the client, and is not imposed from outside forces.
It is the client's task, not the counselor's, to articulate and resolve the client's ambivalence.
Direct persuasion is not an effective method for resolving ambivalence.
The counseling style is generally quiet and elicits information from the client.

⁹ This section assumes the vocational rehabilitation professional has appropriate training and is staying within their scope of practice.

The counselor is directive, in that they help the client to examine and resolve ambivalence. Readiness to change is not a trait of the client, but a fluctuating result of interpersonal interaction. The therapeutic relationship resembles a partnership or companionship.

There are four overlapping processes that comprise Motivational Interviewing: engaging, focusing, evoking and planning. They are both sequential and recursive, and often depicted in diagrams as stair steps, with engaging at the bottom as the first step.

Engaging: the process of establishing a working relationship based on trust and respect. The client should be doing most of the talking, as the counselor utilizes the skill of reflective listening throughout the process. Both the client and counselor make an agreement on treatment goals and on collaborate the tasks that will help the client reach those goals.

Focusing: the ongoing process of seeking and maintaining direction.^[12]

Evoking: eliciting the client's own motivations for change, while evoking hope and confidence.

Planning: involves the client making a commitment to change, and together with the counselor, developing a specific plan of action.

Motivational interviewing details a number of stages an individual goes through in changing behaviour:

Precontemplation Stage:

During the precontemplation stage, patients do not even consider changing. Smokers who are “in denial” may not see that the advice applies to them personally. Patients with high cholesterol levels may feel “immune” to the health problems that strike others. Obese patients may have tried unsuccessfully so many times to lose weight that they have simply given up.

Contemplation Stage:

During the contemplation stage, patients are ambivalent about changing. Giving up an enjoyed behaviour causes them to feel a sense of loss despite the perceived gain. During this stage, patients assess barriers (e.g., time, expense, hassle, fear, “I know I need to, doc, but ...”) as well as the benefits of change.

Preparation Stage:

During the preparation stage, patients prepare to make a specific change. They may experiment with small changes as their determination to change increases. For example, sampling low-fat foods may be an experimentation with or a move toward greater dietary modification. Switching to a different brand of cigarettes or decreasing their drinking signals that they have decided a change is needed.

Action Stage

The action stage is the one that most physicians are eager to see their patients reach. Many failed New Year's resolutions provide evidence that if the prior stages have been glossed over, action itself is often not enough. Any action taken by patients should be praised because it demonstrates the desire for lifestyle change.

Maintenance and Relapse Prevention

Maintenance and relapse prevention involve incorporating the new behaviour “over the long haul.” Discouragement over occasional “slips” may halt the change process and result in the patient giving up. However, most patients find themselves “recycling” through the stages of change several times before the change becomes truly established.

3.11 Vocational counselling process

Vocational rehabilitation counselling is a systematic process which assists persons with physical, developmental, cognitive, and emotional disabilities to achieve their personal, career, and independent living goals in the most integrated setting possible.

Vocational rehabilitation counselling is not the same thing as job placement, job development, or even case management. While the focus is vocational, rehabilitation counselling also includes behavioural, social, and psychological aspects¹¹⁹. Rehabilitation counselling is a “comprehensive sequence of services, mutually planned by the client and rehabilitation vocational rehabilitation professional, to maximize employability, independence, integration, and participation of people with disabilities in the workplace and community”. The key difference separating rehabilitation counselling from other types of counselling is the rehabilitation vocational rehabilitation professional’s knowledge of disabilities and related concerns. Similar to other forms of counselling, the purpose of rehabilitation counselling is to help clients accomplish their goals through communication and facilitation of growth, but rehabilitation vocational rehabilitation professionals ordinarily focus on achieving these goals in an integrated employment setting. The Commission on Rehabilitation vocational rehabilitation professional Certification states that rehabilitation counselling is a specialization within the larger field of rehabilitation, and that counselling forms the heart of the profession. Patterson et al.¹²⁰ believe that counselling skills are paramount, although controversy exists over rehabilitation counselling’s relationship separately to rehabilitation and to counselling.

The client comes to vocational rehabilitation counselling with an affective state that ranges from, at worst, crisis to, at best, nagging self-doubt about making the right decision. This feeling state is the result of irrational negative self-evaluation to the extent that normal, rational decision-making processes are paralyzed¹²¹. What the client must do at this point in counselling is to integrate the actuarial data presented with his or her own self-appraisal.

The client compares themselves with new reference points provided by the VR vocational rehabilitation professional; generates action hypotheses to be tried; assesses the probability of success of different alternatives; and then tries those alternatives out in the real world. During this process the final judgment for evaluating and acting on the information is the client's)¹²².

To apply appropriate counselling techniques, the VR vocational rehabilitation professional must make a differential diagnosis of client problems. To obtain a diagnosis the vocational rehabilitation professional must work with the client to differentiate presenting problems, set priorities among goals, and assess current resources and stressors that could either foster or inhibit planning or adjustment. Based on this information alternative intervention strategies can be developed.¹²³ Such a role calls for the vocational rehabilitation professional to be well grounded in assessment procedures and to have the ability to analyze and apply such data to each client's needs. The vocational rehabilitation professional is an action therapist who assesses and deals with issues in the client's life with the notion that what is gained from counselling will aid the client's self-development for the rest of his or her life. To accomplish

this task the vocational rehabilitation professional (1) helps the client to understand himself or herself; (2) suggests steps to be taken by the client; (3) directly helps the client to explore his or her own assets and liabilities; and (4) refers the client to other personnel workers for special help.

To accomplish these four services the vocational rehabilitation professional often functions as a mentor or teacher. The vocational rehabilitation professional not only delivers information on abilities, aptitudes, and interests, but also helps clients identify motivating forces in their lives, appraises them of the future implications such forces may have, and, when appropriate, encourages clients to substitute alternative behaviours that will help them reach desired life goals.

The vocational rehabilitation counselling process requires a number of steps:

- 1. Information Gathering:** Through referral documents and the interview process the VR professional gains an understanding of the client's present situation. There are two important pieces of information that are needed: the objective opinions reflected in such things as medical information, education level, work history, etc. And, the individual's subjective view of their present situation and hopes for the future.

Objective information can come from a number of sources. For individuals entering the work force for the first time this information could include:

- Education record – this information can be obtained from the individual's education system. This will tell the VR professional the client's grade level, type of education (e.g. vocational/academic), areas of strength and areas of weakness. Care needs to be taken in interpreting education records. For example even though an individual may have academic records that they graduated from High School it may not necessarily mean that they can go on to further education as they may have been in a "special education" program.
- Medical documentation – depending on the individual's disabling condition there may be extensive medical information. This could include diagnosis, limitations/restrictions, prognosis, treatment, etc.

Great care must be taken in reviewing medical information. The VR professional must stay within their scope of practice and not make medical interpretations. In most (if not all) instances there is only a need for the individual's limitations/restrictions and not the diagnosis.

- Assessments/Evaluations – The VR professional may request or administer a wide variety of objective assessments. These could include: interest tests, achievement tests, aptitude tests, neuropsychological evaluation, etc. All of these tests add to the information regarding the individual's present functioning level and/or their future potential.

If the individual has a work history and is returning to their pre-disability occupation, considering alternate employment with employer or a looking at a new vocational direction the VR professional could also consider:

- Transferable Skills Analysis – A TSA can be used to make prediction of appropriate directions for the client.
- Functional Capacity Evaluation (FCE) – this information is particularly useful if the individual is looking at returning to their pre-disability employer. An FCE provides the VR professional with a delineation of the individual's physical abilities and limitations. This can be compared to an occupation's "job demands" to assure there is a match.

Subjective information can be as important, if not more important, than objective information. Subjective information provides the VR professional a better understanding on how the disability is perceived. As was detailed above "the interview" is an important technique to obtain subjective information from the individual. This will give the VR an idea of how the client sees their disability which may be different than the objective information. For example, the client may see themselves as more "able" than what is reflected in the documentation; or they may see themselves as less able. This information will be important as the individual moves through the VR process.

In some instances important subjective information can be obtained from interested third parties. These could include: supervisors, union representatives, spouse, family members, co-workers, friends, etc. Obtaining this type of information would be dependent on the situation. In every case the VR professional must take into consideration the issues of "confidentiality" and must have permission from the client to speak to any third party.

2. Occupational Exploration: The second step in the vocational rehabilitation process is to explore with the client his/her vocational options. In this process the VR must keep in mind such areas as:

- the client's restrictions/limitations
- medical stability
- aptitudes
- achievements
- interests
- rehabilitation needs and medication
- work history
- education

In addition to this background information there must also be a consideration of external information such as:

- unemployment rate
- job availability
- wages

- long term stability
- education/training requirements

During this phase of the process the VR professional has a number of roles including:

- expand the client's knowledge of vocational opportunities
- facilitate the understanding of job requirements
- assist the individual in understanding how their disability will impact their job performance
- facilitate the client's understanding of training or education requirements

Vocational rehabilitation counselling needs to not only provide the individual an understanding of future realistic occupational choices, but adjustment to their disability within the work force. The role of the VR professional is to give the individual the range of possible occupational choices which could be realistically pursued. This would include such things as education requirements, expected wages, future outlook, etc.

3. Action Plan: The final step is to support the individual in the pursuit of their chosen occupational direction. There are a variety of options that could be pursued by the individual depending on the factors associated with their case. Some possible options could be:

- return to pre-disability occupation
- pre-disability occupation with accommodation
- another job with own employer
- job placement
- job club
- job coaching
- job search
- retraining/education

The VR professional needs to treat clients individually and in so doing the vocational direction/support will vary from depending on strengths and needs.

In each of these steps the VR professional provides an objective "sounding board" for the client. The goal is to provide support in those pursuits which fits the client's potential aptitudes, interests and physical limitations. Keeping in mind that the client is the one who must make the final determination in every choice, the VR professional role is to provide alternative directions where appropriate.

4. Referral to Other Professional: There are occasions when a client's presenting needs go beyond the skills or expertise of the vocational rehabilitation professional. For example, the individual displays behaviours or thinking that may be reflective of a mental illness. The VRP must always be aware of moving beyond their scope of practice. In those instances where a client's needs exceeds the skills of the vocational rehabilitation

professional a referral should be made (with client's agreement) to an appropriate professional.

- 5. Addressing Psycho-Social Needs:** Very often the most significant barriers for a client to enter or re-enter the work force are not the presenting needs; rather they are psychological and/or social barriers. It is important to recognize that every disability has a psychological and social component that may be overwhelming for the client.

Psycho-social issues could include:

- Fear of re-injury
- Difficulties with co-workers and/or management
- Child care concerns
- Concern over loss of wage-loss benefits
- Social isolation
- Fear over future income
- Being able to undertake job demands
- Pain
- Etc.

If these issues are not addressed with the client they could prove to impede any entry or re-entry into the work force.

In working with a client, the vocational rehabilitation professional needs to be aware of any psych-social barriers to employment. These issues can be worked through with the VRP; or referred to the most appropriate resource.

3.12 Client motivation

Motivation is a difficult concept to define. Lai¹²⁴ suggests that motivation could be a purely internal 'personality trait' that exists unaffected by external factors. Alternatively, Miller¹²⁵ suggests that motivation should not be considered an intrinsic personality trait, but a critical implication of client-counsellor interaction in rehabilitation. Motivation and understanding are key to the vocational rehabilitation and counselling process. Meanwhile, Ryan et al.¹²⁶ take a more behavioural approach and broadly define motivation as that which moves people to act and involves energy and direction. Rijk, Janssen, Lierop, Alexanderson and Nijhuis¹²⁷ enhance this behavioural approach by stating that motivation is focused through the internal process that influences the direction, persistence and strengths of a person's goal-directed behaviour. The definition of motivation that will be used throughout this discussion is a combination of the above interpretations, taking the view that it is too simplistic to say people are motivated or not; rather, that people are motivated by different things and this can be influenced. In this paper, motivation refers to the underlying internal and external influences on behaviour that determine whether a person will achieve the desired rehabilitation goals. A key focus of this

definition of motivation is the implied behaviour and actions undertaken in order to achieve these objectives.

Immediately after the onset of work disability, the return to work aspect of rehabilitation may not be a priority; however as the rehabilitation and return to work process develops, priorities change and motivations to reach personal goals are highlighted. Motivation can be measured or closely linked with the client's readiness to change and the work readiness scale¹²⁸. During the rehabilitation process, work demands and individual capacities need to be stabilised in relation to each other to achieve a sustainable fit between work demands and the capacity to meet those demands¹²⁹. Grahn, Borgquist and Ekdahl¹³⁰ indicate that rehabilitation aims to help the client return to an active and independent life. They state that multidisciplinary rehabilitation, which focuses not only on physical restrictions but also emotional and social factors, has an important effect on the health-related quality of life for a client. In linking this concept, Ryan et al. suggest that motivation is not a focus at any one point in the rehabilitation process, as it should be maintained throughout the return to work process. As a result Ryan et al. recommend that positive and lasting results most likely occur when a client becomes motivated, actively engaged, and invested in change in all aspects of their life.

Theories of Motivation:

- **Need achievement theory (McClelland, 1961; Atkinson, 1974)**

The aim of need achievement theory is to explain why certain individuals are more motivated to achieve than others. It is based on two psychological principles: the motive of an individual to achieve success and the motive of an individual to avoid failure. This theory is described as an approach-avoidance model because an individual will be motivated either (a) to take part in (approach) or (b) to withdraw from (avoid) a situation, based on the strength of the two forces in relation to each other. If an individual's intrinsic motivation to take part is stronger than their fear of failure, they will engage in a task. However, if their fear of failure is stronger than their intrinsic motivation to take part, they will either avoid or withdraw from the task. This theory can be said to be a trait-centred approach because achievement motivation is a personality trait (a relatively consistent way of behaving). However, this personality trait may not be the only factor affecting motivation. Another important factor is the role the situation plays in terms of the 'probability of success' and the 'incentive for success'. An individual who has low intrinsic motivation may become motivated to be successful if the probability of success is high and the reward on offer for success is great.

This theory is able to explain why individuals who are 'high achievers' choose difficult or challenging tasks (they will see value in their success in difficult challenges). It also explains that a 'low achiever' will choose easier tasks because they are less likely to fail and are therefore usually guaranteed success. For example, a high achiever may choose a task such as assessing the success of their organisation's marketing and then

developing a new strategy to increase income by 10 per cent. A low achiever would avoid a high-risk activity like this and might just settle for leaving things as they are.

For the Vocational Rehabilitation Professional this theory could mean that assisting an individual enter employment would be impacted by their desire to take part in the VR process (i.e. enter or re-enter employment) or withdraw from the situation (e.g. avoid an unpleasant work place, fear of reinjury, etc.). Understanding the driving forces that impact on the individual is one of the keys to determining motivation level.

- **Weiner's attribution theory (Weiner, 1985)**

Attribution theory focuses on how people explain their success or failure. Humans seek to understand the reasons for why things happen and an attribution is the reason we give for a particular outcome. We may also make an attribution to the behaviour we see in people or teams around us. Attributions can be categorised in two ways: firstly, whether they are stable (permanent) or unstable (constantly changing); and secondly, whether they are internal (inside us) or external (outside us). An internal factor is seen as being within our control and an external factor as outside of our control. These factors combined mean that a success or a failure can be attributed to either ability or effort, or task difficulty or luck. In the Table below these are presented as four quadrants, with an example of each attribution.

Attribution Categories		
Internal		External
Stable	Ability – <i>"It comes naturally to me"</i>	Task Difficulty – <i>"She was just too good for me to compete against."</i>
Unstable	Effort – <i>"I worked really hard today"</i>	Luck – <i>"I just didn't get the rub of the green today"</i>

The attributions that our clients make are important because they will affect motivation in an indirect way. They will have an effect on their self-confidence and thus on their expectations of future success. An attribution can be either *ego enhancing*, to make them feel better about themselves, or *ego protective*, to stop themselves feeling bad. A positive attribution to internal factors will enhance the ego and one attributed to task difficulty may serve to protect the ego. In turn, their level of self-confidence will influence motivation because the more confidence of success they show, the greater their motivation will become. For example, a tennis player who keeps winning can become more driven and seek out competition rather than avoid it. Or a client who is successful at small tasks will be more likely attempt more complex tasks.

3.13 Dealing with psycho-social issues

Some in the vocational rehabilitation profession may look at psychology as being a completely different discipline with only tangential ties to what we do within our profession. They may feel that our role is to only assist clients get into jobs, and this has little or nothing to do with the field of psychology.

To answer this question we need first to take a look at the field of “psychology”. Psychology, the study of the behaviour of living organisms, has four main goals:

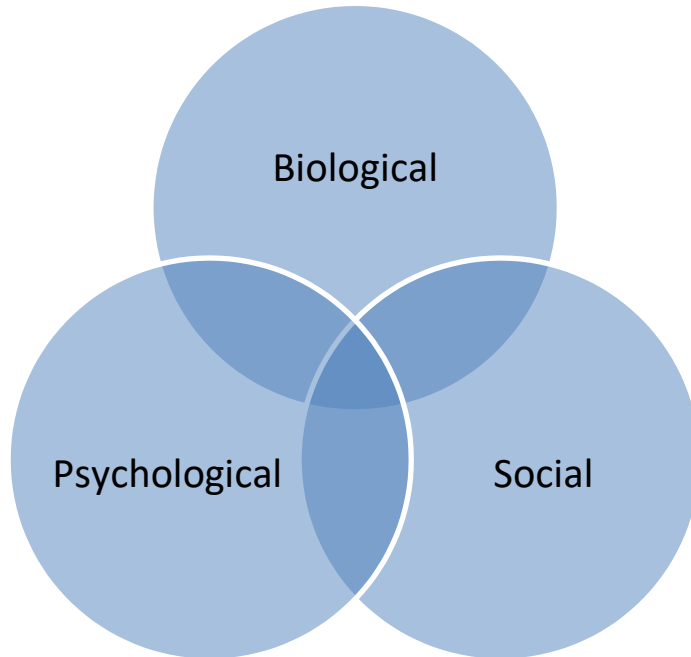
- to describe what occurred,
- to explain why it occurred,
- to predict what is likely to occur next, and
- to change or prevent unwanted outcomes

Psychologists study the process of thinking, learning, cognition, emotions, motivations, and personalities; the main area of study within this field, clinical psychology, addresses the diagnosis and treatment of mental disorders. The field of psychology which uses scientific methods to study mental process is called cognitive psychology.

A key concept in vocational rehabilitation is that every disability has a psychological and social component. Disabilities do not occur in isolation but have an impact on every part of an individual. A simple example would be when an individual hits their thumb when hammering a nail. Typically, not only is there biological damage to the thumb but there are significant changes in their social interactions and psychological well-being. Their language may change (e.g. cursing) and they may have a very difficult time interacting with others around them.

In understanding the biopsychosocial model of vocational rehabilitation three definitions are important:

- Biological Damage (bio): This is the organic damage an individual has in relation to their disability. It could be congenital, illness, or by any other mechanism.
- Psychological Factors (psycho): These are the personal factors an individual brings into their disability. This includes such things as: coping mechanisms, mental health, life satisfaction, etc.
- Social Factors (social): These include the environmental factors that impinge on the individual. These encompass such things as: family, community, job satisfaction, involvement with legal systems, etc.



The medical community has to give verdicts on disabilities, yet a certain number of individuals display inconsistency in the connection between the severity of their organic damage and their effects on personal and social performance. It is difficult to understand how some individuals with minimal injuries can develop serious dysfunction while others, much more seriously affected physically, succeed in resuming a level of total autonomy and a good quality of life. This apparent contradiction leads to a re-examination of the widely held belief that a link of linear and proportionate causality exists between a physical injury and any resultant personal and/or social handicap. The biopsychosocial model put forward by Engel¹³¹ seems to be the one that best accounts for the complexity of this disability process.

There are numerous psycho-social factors that can impact return to work including financial motivation, family support and attachment to the workforce.

3.14 Client involvement in development of VR plan

The ethical value of “autonomy” needs to be a driving force in the development of any vocational rehabilitation plan. The client should be involved in each step of the plan development and implementation. In the end, even though there may be significant consequences, it is up to the client to make decisions regarding the plan and their future.

3.15 Written vocational rehabilitation plan

One of the most important documents in the vocational rehabilitation process is the plan. This is sometimes called the “initial vocational plan” or the “individual vocational rehabilitation plan” (or other similar term). This is the plan that is put together by the vocational rehabilitation professional and the client after the gathering of all pertinent information. It may be a one-

step (e.g. return to work after surgery) or multi-step (e.g. complete GED, formalized training, job search).

This plan serves as the basis for the final “Employability Assessment”. This plan details what will be done in the future; whereas the Employability Assessment makes a determination of the success of the plan and any functional/financial deficits which may still exist.

Typically an initial vocational rehabilitation plan would contain the following:

- Demographics – e.g. client name, insurance claim number (if any), date of birth, pre-disability job, education, employment history, etc.
- Third party information – this is the objective information obtained from other professional sources. This could include any medical information, results of vocational evaluation, functional capacity evaluation, etc.
- Subjective information – client’s view of present level of disability and future direction
- Transferable Skills Analysis
- Labour market information and/or education information
- Recommendations

Ideally, the vocational plan would be signed by both the vocational rehabilitation professional and the client.

3.16 Labour market research

Labour market research provides crucial information for clients to make informed choices concerning their future. It can provide significant data including:

- Skills/education requirements
- Physical/cognitive/social requirements
- Potential for job accommodation
- Present/future job availability
- Potential growth of occupation
- Present/future earning potential
- Geographic distribution of job availability

3.17 Cognitive dissonance

Cognitive dissonance is the mental discomfort experienced by a person who simultaneously holds two or more contradictory beliefs, ideas, or values. The occurrence of cognitive dissonance is a consequence of a person performing an action that contradicts personal beliefs, ideals, and values; and also occurs when confronted with new information that contradicts said beliefs, ideals, and values.

For the vocational rehabilitation professional, the issue of cognitive dissonance may occur in providing to a client, particularly where events challenge the client's view of themselves. For example a client may have invested considerable time and energy in viewing themselves as "a disabled individual". When confronted with the possibility of entry or re-entry into the workforce and becoming a productive worker, this may create "cognitive dissonance" with the client. This is an uncomfortable mental state trying to hold two contradictory ideas.

3.18 Transference and counter-transference

Transference and Counter Transference are not the easiest of concepts to understand and many new vocational rehabilitation professionals find these difficult. The term transference originates from Psychodynamic Therapy where it is defined as a client's unconscious conflicts that can cause problems in everyday life. It is where the individual transfers feelings and attitudes from a person or situation in the past on to a person or situation in the present and where the process is likely to be, at least to some degree, inappropriate to the present. Although the concept is originally a therapeutic one, it is also used to understand what can happen in any type of relationship whether personal or professional such as that experienced in the vocational rehabilitation relationship.

Transference between the client and the vocational rehabilitation professional can occur in such situations where the vocational rehabilitation professional is blamed by the client for all the problems in their lives. The vocational rehabilitation professional can become the center of the client's anger, frustration and bitterness. The client "transfers" their feelings to the vocational rehabilitation professional and can see them as the enemy.

On the other hand, transference can also create positive emotions in the client. For example, they may come from a background of abuse and neglect and the vocational rehabilitation professional is perhaps the first individual to listen to their concerns. This may create positive and even emotional feelings in the client towards the vocational rehabilitation professional.

Countertransference occurs when the vocational rehabilitation professional reacts emotionally to his/her client. There is an emotional entanglement with the client that can be detrimental to the vocational rehabilitation process. For example: if a client responds to the vocational rehabilitation professional in a particular way they may find themselves responding back to the way s/he is treating them. In this case the term Counter Transference is used to describe the unconscious feelings the vocational rehabilitation professional may experience towards the client based on the way the client is acting towards them. Again this could either be a positive or negative Counter Transference.

As the vocational rehabilitation process can be a very intense experience for both the vocational rehabilitation professional and the client, it is important to be able to recognize when transference/countertransference is occurring. One big clue that the vocational rehabilitation professional may be experiencing a counter transference is where they find

themselves experiencing feelings and/or acting outside of their normal pattern of behaviour towards a client.

3.19 Transferable skills

Typically the development of a transferable skills analysis is undertaken during the initial stages of the vocational rehabilitation process. Transferable skills analysis is a set of tests or logic to determine what positions a person may fill if their previous position(s) no longer exists in the local job market, or they can no longer perform their last position(s) (e.g., because of an injury)¹⁰.

3.20 Decision making process

The career decision making process for a client after a disabling incident is different compared to the process most individuals use when entering the work force for the first time. There are a number of decision making styles which many use in making their initial career decisions:

- Planning – Using rational thought to weigh the facts, obtain the necessary information, and explore consequences.
- Impulsive – This is the “leap before you look” approach, or giving little thought to the decision before taking action.
- Intuitive – Making the decision based on a “gut feeling” and striving to preserve harmony. Compliant – This is when a person is content to let someone else decide and typically doesn’t assert his or her own preferences.
- Delaying – Avoiding thinking about it or taking action. In this approach the decision maker procrastinates and hopes that something happens on its own to avoid making a decision.
- Fatalistic – The belief that the decision is up to fate and it will happen how it is supposed to.
- Agonizing – Worrying that any decision made will be the wrong one — being overwhelmed by the details.
- Paralytic – Experiencing complete indecision and fear, resulting in the inability to act.
- Defaulting – “Playing it safe” by choosing the direction with the lowest level of risk.

In the vocational rehabilitation process the emphasis is on the “planning” style of career decision making. With the assistance of the vocational rehabilitation professional the client should:

1. Assess career goals – which job match the client’s interests
2. Assess career alternatives
3. Gather information – which jobs fit skills, limitations, education (need for education/training), job availability, income potential, etc.
4. Assess the outcomes – what are the foreseeable consequences of job choice

¹⁰ Transferable Skills Analysis construction and use explained in detail in Domain 4

5. Establish a plan of action – vocational rehabilitation plan

The typical steps in the decision making process are:

- Recognition of an issue
- Making a judgement
- Intention to Act and
- Action

D. Working with Families

3.21 Importance of client relationship with family

Families of the client play a significant role in the vocational rehabilitation process. They can be of great assistance or they can create significant barriers for the client in entering or re-entering the work force. Ethically, the vocational rehabilitation professional only has the individual referred to them as their client; but since the family plays such an important role there needs to be an understanding of their role and impact on vocational rehabilitation services.

3.22 Confidentiality

When a family is involved in the vocational rehabilitation process there are a number of considerations which need to be kept in mind:

- Confidentiality is often a concern when working with a worker's family member. Information which is provided by the worker to the vocational rehabilitation professional needs to be carefully guarded, even with members of the family. Any discussions which have been held, or the VR process need to be kept confidential, unless express consent has been provided by the client
- When using family members to support the VR process, the vocational rehabilitation professional needs to have an open and honest discussion with the worker (fidelity). The use of family members should never be behind the back of the client
- The vocational rehabilitation professional needs to be particularly careful to stay within their scope of practice when working with the client and his/her family. This type of activity can lead to a situation where there is an expectation that the vocational rehabilitation professional provide assistance outside their area of expertise. For example, the VR professional may be asked to provide assistance in marital problems. As has been noted in other domains the client's autonomy in decision-making is of central importance. However, experience has shown that family members can certainly coerce, persuade or manipulate an individual towards a particular course of action. For example, a client's partner may discourage him/her from participating in a return to work plan due to concerns of such things as increased likelihood of injury, decreased

income, etc. It is important for the vocational rehabilitation professional to allow a client to consider how a decision he or she makes might affect his or her family. It is both common and socially acceptable for a client to consult family members in order to aide in decision making. Focusing on the strict definition of autonomy and failing to recognize an individual as part of a family leads to an incomplete understanding of decision making for informed consent.

3.23 Rapport building

Rapport is achieved when two or more people can see the others viewpoint, appreciate each other's feelings, and be on the same wavelength. We all have different maps of reality – ways in which we perceive the world – and "we can only really trust people who look at the world the way we do. If we feel understood, we give people our trust and open up to them more easily." Taking the other person's perceptual position will help you achieve rapport and build trust.

E. Crisis Intervention

3.24 Identification of areas of risk

Vocational rehabilitation professionals are encouraged to be aware of the typical responses of those who have experienced a crisis or currently struggling with the trauma. On the cognitive level they may blame themselves or others for the trauma. Often the person appears disoriented, becomes hypersensitive or confused, has poor concentration, uncertainty, and poor troubleshooting. Physical responses to trauma include: increased heart rate, tremors, dizziness, weakness, chills, headaches, vomiting, shock, fainting, sweating, and fatigue. Some emotional responses the person may experiences consist of apathy, depression, irritability, anxiety, panic, helplessness, hopelessness, anger, fear, guilt, and denial. When assessing behaviour some typical responses to crisis are difficulty eating and/or sleeping, conflicts with others, withdrawal from social situations, and lack of interest in social activities.

3.25 Training of individuals prior to crisis

Preparing contingency plans in advance, as part of a crisis-management plan, is the first step to ensuring an organization is appropriately prepared for a crisis. Crisis-management teams can rehearse a crisis plan by developing a simulated scenario to use as a drill.

In those instances where suicide might be a factor, individuals should be trained (well in advance) in such programs as Applied Suicide Intervention Skills Training (ASIST).

3.26 Immediate follow-up after crisis

A crisis intervention process should be in place prior to a crisis occurring. Vocational rehabilitation professionals can advocate for the development of such a process or a crisis

intervention committee. Key concepts that should be built into any crisis intervention process include:

- *Identification of any areas of risk*: may involve accident prevention, development of policy regarding workplace violence.
- *Training of workers prior to a crisis*: fire drills at workplaces are an example of the type of training that should take place prior to crises occurring.
- *Immediate follow up after a crisis*: involves individual or group debriefing sessions where clients are able to discuss the incident, their emotions or reactions to the event and to obtain support. Involvement of the workplace Employee Assistance Program (EAP) is suggested as they generally have staff who are trained in debriefing strategies. Follow up should take place within the first 24-72 hours after the event.

A crisis occurs when a stressful life event overwhelms an individual's ability to cope effectively in the face of a perceived challenge or threat. More specifically, a crisis may be thought of as a response condition wherein:

- psychological homeostasis has been disrupted;
- one's usual coping mechanisms have failed to re-establish homeostasis; and,
- the distress engendered by the crisis has yielded some evidence of functional impairment.

3.27 Styles of dealing with crisis

There are five common ways of dealing with conflict. Learning about the alternative means of handling conflict gives the vocational rehabilitation professional a wider choice of actions to employ in any given situation and makes them better able to tailor our responses to the situation. Although listed below in an order of increasing elegance, the reality is that everyone utilizes each of these ways of dealing with conflict at least some of the time. We approach conflict in the way that we believe will be most helpful to us in our life. Our style for dealing with conflict will change with the circumstances.

Denial or Withdrawal

With this approach, a person attempts to get rid of conflict by denying that it exists. He or she simply refuses to acknowledge it. Usually, however, the conflict does not go away. It grows to the point that it becomes unmanageable. When the issue and the timing are not critical, denial may be a productive way to deal with conflict.

Suppression or Smoothing Over

"We run a happy ship here." "Nice people don't fight." A person using suppression plays down differences and does not recognize the positive aspects of handling the conflict openly. The source of the conflict rarely goes away. Suppression may, however, be employed when it is more important to preserve a relationship than to deal with a relatively insignificant issue.

Power or Dominance

Power is often used to settle differences. Power may be vested in one's authority or position. Power may take the form of a majority (as in voting) or a persuasive minority. Power strategies result in winners and losers. The losers do not support a final decision in the same way the winners do. Future meetings of a group may be marred by the conscious or unconscious renewal of the struggle previously "settled" by the use of power. In some instances, especially where other forms of handling conflict are not effective, power strategies may be necessary.

Compromise or Negotiation

Although regarded as a virtue, compromise ("you give a little, I'll give a little, and we'll meet each other half-way") has some serious drawbacks. Such bargaining often causes both sides to assume initial inflated positions, since they are aware that they are going to have to "give a little" and want to buffer the loss. The compromise solution may be watered down or weakened to the point where it will not be effective. There may be little real commitment by any of the parties. Still, there are times when compromise makes sense, such as when resources are limited or a speedy decision needs to be made.

Integration or Collaboration

This approach suggests that all parties to the conflict recognize the interests and abilities of the others. Each individual's interests, positive intentions and desired outcomes are thoroughly explored in an effort to solve the problems in a maximizing way. Participants are expected to modify and develop their original views as work progresses.

Participants come to appreciate that the apparent presenting problem does not need to limit their discussions. Participants are encouraged to express the full breadth and depth of their interests, with each participant seeking to identify "value" that they can bring to the discussion and the maximized satisfaction of underlying interests and intentions.

In providing crisis intervention the vocational rehabilitation professional must have a clear idea the issues and the end goal.

Crises at the workplace can occur at any time and could result from the following types of events:

- Accidents at the workplace where a client is involved and other clients witness a severe or fatal accident
- Violence at the workplace can include events where a client is threatened, harassed or assaulted by another client or where clients are exposed to violence from individuals who visit or interact with the workplace
- Suicide of a co-client either at the workplace or off site

The first step for the vocational rehabilitation professional is to have a clear understanding of the issues. Without this step the individual could potentially give wrong advice or further confuse an already volatile situation.

As the very nature of a crisis leads to confusion it is sometimes difficult for the vocational rehabilitation professional to obtain a clear picture of what has occurred. Assumptions are often made that are based on rumours and innuendos with little basis in reality. It is important to gain as much “accurate” information as possible prior to making any decision. This may require gathering information from a number of sources and delaying decisions until a clearer picture is obtained. The role of the vocational rehabilitation professional should be to “calm” the crisis environment and not add to the confusion.

Many crisis events have more than one interpretation. The participants in these crises may see the events from totally different perspectives. The vocational rehabilitation professional may need to examine the “goals” of crisis intervention from the differing viewpoints. For example, a crisis may occur after a significant workplace accident. The injured employee’s co-clients may see a resolution to the crisis event differently than Health and Safety Officer. For the co-clients it probably will be a highly emotional event where “feelings” are the utmost priority. Whereas, for the Health and Safety Officer it could be “actions” (e.g. getting the hazard fixed) could be the highest priority. The vocational rehabilitation professional needs to have an understanding of not only the viewpoints of individuals in a crisis but also what would be the most effective goals to strive towards.

There could be a variety of goals for the vocational rehabilitation professional such as:

- Lower the emotional level (this is often the most important and common goal).
- Remove individual from the crisis area, especially if there is an indication of violence occurring.
- Come to a win-win solution for individuals involved in crisis.
- Etc.

One of the most important skills of a vocational rehabilitation professional is “tact”. Tact has been defined as: “acute sensitivity to what is proper and appropriate in dealing with others, including the ability to speak or act without offending.” The goal is to negotiate towards a positive goal without offending the participants.

Emotions can run very during a time of crisis. The vocational rehabilitation professional needs to be the calming factor, assuring that everyone is heard and negotiating the most appropriate goal. This can only be undertaken if the individual is tactful and diplomatic (e.g. keeps their own emotions in check).

It is obvious that each decision one makes has consequences. During a crisis the decisions made can carry more long term consequences than is typical. Consequences can take at least two forms:

- Known consequences: These are the most obvious outcomes and the easiest to deal with. The consequences of these decisions can be determined and decisions made accordingly.
- Unknown consequences: These are the outcomes from decisions that are not readily apparent. It would be impossible for the vocational rehabilitation professional to have total knowledge of all aspects of a crisis. As a result there may be outcomes from decisions that

may not be predetermined. There is little the individual can do about unknown consequences other than be aware that they may occur.

The next step in the crisis intervention process is to determine the best course of action. This can range from doing nothing to full intervention, depending on the circumstances. There may be instances where the crisis is fairly minor that, based on available evidence, doing nothing may be the best course of action. This could be in situations where there is limited emotional involvement and the parties have the skills and willingness to work things out amicably. However, in situations where there is a high emotional content, particularly with the threat of physical violence, the vocational rehabilitation professional needs to utilize a wide range of individuals and services. The purpose in this situation is to contain the crisis and provide an avenue where the needs of the participants can be met.

After the vocational rehabilitation professional gathers the information concerning a crisis, he/she makes a judgement regarding the potential goals and weighs the consequences of any action; action needs to be taken. Crisis intervention requires action as soon as possible or, in many cases, the problems escalate. By taking well thought out action the vocational rehabilitation professional is able to limited the destructive quality of the crisis and provide a viable and workable solution.

The final step in crisis intervention is to evaluate the outcomes. Questions such as: "What it the result that had been hoped for? What information was missing when determining the goal(s)? Did all parties feel they were heard?" need to be answered. This not only assists the vocational rehabilitation professional to put into place any missing pieces in the present crisis; but to be better prepared for any other crises in the future.

Review

1. Both vocational rehabilitation professionals and clients generally accept that notion that the goals of the vocational rehabilitation process can be better achieved when:
 - a. There is maximum client involvement in the development, implementation and use of VR services.
 - b. There is a well-defined vocational rehabilitation program which all clients' progress through in an orderly manner.
 - c. There is a vocational rehabilitation professional who has the skills and knowledge to develop solely develop services on their own.
 - d. There is minimal involvement by the client in order to limit stress and concern for their future.
2. The difference between career guidance and career counselling is:
 - a. Guidance is a structured process of intervention and counselling is giving of information.
 - b. Guidance is the giving of information and counselling is a structured process of intervention.
 - c. There is no difference between career guidance and counselling.
 - d. Guidance is an unstructured process of intervention and counselling is providing information.
3. The two most common goals of career counselling are:
 - a. Job search and job maintenance
 - b. Occupational interest and aptitude testing
 - c. Selection of an occupation and the adjustment to an occupation
 - d. Achievement testing and education requirements
4. In Parson's Trait-Factor theory a "trait" is:
 - a. The characteristics of a chosen occupation
 - b. The characteristics of the client's education and employment history
 - c. The characteristics required for successful job performance
 - d. The characteristics of an individual that can be measured through testing
5. In the Trait-Factor theory the choice of occupation is:
 - a. Complex and difficult to determine
 - b. Rather straightforward process
 - c. Not part of the process
 - d. Cannot be determined until client has obtained a job
6. How many vocational types are in Holland's theory:
 - a. 6
 - b. 8
 - c. 7
 - d. 5

7. In the Holland theory an individual who has a thoughtful and analytic approach to problems, likes to explore and is not social would be which “type”:
 - a. Artistic
 - b. Entrepreneurial
 - c. Investigative
 - d. Realistic
8. Holland theory believes that occupation choice is:
 - a. An expression of personality and not random
 - b. An expression of interests and can be random
 - c. Based solely on an individual’s education background
 - d. Based on an individual’s employment background
9. According to Donald Super, self-concept:
 - a. Is an illusion and does not exist in reality
 - b. Changes over time and develops as a result of experience
 - c. Is stable and is developed in the individual’s first six years
 - d. Changes over time due to unknown reasons
10. Donald Super stage that was characterized by entry-level skill building and stabilization through work experience is called:
 - a. Exploration
 - b. Maintenance
 - c. Decline
 - d. Establishment
11. In the Social Cognitive Career Theory there are three concepts that are intricately linked variables; they are:
 - a. Self-efficacy beliefs, outcome expectations and goals
 - b. Interests, aptitudes and experience
 - c. Confidence, experience and self-esteem
 - d. Self-esteem beliefs, aptitudes and goals
12. The purpose of an intake interview is to:
 - a. Set occupational goals
 - b. Determine functional ability
 - c. Gather information about the client
 - d. Determine employability
13. Emotional noise is a term for:
 - a. A psychological difficulty
 - b. Feelings that distract you from the present communication
 - c. Feelings that enhance communication
 - d. Physiological reaction to emotional situation
14. “Do you enjoy working with your hands” is an example of a:
 - a. Open question
 - b. Mixed question

- c. Closed question
 - d. Determined question
15. "I'm sure you would agree that a job working with your hands is the best direction, wouldn't you?"
- a. Rhetorical question
 - b. Culturally inappropriate question
 - c. Open question
 - d. Appropriate question
16. Denotative language conveys:
- a. Content
 - b. Emotion
 - c. Questions
 - d. Behaviour
17. "My spouse and I are always arguing" is an example of:
- a. A secondary problem
 - b. A primary problem
 - c. A oppositional problem
 - d. A confrontational problem
18. The most effective vocational rehabilitation programs use the:
- a. Medical model
 - b. Social model
 - c. Biopsychosocial model
 - d. Psychological model
19. Egan's skilled helper model assists the client answer three questions. Which of the following is not one of the questions::
- a. What is going on?
 - b. How did my past impact me?
 - c. What do I want instead?
 - d. How might I get to what I want?
20. The definition of what model is: *"a collaborative, person---centered form of guiding to elicit and strengthen motivation for change."*
- a. Motivational interviewing
 - b. Motivational counselling
 - c. Motivational guidance
 - d. Motivational psychoanalysis
21. Addressing a client's psycho-social needs:
- a. Is not part of the vocational rehabilitation process
 - b. Should not be addressed unless the individual is a psychologist
 - c. Is outside the vocational rehabilitation professional's scope of practice
 - d. Should be addressed as they can create significant barriers to employment

22. Cognitive dissonance is:
- a. The difference between what wants and what the person has.
 - b. The mental discomfort experienced by a person who simultaneously holds two or more contradictory ideas.
 - c. A theory that is no longer believed as it has been shown to be false by numerous research studies.
 - d. The uncomfortable feeling an individual experience when they obtain what they have wanted but it does not live up to expectations.
23. A client blames a vocational habitation professional for all the problems in his/her life is an example of:
- a. Counter-transference
 - b. Transference
 - c. Cognitive dissonance
 - d. Psycho dynamics
24. After a crisis occurs within an organization, follow-up should take place within the first:
- a. 24-72 hours after the event
 - b. 3 to 4 days after the event
 - c. Week after the event
 - d. Month after the event
25. In dealing with conflict the statement "Nice people don't fight" is an example of:
- a. Power or dominance
 - b. Compromise or negotiation
 - c. Integration or collaboration
 - d. Suppression or smoothing over

Answers

1. There is maximum client involvement in the development, implementation and use of VR services-
2. Guidance is the giving of information and counselling is a structured process of intervention.
3. Selection of an occupation and the adjustment to an occupation
4. The characteristics of an individual that can be measured through testing
5. Rather straightforward process
7. Investigative
8. An expression of personality and not random
9. Changes over time and develops as a result of experience
10. Establishment
11. Self-efficacy beliefs, outcome expectations and goals
12. Gather information about the client
13. Feelings that distract you from the present communication
14. Closed question
15. Rhetorical question
16. Content
17. A primary problem
18. Biopsychosocial model
19. How did my past impact me?
20. Motivational interviewing
21. Should be addressed as they can create significant barriers to employment
22. The mental discomfort experienced by a person who simultaneously holds two or more contradictory ideas.
23. Transference
24. 24-72 hours after the event
26. Suppression or smoothing over

Domain Four

Vocational Rehabilitation Assessment and Evaluation

Vocational assessment is defined as the global appraisal of an individual's work/training background, general functional capacities, and social/behavioural characteristics. It usually includes an evaluation of medical factors, psychological makeup, educational background, social behaviours, attitudes, values, work skills and abilities. The goal is to describe and predict an individual's occupational potential.

Vocational evaluation, on the other hand, is a specific process that involves the appraisal of a person's work related characteristics important for education and training to obtain and maintain employment. It includes a comprehensive review of specific work characteristics, including but not limited to occupational interests, specific job skills, worker traits, general intelligence, temperament, physical capacities, strength, range of motion and other work-related functions and aptitudes.

A.Role of Assessment and Assessment Procedures in Vocational Rehabilitation

Assessment is defined broadly as "any systemic method of obtaining information from tests and other sources, used to draw inferences about people, objects of programs."¹³² Test is defined broadly as "an objective and standardized measure of a sample of behaviour".¹³³ Assessment is more complex than testing; it typically requires integrating information from multiple sources and clinical judgments that go beyond psychometric data.

The purpose of assessment in vocational rehabilitation is to integrate information from multiple sources to plan a course of action. Vocational assessment involves exploring a person's strengths, weaknesses and preferences and discovering how the individual's potential for vocational adjustment can be enhanced. The scope of assessment is sufficiently broad to include the identification of career goals and the panning of strategies to resolve problems and attain established objectives. Assessment procedures can include interviews, standardized tests, inventories, observations, job tryouts and medical examinations.

The main factors considered in a vocational assessment are: motivation level, interests, acquired skills, physical abilities, education and training.

4.1 Intake interview

A comprehensive assessment begins with the information-collection process, called an intake or initial interview. The intake interview generates a social-vocational history, which is useful in formulating the VR plan and in determining whether subsequent evaluations are needed. The focus of the intake should be:

- Determining the person's reason for needing VR services
- Providing the individual with necessary information about the role and function of the VR professional
- Developing adequate rapport
- Initiating the diagnosis process and
- Informing the client of any medical, vocational or psychological evaluations that need to be completed and the purposes of such evaluations.

4.2 Medical evaluation

The medical evaluation is used to:

- Establish the presence and extent of the disability,
- Provide information on the physical functioning of the client,
- Determine the types of activities the types of activities precluded by the disability and
- Identify any additional medical evaluation necessary for achieving the first three purposes.

4.3 Psychological evaluation

Psychological assessments yield information regarding clients' intelligence, aptitudes, achievement, personality, interests and adjustment related to vocational functioning. Psychological assessment results help to determine:

- The appropriateness of long-term vocational training.
- The need for adjustment services and,
- The need to confront the client regarding unrealistic vocational choices.

This evaluation can also be used to establish the presence of cognitive or psychiatric disability.

4.4 Vocational evaluation

The purpose of vocational evaluation is to provide reliable and valid data to:

- Generate information about the client's current vocationally relevant levels of social, educational, psychological and physiological functioning;
- Estimate the client's potential for behaviour change and skill acquisition;
- Determine the client's most effective learning style;

- Identify possible jobs the client can perform without additional vocational rehabilitation services;
- Identify education or special training programs that might increase the vocational potential;
- Identify potentially feasible jobs for the client with further vocational rehabilitation services; and
- Identify the community support services that might augment job retention following a successful client placement. This step consists of different techniques, focusing on assessing the relationship of the person's skills, abilities, personality characteristics and physical tolerance to perform the required tasks associated with potential jobs.

4.5 Psycho-vocational Assessment

A psycho-vocational assessment focuses on identifying suitable occupational options by taking into account the client's aptitudes, achievements, vocational interests, personality characteristics, general psychological functioning, transferable skills and labour market information. This type of assessment can be used to gather evidence on client's psychological capacity/functioning, and to identify any limitations/concerns impacting the readiness to engage in the return-to-work process when there is minimal information regarding suitable occupational options. It can also be used when retraining is considered and there is a question as to whether the client possesses the intellectual potential to succeed in an academic upgrading or training program. This assessment can also comment on the client's general psychological functioning in terms of their ability to function in the workplace, and also looks at self-perception of pain (if applicable) and its effect on the client's daily life.

A particular type of psycho-vocational assessment is a psycho-educational assessment. When an individual has learning problems, it can be very helpful to have a **psycho-educational assessment**. Where the goal of a psycho-vocational assessment is to assist in defining employment barriers and strengths; the goal of a psycho-educational assessment is to determine learning strengths and weaknesses.

B. Employability Assessment

4.6 Content

Often this is the final report on the client and is written at the end of the vocational rehabilitation services. This report details where the client is in relation to returning to his/her former earning capacity. After the delivery of VR services the client's long term earning capacity may be:

- Lower than then expected or earned prior to disability
- At the same level as pre-disability
- On occasion the client's expected earning capacity could be higher than pre-disability

4.7 Documentation

This report would typically contain:

- Pre-disability profile – e.g. earning capacity, physical/cognitive abilities, work potential, etc.
- Vocational rehabilitation assessment – e.g. vocational testing, third party documentation of limitations/restrictions, transferable skills analysis, etc.
- Vocational rehabilitation services provided – e.g. job search, placement, job club, education, training, etc.
- Current earning capacity and job availability – this section looks at the client's present status and his/her earning capacity based on restrictions/limitations and vocational services. In many instances this may require a labour market analysis.

C. Test Coverage and Use/Statistics

4.8 Scales of measurement

- Nominal: Classifies, assigns numerals but does not distinguish size, amount (e.g. any categorical variable, such as ethnicity or gender).
- Ordinal: Indication of ordering, but no indication of distance between objects on the scale (e.g. placing first, second and third).
- Interval: Equal intervals on the scale (e.g. Celsius temperature scale).
- Ratio: Possesses a non-arbitrary zero point (e.g. measures of weight).

4.9 Test Standardization

A **standardized test** is a **test** that is administered and scored in a consistent, or "standard", manner. Standardized tests are designed in such a way that the questions, conditions for administering, scoring procedures, and interpretations are consistent¹³⁴ and are administered and scored in a predetermined, standard manner.¹³⁵

Any test in which the same test is given in the same manner to all test takers, and graded in the same manner for everyone, is a standardized test. Standardized tests do not need to be high-stakes tests, time-limited tests, or multiple-choice tests. The questions can be simple or complex.

The opposite of standardized testing is *non-standardized testing*, in which either significantly different tests are given to different test takers, or the same test is assigned under significantly different conditions (e.g., one group is permitted far less time to complete the test than the next group) or evaluated differently (e.g., the same answer is counted right for one student, but wrong for another student).

Standardized tests are perceived as being fairer than non-standardized tests, because everyone gets the same test and the same grading system. This is fairer and more objective than a system in which some students get an easier test and others get a more difficult test. The consistency also permits more reliable comparison of outcomes across all test takers, because everyone is taking the same test.^[3] The prevalence of standardized testing in formal education has also been criticized for many reasons.

4.10 Criterion Referenced Testing

A criterion-referenced test is a style of test which uses test scores to generate a statement about the behaviour that can be expected of a person with that score. Most tests and quizzes that are written by school teachers can be considered criterion-referenced tests. In this case, the objective is simply to see whether the student has learned the material. Criterion-referenced assessment can be contrasted with norm-referenced assessment and ipsative assessment (i.e. based on prior experience).

Criterion-referenced testing was a major focus of psychometric research in the 1970s.¹³⁶

4.11 Test Reliability:

A test is said to be “reliable” if it produces consistent results under consistent conditions. Key concepts of test reliability include:

- **Reliability Coefficients:** *Reliability* refers to the extent to which assessments are consistent. Just as we enjoy having reliable cars (cars that start every time we need them), we strive to have reliable, consistent instruments to measure a client’s achievement. Another way to think of reliability is to imagine a kitchen scale. If you weigh five pounds of potatoes in the morning, and the scale is reliable, the same scale should register five pounds for the potatoes an hour later (unless, of course, you peeled and cooked them). Likewise, instruments such as a vocational standardized assessment should be reliable – it should not make any difference whether a client takes the assessment in the morning or afternoon; one day or the next.

The values for reliability coefficients range from 0 to 1.0. A coefficient of 0 means no reliability and 1.0 means perfect reliability. Since all tests have some error, reliability coefficients never reach 1.0. Generally, if the reliability of a standardized test is above .80, it is said to have very good reliability; if it is below .50, it would not be considered a very reliable test.

Two of the most common statistical tests which are used to determine reliability coefficients are: Kuder-Richardson Formula 20 (KR20) or Cronbach's Alpha

- **Test-Retest Reliability:** Test-retest reliability is a measure of the consistency of a psychological test or assessment. This kind of reliability is used to determine the consistency of a test across time. Test-retest reliability is best used for things that are stable over time, such as intelligence.

Test-retest reliability is measured by administering a test twice at two different points in time. This type of reliability assumes that there will be no change in the quality or construct being measured. In most cases, reliability will be higher when little time has passed between tests.

- **Alternate Forms Reliability:** This type of reliability makes a second form of a test consisting of similar items, but not the same items. Researchers administer this second “parallel” form of a test after having already administered the first form. This allows researchers to determine a reliability coefficient that reflects error due to different times and items and allow to control for test form. By administering form A to one group and form B to another group, and then form B to the first group and form A to the second group for the next administration of the test, researchers are able to find a coefficient of stability and equivalence. This is the correlation between scores on two forms and takes into account error of different times and forms.
- **Internal Consistency Reliability:** Internal consistency reliability defines the consistency of the results delivered in a test, ensuring that the various items measuring the different constructs deliver consistent scores.

There are three main techniques for measuring the internal consistency reliability, depending upon the degree, complexity and scope of the test.

They all check that the results and constructs measured by a test are correct, and the exact type used is dictated by subject, size of the data set and resources.

- **Split-Halves Test:** The split halves test for internal consistency reliability is the easiest type, and involves dividing a test into two halves. For example, a questionnaire to measure extroversion could be divided into odd and even questions. The results from both halves are statistically analyzed, and if there is weak correlation between the two, then there is a reliability problem with the test. The split halves test gives a measurement of in between zero and one, with one meaning a perfect correlation. The division of the question into two sets must be random. Split halves testing were a popular way to measure reliability, because of its simplicity and speed. However, in an age where computers can take over the laborious number crunching, scientists tend to use much more powerful tests.
- **Kuder-Richardson Test:** The Kuder-Richardson test for internal consistency reliability is a more advanced, and slightly more complex, version of the split halves test. In this version, the test works out the average correlation for all the possible split half

combinations in a test. The Kuder-Richardson test also generates a correlation of between zero and one, with a more accurate result than the split halves test. The weakness of this approach, as with split-halves, is that the answer for each question must be a simple right or wrong answer, zero or one. For multi-scale responses, sophisticated techniques are needed to measure internal consistency reliability.

- **Cronbach's Alpha Test:** The Cronbach's Alpha test not only averages the correlation between every possible combination of split halves, but it allows multi-level responses. For example, a series of questions might ask the subjects to rate their response between one and five. Cronbach's Alpha gives a score of between zero and one, with 0.7 generally accepted as a sign of acceptable reliability. The test also takes into account both the size of the sample and the number of potential responses. A 40-question test with possible ratings of 1 - 5 is seen as having more accuracy than a ten-question test with three possible levels of response. Of course, even with Cronbach's clever methodology, which makes calculation much simpler than crunching through every possible permutation, this is still a test best left to computers and statistics spreadsheet programs.

4.12 Test Validity:

Validity is the extent to which a test measures what it claims to measure. It is vital for a test to be valid in order for the results to be accurately applied and interpreted.

Validity isn't determined by a single statistic, but by a body of research that demonstrates the relationship between the test and the behaviour it is intended to measure. There are three types of validity:

- **Content validity:** When a test has content validity, the items on the test represent the entire range of possible items the test should cover. Individual test questions may be drawn from a large pool of items that cover a broad range of topics.

In some instances where a test measures a trait that is difficult to define, an expert judge may rate each item's relevance. Because each judge is basing their rating on opinion, two independent judges rate the test separately. Items that are rated as strongly relevant by both judges will be included in the final test.

- **Criterion-related Validity:** A test is said to have criterion-related validity when the test has demonstrated its effectiveness in predicting criterion or indicators of a construct. There are two different types of criterion validity:
 - **Concurrent Validity** occurs when the criterion measures are obtained at the same time as the test scores. This indicates the extent to which the test scores accurately estimate an individual's current state with regards to the criterion.

For example, on a test that measures levels of depression, the test would be said to have concurrent validity if it measured the current levels of depression experienced by the test taker.

- **Predictive Validity** occurs when the criterion measures are obtained at a time after the test. Examples of test with predictive validity are career or aptitude tests, which are helpful in determining who is likely to succeed or fail in certain subjects or occupations.
- **Construct Validity**: A test has construct validity if it demonstrates an association between the test scores and the prediction of a theoretical trait. Intelligence tests are one example of measurement instruments that should have construct validity.
- **Face Validity**: is the extent to which a test is subjectively viewed as covering the concept it purports to measure. It refers to the transparency or relevance of a test as it appears to test participants. In other words, a test can be said to have face validity if it "looks like" it is going to measure what it is supposed to measure. For instance, if a test is prepared to measure whether students can perform multiplication, and the people to whom it is shown all agree that it looks like a good test of multiplication ability, this demonstrates face validity of the test. Face validity is often contrasted with content validity and construct validity.

4.13 Measure of central tendency

Often, data tends to group itself around some central value. This value may, in turn, be used to describe or represent the data set as a whole. Methods of determining these central values are called measures of central tendency. There are three main measures of central tendency used by psychologists. They are the *mean*, the *median*, and the *mode*.

- **Mean**: When people talk about averages, they're often referring to the mean, which is the arithmetic average of a set of scores. You have probably calculated the mean of a set of Psychology score many times in the past. Every time you sum a set of scores and divide that sum by the total number of scores you have calculated the arithmetic mean of those scores.

As you probably know from experience, the mean can be affected by extreme scores. For example, if a student were to receive five test marks over 90% and one test mark less than 20%, (let us say marks of 98%, 96%, 94%, 94%, 92%, and 18%), the mean of the test scores would be $(98 + 96 + 94 + 94 + 92 + 18) / 6 = 82$. Obviously, the mean in this case has been pulled in the direction of the score of under 20%. For this reason, the mean can be very misleading description of a set of scores with a heavily skewed distribution. However, it is an immediate reference point for comparing individual performance to group performance

- **Median:** The median is the middle score in a set of scores that have been ranked in numerical order. In cases where there are an even number of scores, the median lies between the two middle scores, and is given the value of the midpoint between those scores. Of course, if the middle two scores in an even number of scores are the same, the median has the same value as the two scores themselves. There is no formula for quickly calculating the median without doing some initial data analysis. Typically, when dealing with large data sets, researchers construct a *frequency distribution* representing all the scores in the data set. This allows them to use a formula to calculate each measure of central tendency using the information provided by the frequency distribution.

Unlike the mean, the median is a good measure of central tendency to use when describing a heavily skewed set of scores. Returning to our example from above, our student's median test score would be 94%, which is a much better indication of the student's overall performance. Thus, the median is a better representation of the scores within a skewed data set than is the mean. In fact, the median is the best method of central tendency to use when describing skewed data.

- **Mode:** The mode is simply the most frequently occurring score in a data set. Returning once again to the test scores of our sample student, the mode for this dataset is would be 94%, as it occurs twice within the data set. If two scores occur equally often within a data set, the set has two modes and is termed *bimodal*. Any data set that has two or more modes can be referred to as *multimodal*.

Like the median, there is no formula for calculating the mode without conducting at least some preliminary data analysis. For small data sets the mode may simply be determined by comparing the number of times the most popular scores appear in the set.

4.14 Key Vocational Evaluation Statistics

Correlation Coefficient: A correlation coefficient examines the degree to which variations or differences in one variable are related to variations or differences in another. Although a statistical measure of relationship demonstrates a relation exists between two sets of data, it does not show causation. The Pearson *r* is the most commonly used tool to predict correlation on interval and ratio data. The correlation coefficient can range from +1 (positive correlation) to -1 (negative correlation). When a correlation exists, a second score may generally be predicted from a known score.

Typically, the researcher gathers data from two variables for each individual and then calculates a correlation coefficient.

- Perfect correlation = +1.00 or - 1.00

It is helpful to plot the pairs of scores on a scattergram to visually inspect the relationship. The straight-line vector that connects those points is termed the line of regression. One variable correlates meaningfully with another only when a common causal bond links the phenomena of both variables.

Variability: Almost all data sets demonstrate some degree of *variability*. In other words, data sets usually contain scores which differ from one another. Only under very rare circumstances do researchers encounter data sets which have no variability. Needless to say, of the few sets of data which demonstrate no variability, fewer still will be of any interest to psychological researchers. The truly interesting observations are those of characteristics which vary within a population or sample.

This variability cannot be captured or shown by measures of central tendency. For example, if two data sets have the same mean, there is no guarantee that the two sets are very similar at all. What is needed are *measures of variability* which allow the researcher to determine the degree of variation within a population or sample, and thus to determine just how representative a particular score is of the data set as a whole.

This in turn allows the researcher to determine the scope and validity of any generalizations he or she wishes to make based on his or her observations. The measures of variability used by researchers include the *range*, the *variance*, and the *standard deviation*.

- **Range:** The range is simply the difference between the highest and lowest scores in a distribution, and is found by subtracting the lowest score from the highest score. This measure of variability gives the researcher only a limited amount of information, as data sets which are skewed towards a low score can have the same range as data sets which are skewed towards a high score, or those which cluster around some central score. The range is, however, useful as a rough guide to the variability demonstrated by a data set, as it tells the researcher how a particular score compares to the highest and lowest scores within a data set. For example, a student might find it useful to know whether his or her score was near the best or worst on an exam.
- **Variance:** A more informative measure of variability is the variance, which represents the degree to which scores tend to vary from their mean. This tends to be more informative because, unlike the range, the variance takes into account every score in the data set. Technically speaking, the variance is the average of the squared deviations from the mean.

To calculate the variance for a set of quiz scores:

1. Find the mean score.
2. Find the *deviation* of each raw score from the mean. To do this,
3. Subtract the mean from each raw score. (Note that deviation scores will be negative for scores that are below the mean.) To check your calculations sum the deviation scores. This sum should be equal to zero.

4. Square the deviation scores. By squaring the scores, negative scores are made positive and extreme scores are given relatively more weight.
5. Find the sum of the squared deviation scores.
6. Divide the sum by the number of scores. This yields the average of the squared deviations from the mean, or the variance.

Percentile Rank: A **percentile rank**, most commonly, is the percentage of scores in a specified distribution that fall below the point at which a given score lies. Sometimes the percentage is defined to include scores that fall at the point; sometimes the percentage is defined to include half of the scores at the point. Percentile ranks indicate the status or relative standing of a pupil in comparison to other pupils. The percentile rank tells the percent of pupils in a particular norm group who obtain lower scores.

For example, if Ann earns a percentile rank of 70 on a particular test it means she scored better than 70% of the pupils in the norm group and 30% scored as well or better than she did. The scale goes from 1% to 99%. If three points are used to divide the scale into four equal quarters the points are called quartiles; quartile one, quartile two and quartile three.

Quartiles are points, not areas. A score does not fall in a quartile. A score can be above, at or below a quartile. A score can be within two quartiles. There is not a fourth quartile. Many people have the misconception that since there are four quarters, there should also be four quartiles, but this is not the case. Quartiles are points, not areas, so there are four areas divided by the three quartiles, but there are not four quartiles.

Z-SCORE: The Z-score measures how many standard deviations away from the mean our observations are. It indicates how typically our observation represents the population.

- For a confidence level of .95, a Z-score between -2.00 and +2.00 is acceptable
- Beyond those values, the null hypothesis should be rejected

T-SCORES: T-scores are a way of counting standard deviations. A T-score of 50 represents the mean, and standard deviations are measured in units of tens (one standard deviation equals ten points, one and a half standard deviations equals fifteen points, and so on). The closer a T-score is to 50, the better (and it doesn't matter whether it is above or below 50).

It helps to think in football terms here. If the 50-yard line is the mean, the 40-yard lines are 10 yards (1 T-score) away from the mean. The 30-yard lines are 2 T-scores (20 yards) higher or lower than the mean. In stats, a T-score of 65 (50 plus 15) would represent a difference of one and a half standard deviations above the average. A T-score of 35 (50 minus 15) would represent a value that is one and a half SD's below the average.

Likewise, a T-score of 60 is one standard deviation above the mean, while a T-score of 30 is two standard deviations below the mean. A T-score of 0 would represent a value that is 5 standard deviations below the mean. A T-score of 100 represents a value that is 5 standard deviations above the average.

Stanine Scores: Like Z-scores and T-scores, a **stanine score** is simply a way of indicating the position of a person or thing in a group relative to the other people (or things) that have been measured in that group. It lets us know whether a person or thing scored near the group's mean, above the group's mean or below the group's mean. Not only that, we'll have a sense for how far above-average or below-average a result is from the mean of the group.

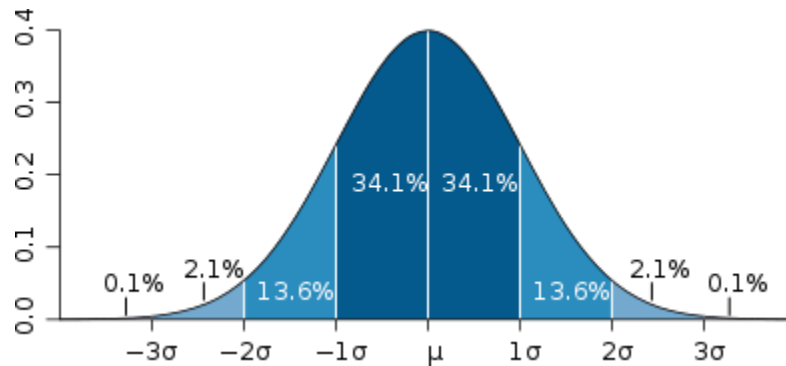
Stanine scores are normalized standard scores with a range of 1-9, a mean of 5 and a standard deviation of 2. Like percentile ranks they are status scores within a particular norm group. The first stanine is the lowest scoring group and the 9th stanine is the highest scoring group. Advocates of stanine reporting site the fact that the single digit scale is simple and convenient to use and its use minimizes the apparent importance of small score differences. On the other hand, the stanine scale may be regarded as unnecessarily coarse particularly for relatively reliable tests.

For example, all pupils scoring between the 40th and 60th percentiles are assigned a stanine of 5. However, a pupil scoring at the 59th percentile, which is in stanine 5, is probably much more similar in achievement level to a pupil scoring at the 61st percentile, stanine 6, than to one at the 41st, stanine 5.

In some instances the width of the stanine band exceeds the standard error of measurement. Another reservation about the use of stanine scores is based on evidence that skills development in the elementary schools is more variable in subjects such as reading, in which the pupils have many opportunities for advancing "on their own", than they are in subjects such as mathematics in which pupils' progress is more rigidly controlled through placement of concepts and processes in the curriculum.

Standard Deviation: More informative still is the standard deviation, which is simply the square root of the variance. You may be asking yourself 'Why not simply use the variance?' One reason is that, unlike the variance, the standard deviation is in the same units as the raw scores themselves. This is what makes the standard deviation more meaningful. For example, it would make more sense to discuss the variability of a set of IQ scores in IQ points than in squared IQ points.

In statistics and probability theory, standard deviation (represented by the symbol sigma, σ) shows how much variation or "dispersion" exists from the average (mean, or expected value). A low standard deviation indicates that the data points tend to be very close to the mean, whereas high standard deviation indicates that the data points are spread out over a large range of values.



Standard Errors:

- **Standard Error of Means:** The standard error of the mean, also called the standard deviation of the mean, is a method used to estimate the standard deviation of a sampling distribution. To understand this, first we need to understand why a sampling distribution is required.

As an example, consider an experiment that measures the speed of sound in a material along the three directions (along x, y and z coordinates). By taking the mean of these values, we can get the average speed of sound in this medium.

However, there are so many external factors that can influence the speed of sound, like small temperature variations, reaction time of the stopwatch, pressure changes in the laboratory, wind velocity changes, and other random errors. Thus instead of taking the mean by one measurement, we prefer to take several measurements and take a mean each time. This is a sampling distribution. The standard error of the mean now refers to the change in mean with different experiments conducted each time.

Mathematically, the standard error of the mean formula is given by:

$$\sigma_M = \frac{\sigma}{\sqrt{N}}$$

σ_M = standard error of the mean

σ = the standard deviation of the original distribution

N = the sample size

$\sqrt{N}$ = Root of the sample size

It can be seen from the formula that the standard error of the mean decreases as N increases. This is expected because if the mean at each step is calculated using a lot of data points, then a small deviation in one value will cause less effect on the final mean.

The standard error of the mean tells us how the mean varies with different experiments measuring the same quantity. Thus if the effect of random changes are significant, then the standard error of the mean will be higher. If there is no change in the data points as experiments are repeated, then the standard error of mean is zero.

- **Standard Error of Measurement:** The standard error of measurement (SEm) estimates how repeated measures of a person on the same instrument tend to be distributed around his or her “true” score. The true score is always an unknown because no measure can be constructed that provides a perfect reflection of the true score. SEm is directly related to the reliability of a test; that is, the larger the SEm, the lower the reliability of the test and the less precision there is in the measures taken and scores obtained. Since all measurement contains some error, it is highly unlikely that any test will yield the same scores for a given person each time they are retested.

Statements about an examinee’s obtained score (the actual score that is received on a test) are couched in terms of a confidence interval — a band, interval, or range of scores that has a high probability of including the examinee’s “true” score. Depending on the level of confidence one may want to have about where the “true” score may lie, the confidence band may be small or large. Most typical confidence intervals are 68%, 90%, or 95%. Respectively, these bands may be interpreted as the range within which a person’s “true” score can be found 68%, 90%, or 95% of the time. It is not possible to construct a confidence interval within which an examinee’s true score is absolutely certain to lie. It is important to report the confidence interval associated with a child’s obtained score so that the reader can be informed of the probability that the examinee’s true score lies within a given range of scores.

The standard error of the mean (SEm) is the standard deviation of the sample-mean’s estimate of a population mean. (It can also be viewed as the standard deviation of the error in the sample mean relative to the true mean, since the sample mean is an unbiased estimator.) SEM is usually estimated by the sample estimate of the population standard deviation (sample standard deviation) divided by the square root of the sample size (assuming statistical independence of the values in the sample):

$$SE_{\bar{x}} = \frac{s}{\sqrt{n}}$$

Where s is the sample standard deviation (i.e., the sample-based estimate of the standard deviation of the population), and n is the size (number of observations) of the sample.

Statistical Significance:

In a test of significance, the statement being tested is called the **null hypothesis (Ho)**. The test of significance is designed to assess the strength of the evidence against the null hypothesis. Usually, the null hypothesis is a statement of no difference or no effect. The probability of observed outcomes equaling the expectation if Ho were true is called the p-value. The smaller the p-value, the stronger the evidence is against Ho provided by the data.

Because the strength of the evidence provided by the data is measured by the p-value, an acceptable p-value must be determined. This decisive value is called the **significance level**.

If the required significance level is set at 0.05, the data evidence against Ho must be so strong that the occurrence being tested would happen no more than 5% of the time (1/20)S when Ho is really true. If the value is set at 0.01, stronger evidence against Ho is required, such that it would appear only 1% of the time (1/100) if Ho is true. A common way to state significance at level 0.01 is $p < 0.01$. Here p stands for the p-value.

4.15 Key Research Concepts

Population:

Population refers to the entire group of individuals to which researchers are interested in generalizing the conclusions. The target population usually has varying characteristics and it is also known as the theoretical population.

Control Group:

The control group is defined as the group in an experiment or study that does not receive treatment by the researchers and is then used as a benchmark to measure how the other tested subjects do.

Sample Size:

Sample size determination is the act of choosing the number of observations or replicates to include in a statistical sample. The sample size is an important feature of any empirical study in which the goal is to make inferences about a population from a sample.

Statistically Significant:

Statistically significant is the likelihood that a relationship between two or more variables is caused by something other than random chance. Statistical hypothesis testing is used to determine whether the result of a data set is statistically significant.

Null Hypothesis:

The term "**null hypothesis**" is a general statement or default position that there is no relationship between two measured phenomena, or no association among groups. Rejecting or disproving the **null hypothesis**—and thus concluding that there are grounds for believing that there is a relationship.

Regression:

Regression analysis is a set of statistical processes for estimating the relationships among variables. It includes many techniques for modeling and analyzing several variables, when the focus is on the relationship between a dependent variable and one or more independent variables (or 'predictors'). More specifically, regression analysis helps one understand how the typical value of the dependent variable (or 'criterion variable') changes when any one of the independent variables is varied, while the other independent variables are held fixed.

Multiple Regression:

Multiple regression is an extension of simple linear regression. It is used when we want to predict the value of a variable based on the value of two or more other variables. The variable we want to predict is called the dependent variable (or sometimes, the outcome, target or criterion variable).

Regression towards the Mean:

Regression toward (or to) the mean is the phenomenon that if a variable is extreme on its first measurement, it will tend to be closer to the average on its second measurement—and if it is extreme on its second measurement, it will tend to have been closer to the average on its first.

Outlier:

An outlier is an observation point that is distant from other observations. An outlier may be due to variability in the measurement or it may indicate experimental error; the latter are sometimes excluded from the data set.

Norm Referenced Test:

Norm-referenced tests report whether test takers performed better or worse than a hypothetical average test-taker, which is determined by comparing scores against the performance results of a statistically selected group of test takers.

D. Using VR Assessment/Evaluation Tools

4.16 Assessment methods and techniques

The purpose of a specific assessment must be clear. Assessment is not to be done for assessment's sake or beyond the disclosed purposes in informed consent. Vocational

rehabilitation professionals are bound by the Code of Ethics to respect client privacy, which means a VR Professional should never seek information out of curiosity or 'just because.' The purpose of the specific assessment will drive the information sought.

Many forms of recording assessment information are possible. One may use evidenced based, user-led, form-led, standardized assessments or non-standardized assessment tools. Regardless of the type used, accountability is important. Evidenced-based practice is important because it allows the client and VR Professional to track change, and most payers, whether private insurance, publicly funded agencies, not-for-profit agencies, military medicine or other funding (a demonstration of progress is required for reimbursement). Evidenced-based techniques can be used with a variety of theoretical orientations; the issue is measuring behaviour, mood or attitude and its subsequent changes.

Assessment done with an evidenced-based approach will expedite the setting of goals and treatment planning. The assessment process should engage the client in the therapeutic process, creating a working therapeutic alliance on which to base treatment. The client has to feel comfortable enough to share the issues surrounding their presenting complaint and the issues that may have bearing on treatment planning, though they may not be the focus on treatment. The best way to engage the client is through rapport building throughout the assessment process.

It is important to listen actively, attending to both what is and is not said, as well as the client's body language. Responding with full attention, reflecting what is being said and the deeper understanding of the client's situation based on the client's report, clinician observations and information gathered during assessment will assist in the rapport building process. Making culturally sensitive introductions and using the client's preferred name during the session will also aid at putting the client at ease.

During the assessment session, it is important to check in with the client, either directly or indirectly, and to provide validation or normalize feelings, as appropriate. This technique allows the clinician to clarify the information and emotion shared, while also letting the client know he/she is being understood. If inconsistencies are present, addressing them can also be helpful, but should be done with respect.

Assessing the client's communication patterns, as in neuro-linguistic programming, can also be a useful tool in increasing rapport, individualizing the communication response, assessing the individual's subjective experience and empowering the individual's requisite skills to work together in the therapeutic alliance.

Typically, a vocational evaluation provides information to make a determination of a client's potential to return to work, the client's vocational skills and abilities, occupational options and barriers to work.

4.17 Assessment tools – types and instruments

Ranging from various inventories used with adults to specific diagnostic tools for children, Assessment Tools provide a helpful measure of an individual's function in achievement, aptitude, intelligence, personality and behaviour.

One of the most important factors in interpreting the results of any of these norm referenced assessment tools is the sample group.

Intelligence Tests

- **Wechsler Adult Intelligence Scale** - An IQ test for older children and adults, the WAIS provides a Verbal, Performance, and Full Scale score, as well as scores for verbal comprehension, perceptual organization, working memory, and processing speed. This is the intelligence test most often use in a psycho-vocational assessment.
- **Wechsler Intelligence Scale for Children** – this is used on children ages 6 to 16. This test yields a Full Scale score and scores for Verbal Comprehension, Working Memory, Perceptual Reasoning, and Processing speed.
- **Stanford-Binet** - In addition to providing a Full Scale score, it assesses Fluid Reasoning, Knowledge, Quantitative Reasoning, Visual-Spatial Processing, and Working Memory as well as the ability to compare verbal and nonverbal performance.
- **Woodcock-Johnson Tests of Cognitive Abilities** - This test gives a measure of general intellectual ability, as well as looking at working memory and executive function skills.
- **Kaufman Assessment Battery for Children.** – This test measures simultaneous and sequential processing skills, and has subscales that measure academic achievement as well.
- **Toni 4 (nonverbal intelligence)** - The TONI-4 is a norm-referenced nonlinguistic problem solving ability assessment tool used; with individuals who have severe spoken language disorders (i.e. aphasia); with individuals who are deaf or hearing impaired; with non-English speakers, or English-language learners; to assess cognitive, language, or motor impairments due to neurological conditions (i.e. cerebral palsy); and to identify individuals suspected of intellectual impairment..

Many IQ tests have chosen a median score of 100 with a standard deviation of 15. When an individual takes an IQ test, the result is ranked compared to the results of the standardization sample and the subject is given an IQ score equal to those with the same test result in the standardization sample.

Achievement tests

An achievement test is a test of developed skill or knowledge. The most common type of achievement test is a standardized test developed to measure skills and knowledge learned in a given grade level, usually through planned instruction, such as training or classroom instruction.¹³⁷ Achievement tests are often contrasted with tests that measure aptitude, a more general and stable cognitive trait. This type of test is often requested/administered by a vocational rehabilitation professional in determining the appropriateness of training/education for a client. Three examples of commonly used achievement tests are the Canadian Adult Achievement Test, Wechsler Achievement Test and the Wide Range Achievement Test.

- **Canadian Adult Achievement Test (CAAT):** The Canadian Adult Achievement Test is a measure of an adult's current functional level in mathematics, reading and language. This battery of achievement tests has been designed specifically for the Canadian adult, regardless of his or her previous school experience.

The CAAT helps determine an individual's present educational level and readiness for literacy instruction, general academic upgrading, core skills development and vocational selection.

Two main kinds of scores can be obtained from the CAAT series: content referenced and norm referenced scores. An important score under the first category is the objective raw score. Average (mean) raw scores for all CAAT objectives at each level have been determined for the sample taking each level of the test as part of the CAAT research program. The performance of individual learners or groups of learners on each CAAT's objective can be evaluated in relation to those average scores for the purpose of identifying relative strengths and weaknesses.

Norm referenced scores are used to compare a learner's performance to that of an appropriate reference group. Grade equivalence and scale scores are types of norm referenced scores that can be used for this purpose when CAAT has been administered. Grade equivalence relate learners' scores to the typical performance of a number of groups of adults in specified grade tested in a given month of the school year. The CAAT grade equivalence ranges from K.0 to 12.9 with grade equivalence higher than 12.9 designated as post-secondary. Despite the limitations, grade equivalence scores can provide an indication as to the approximate level at which adult instruction can be initiated.

- **Wechsler Individual Achievement Test:** The Wechsler Individual Achievement Test developed by David Wechsler, assesses the academic achievement of children, adolescents, college students and adults, aged 4 through 85. The test enables the assessment of a broad range of academics skills or only a particular area of need.

There are four basic scales: Reading, Math, Writing, and Oral Language. Within these scales there is a total of 9 sub-test scores.

- Reading
 - Word Reading
 - Reading Comprehension
 - Pseudoword (phonetic) Decoding:
- Math
 - Numerical Operations
 - Math Reasoning
- Written Language
 - Spelling
 - Written Expression
- Oral Language
 - Listening Comprehension
 - Oral Expression

The WIAT consists of 16 subtests including several not featured in the second edition: Oral Reading Fluency, Math Problem Solving, Math Fluency Addition/Subtraction /Multiplication, Early Reading Skills, Alphabet Writing Fluency, Sentence Composition and Essay Composition. The test takes 45-90 minutes to administer depending on the age of the participant. The mean score for the WIAT is 100 with a standard deviation of 15, and the scores on the test may range from 40 to 160. 68% of participants in the UK standardization sample obtained scores of 85-115 and 95% obtained scores of 70-130.

- **Wide Range Achievement Test (WRAT):** The Wide Range Achievement is an achievement test which measures an individual's ability to read words, comprehend sentences, spell, and compute solutions to math problems. The test currently is in its fourth revision.

The test is appropriate for individuals' ages 5–94 years. The WRAT4 provides two equivalent forms (Blue and Green), which enables retesting within short periods of time without potential practice effects that occur from repeating the same items. The alternate forms also may be administered together in a single examination.

The Wide Range Achievement Test 4 (WRAT4) is the latest offering in a test series first published in 1946. The various editions of the Wide Range Achievement Test (WRAT) have enjoyed widespread use in a variety of settings as a measure of the basic academic skills necessary for effective learning, communication, and thinking: reading and spelling words and performing basic mathematical calculations.

Aptitude tests

These tests attempt to determine and measure a person's ability to acquire, through future training, some specific set of skills (intellectual, motor, and so on). The tests assume that people differ in their special abilities and that these differences can be useful in predicting future achievements.

There are numerous aptitude tests of the market, which are used for measuring aptitudes with different populations, but the most common ones are the General Aptitude Test Battery and the Differential Aptitude Test:

- **General Aptitude Test Battery (GATB):** The GATB is used extensively in Canada in vocational counselling, rehabilitation, and occupational selection settings. The GATB profile of occupational aptitudes can be used to determine appropriate career and/or training paths. The general working population is the reference group for this test. The GATB test-taker needs at least a Grade 6 level of knowledge.

The GATB measures nine distinct aptitudes using 12 separate tests (eight pencil and paper tests, and four performance tests):

- General Learning Ability¹¹ (G): Ability to "catch on" or understand instructions and underlying principles; to reason and make judgments.
- Verbal Ability (V): Ability to understand the meaning of words and the ideas associated with them, and to use them effectively; to comprehend language, to understand relationships between words and to understand the meaning of whole sentences and paragraphs; to present information or ideas clearly.
- Numerical Ability (N): Ability to carry out arithmetical processes quickly and accurately.
- Spatial Perception (S): Ability to think visually about geometric forms and comprehend the two-dimensional representation of three-dimensional objects; to recognize the relationships resulting from the movement of objects in space. May be used in such tasks as blueprint reading and in solving geometry problems. Frequently described as the ability to "visualize" objects of two or three dimensions.
- Form Perception (P): Ability to perceive pertinent detail in objects and in pictorial and graphic material; to make visual comparisons and discriminations and to see slight differences in shapes and shadings of figures and widths and lengths of lines.
- Clerical Perception (Q): Ability to perceive pertinent detail in verbal or tabular material; to observe differences in copy, to proofread words and numbers, and to avoid perceptual errors in arithmetical computation.
- Motor Co-ordination (K): Ability to co-ordinate eyes, hands and fingers rapidly and accurately when required to respond with precise movements.

¹¹ The term "ability" means an enduring general trait to perform a function.

- Finger Dexterity (F): Ability to move the fingers and manipulate small objects with the fingers rapidly and/or accurately.
- Manual Dexterity (M): Ability to move the hands easily and skillfully; to work with the hands in placing and turning motions.

One of the advantages of the General Aptitude Test Battery is that it can be used to compare occupational requirements found in the National Occupational Classification. Scores for each of the aptitudes can be given either in percentile scores or in “aptitude levels”. There are five aptitude levels:

- 1 = The highest 10% of the working population
- 2 = Upper third, exclusive of the highest 10%
- 3 = Middle third of the working population
- 4 = Lowest third, exclusive of the lowest 10%
- 5 = Lowest 10% of the working population

- **Differential Aptitude Test (DAT):** The Differential Aptitude Test is one of the most widely used aptitude tests in the world. It has also been adapted for use in Canada. This test measures eight areas:
 - Verbal Reasoning
 - Numerical Ability
 - Abstract Reasoning
 - Clerical Speed and Accuracy
 - Mechanical Reasoning
 - Space Relations
 - Spelling and
 - Language Usage

Interest Inventories

An interest inventory is a self-assessment tool, used in career planning, that assesses one's likes and dislikes of a variety of activities, objects, and types of persons; the premise is that people in the same career (and satisfied in that career) have similar interests.

- **Canadian Work Preference Inventory:** The Canadian Work Preference Inventory (CWPI) is a tool for counselling to measure five career interests in 15 to 20 minutes. The CWPI has been normed on over 2,000 anglophones and francophones across Canada. The CWPI can be used in more general counselling to determine whether an individual's actual job closely matches his or her interest, or whether a mismatch between jobs and interests may be a source of more general problems. The CWPI Job Dictionary links to the National Occupational Classification (NOC).

The Canadian Work Preference Inventory (CWPI) measures five occupational interests:

- Directive (D): Directive persons like to take charge and control situations. They like to take responsibility for projects that require planning, decision making and coordinating the work of others. They are able to give direction and instructions easily. They enjoy organizing their own activities. They see themselves as independent and self-directing.
 - Innovative (I): Innovative persons like to explore things in depth and arrive at solutions to problems by experimenting. They are interested in initiating and creating different ways to solve questions and present information. They enjoy scientific subjects. Innovative persons prefer to be challenged with new and unexpected experiences. They adjust to change easily.
 - Methodical (M): Methodical persons like to have clear rules and organized methods to guide their activities. They prefer working under the direction or supervision of others according to given instructions, or to be guided by established policies and procedures. Methodical persons like to work on one thing until it is completed. They enjoy following a set routine and prefer work that is free from the unexpected.
 - Objective (O): Objective persons enjoy working with tools, equipment, instruments and machinery. They like to repair and/or fabricate things from various materials according to specifications and using established techniques. Objective persons are interested in finding out how things operate and how they are built.
 - Social (S): Social persons like dealing with people. They enjoy caring for and assisting others in identifying their needs and solving their concerns. Social persons like working and co-operating with others. They prefer to be involved in work that requires interpersonal contact.
-
- **Strong Interest Inventory:** The Strong Interest Inventory (SII) is an interest inventory used in assisting clients to determine a vocational direction which matches their personal interests. The goal of this assessment is to give insight into a person's interests, so that they may have less difficulty in deciding on an appropriate career choice for themselves. It is also frequently used for educational guidance as one of the most popular career assessment tools. The test was developed in 1927 by psychologist E.K. Strong, Jr. to help people exiting the military find suitable jobs. It was revised later by Jo-Ida Hansen, and David Campbell. The modern version is based on the typology (Holland Codes) of psychologist John L. Holland. The newly revised inventory consists of 291 items, each of which asks you to indicate your preference from five responses. It is an assessment of interests, and not to be confused with personality assessments or aptitude test.

The test can typically be taken in 25 minutes after which the results must be scored by computer. After scoring, an individual can then view how their personal interests

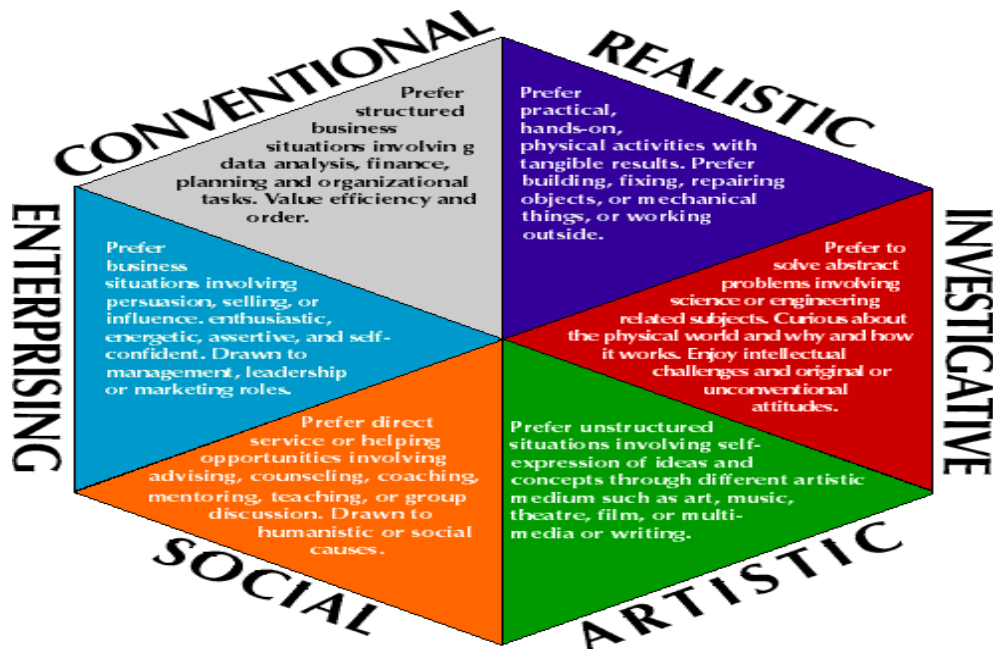
compare with the interests of people in a specific career field. Access to the comparison database and interpretation of the results usually incurs a fee.

The results include:

- Scores on the level of interest on each of the six Holland Codes (see below) or *General Occupational Themes*.
- Scores on 30 Basic Interest Scales (e.g. art, science, and public speaking).
- Scores on 244 Occupational Scales which indicate the similarity between the respondent's interests and those of people working in each of the 122 occupations.
- Scores on 5 Personal Style Scales (learning, working, leadership, risk-taking and team orientation).
- Scores on 3 Administrative Scales used to identify test errors or unusual profiles.

The Holland Codes or the Holland Occupational Themes (RIASEC), developed by the late psychologist John L. Holland Codes, refers to a theory of careers and vocational choice based upon personality types. Each letter or code stands for a particular "type":

- Realistic (Doers),
- Investigative (Thinkers),
- Artistic (Creators),
- Social (Helpers),
- Enterprising (Persuaders) and
- Conventional (Organizers).



- **Self-Directed Search (SDS):** Based on John Holland's six occupational RIASEC themes, the Self-Directed Search Form R: 4th Edition (SDS R) is an assessment of occupational interests. Administered individually or in a group situation, this assessment is geared to help adolescents at the high school level, college students and adults already out in the work force. It matches their skills and interests with an occupation or field of study.

Questions include items on:

- Individual's aspirations
- Activities
- Occupations of interest
- Competencies

The SDS R evaluates the individual using the RIASEC personality scales.

- **Realistic**
 - Technical, mechanical, electrical, physical, outdoor
- **Investigative**
 - Analytic, intellectual, scientific, mathematical
- **Artistic**
 - Creative, imaginative, flexible, e.g., musician, writer, painter, actor
- **Social**
 - Responsible, humanistic, want to help others
- **Enterprising**
 - Leaders, ambitious, managerial, assertive
- **Conventional**
 - Conformer, well-organized, conscientious

Taking the highest scores of the six scales results in a 3-Letter Summary Code yielding the best matches of occupational types with the skills and interests of the individual. It requires 35-45 minutes to complete.

- **Jackson Vocational Survey:** Definition of the JVIS scales was based on a reconceptualization of occupational preferences in terms of *work roles* and *work styles*. *Work roles* refer to relatively homogeneous sets of activities relevant to occupations. A *work role* may strongly relate to certain occupations such as scales for Medical Service or Law, or cut across particular occupations and be relevant to a variety of careers, as in the case of Supervision or Human Relations Management. *Work styles* refer to a preference for certain kinds of work environments. For example, computer programmers and physical scientists are often required to work long hours to find solutions to difficult problems. Their scores on the Stamina scale are consistently high.

Another feature of the JVIS is that it places equal emphasis upon the measurement of interests of women and men. The JVIS was standardized in such a way that an equal number of males and females contributed to the selection of items and scales, and that items were required to show discrimination for each sex separately. The format allows males and females to be measured in terms of a common set of interest dimensions which do not make discriminations on the basis of traditional "male" and "female" occupations. Vocational rehabilitation professionals who wish to give individuals an equal opportunity to consider occupations traditionally associated with only one sex can do so by employing the JVIS.

Perhaps the most unique feature of the JVIS is its method of scale construction. Each scale was designed to measure the interest designated by the scale name and to be relatively unrelated to other scales. To accomplish this result, careful attention was paid to the preparation of a large pool of items reflecting basic *work role* and *work style* dimensions. This was followed by administration of these items to large samples of males and females, well over a thousand of each. Final item selection involved a series of multivariate psychometrically-based procedures designed to select items most clearly related to the interests being assessed, to suppress response biases, and to minimize the redundancy between scales.

- **Career Occupational Preference System (COPS):** The COPS Interest Inventory consists of 168 items, providing job activity interest scores related to 14 different career clusters. Each cluster corresponds to both high school and college curriculum, as well as current sources of occupational information. The COPS interpretive material emphasizes a "hands-on" approach to career exploration, featuring career and educational planning worksheets, along with a listing of suggested activities to gain experience.
- **Reading Free Vocational Interest Inventory:** This nonverbal test illustrates job tasks to help individuals with learning disabilities or intellectual disabilities choose the activities they would most like to do. Identify areas and patterns of interest to assist with occupational planning and job placement. A series of 55 sets of three drawings each depict different job tasks. The individual selects the most preferred activity in each set. Interest areas include:
 - Automotive
 - Building Trades
 - Clerical
 - Animal Care
 - Food Service
 - Patient Care
 - Horticulture
 - Housekeeping

Personal Service
Laundry Service
Materials Handling

- **Career Assessment Inventory (CAI):** Compares an individual's occupational interests to those of individuals in 111 specific careers that reflect a broad range of technical and professional positions in today's workforce. The inventory is used by guidance vocational rehabilitation professionals to help students and adults develop career and study plans, and by psychologists and human resource professionals to advise individuals on career development.

Personality Tests:

- **Minnesota Multiphasic Personality Inventory (MMPI):** The Minnesota Multiphasic Personality Inventory (MMPI) is a psychological test that assesses personality traits and psychopathology. It is primarily intended to test people who are suspected of having mental health or other clinical issues. The MMPI is currently commonly administered in one of two forms — the MMPI-2, which has 567 true/false questions, and the newer MMPI-2-RF, published in 2008 and containing only 338 true/false items. While the MMPI-2-RF is a newer measure and takes about half the time to complete (usually 30 to 50 minutes), the MMPI-2 is still the more widely used test because of its existing large research base and familiarity with psychologists. (Another version of the test — the MMPI-A — is designed exclusively for teenagers.)

The Minnesota Multiphasic Personality Inventory is considered a protected psychological instrument, meaning it can only be given and interpreted by a psychologist trained to do so (you cannot find the test online). While it's commonly administered by computer nowadays (and requires no direct professional involvement during its administration), psychological testing is nearly always preceded by a clinical interview by the psychologist who is doing the testing. After the computer scores the test results, the psychologist writes up a report interpreting the test results in the context of the person's history and current psychological concerns.

The MMPI-2 is designed with 10 clinical scales which assess 10 major categories of abnormal human behaviour, and four validity scales, which assess the person's general test-taking attitude and whether they answered the items on the test in a truthful and accurate manner.

- **Beck Depression Inventory:** The Beck Depression Inventory (BDI, BDI-1A, BDI-II), created by Aaron T. Beck, is a 21-question multiple-choice self-report inventory, one of the most widely used psychometric tests for measuring the severity of depression. Its development marked a shift among mental health professionals, who had until then, viewed depression from a psychodynamic perspective, instead of it being rooted in the patient's own thoughts.

In its current version, the BDI-II is designed for individuals aged 13 and over, and is composed of items relating to symptoms of depression such as hopelessness and irritability, cognitions such as guilt or feelings of being punished, as well as physical symptoms such as fatigue, weight loss, and lack of interest in sex.^[1]

There are three versions of the BDI—the original BDI, first published in 1961 and later revised in 1978 as the BDI-1A, and the BDI-II, published in 1996. The BDI is widely used as an assessment tool by health care professionals and researchers in a variety of settings.

- **Myers-Briggs:** Myers-Briggs Type Indicator (MBTI) is based on Jung's concepts of perception and judgment. The MBTI is scored on eight scales yielding four bipolar dimensions:
 1. Extroversion (E) versus Introversion (I)
 2. Sensing (S) versus Intuition (N)
 3. Thinking (T) versus Feeling (F)
 4. Judgment (J) versus Perception (P)

The MBTI personality type is summarized in four letters; this combination indicates the direction of the person's preference on each of the four dimensions. All possible combinations of the four paired scales result in 16 different potential personality types. Each type combination has its own strengths. It is often used along with interest inventories and other psychological test results.

- **House-Tree-Person Interrogation Form:** The House-Tree-Person (H-T-P) projective technique developed by John Buck was originally an outgrowth of the Goodenough scale utilized to assess intellectual functioning. Buck felt artistic creativity represented a stream of personality characteristics that flowed onto graphic art. He believed that through drawings, subjects objectified unconscious difficulties by sketching the inner image of primary process. Since it was assumed that the content and quality of the H-T-P was not attributable to the stimulus itself, he believed it had to be rooted in the individual's basic personality. Since the H-T-P was an outcropping of an intelligence test, Buck developed a quantitative scoring system to appraise gross classification levels of intelligence

along with a qualitative interpretive analysis to appraise global personality characteristics.

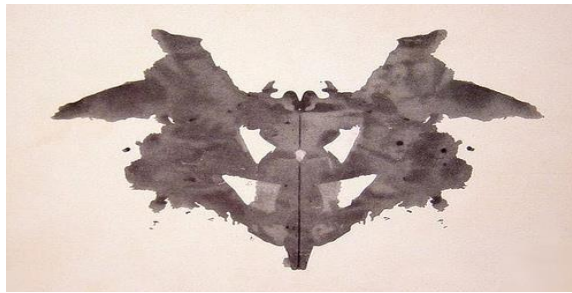
The Post-Drawing Interrogation form (PDI) consists of 60 questions varying from direct and concrete to indirect and abstract. Once the PDI has been administered and the interview has been completed, the examiner records items of detail, proportion, and perspective in the Scoring Folder. After completing the scoring tables, the examiner derives an IQ figure for the percentage of raw G, a net weighted score, a weighted "good" score, and a weighted "flaw" score, which then comprise the items for the profile configuration.

- **Rorschach Psychodiagnostic Test:** The Rorschach test (also known as the Rorschach inkblot test, the Rorschach technique, or simply the inkblot test) is a psychological test in which subjects' perceptions of inkblots are recorded and then analyzed using psychological interpretation, complex algorithms, or both. Some psychologists use this test to examine a person's personality characteristics and emotional functioning. It has been employed to detect underlying thought disorder, especially in cases where patients are reluctant to describe their thinking processes openly. The test is named after its creator, Swiss psychologist Hermann Rorschach.

The tester and subject typically sit next to each other at a table, with the tester slightly behind the subject. This is to facilitate a "relaxed but controlled atmosphere". There are ten official inkblots, each printed on a separate white card, approximately 18x24 cm in size. Each of the blots has near perfect bilateral symmetry. Five inkblots are of black ink, two are of black and red ink and three are multicolored, on a white background. After the test subject has seen and responded to all of the inkblots (*free association* phase), the tester then presents them again one at a time in a set sequence for the subject to study: the subject is asked to note where he sees what he originally saw and what makes it look like that (*inquiry* phase). The subject is usually asked to hold the cards and may rotate them. Whether the cards are rotated, and other related factors such as whether permission to rotate them is asked, may expose personality traits and normally contributes to the assessment. As the subject is examining the inkblots, the psychologist writes down everything the subject says or does, no matter how trivial. Analysis of responses is recorded by the test administrator using a tabulation and scoring sheet and, if required, a separate location chart.

The general goal of the test is to provide data about cognition and personality variables such as motivations, response tendencies, cognitive operations, affectivity, and personal/interpersonal perceptions. The underlying assumption is that an individual will class external stimuli based on person-specific perceptual sets, and including needs, base motives, conflicts, and that this clustering process is representative of the process used in real-life situations.

Methods of interpretation differ. Rorschach scoring systems have been described as a system of pegs on which to hang one's knowledge of personality.



- **Sentence Completion:** Sentence completion tests are a class of semi-structured projective techniques. Sentence completion tests typically provide respondents with beginnings of sentences, referred to as “stems,” and respondents then complete the sentences in ways that are meaningful to them. The responses are believed to provide indications of attitudes, beliefs, motivations, or other mental states. There is debate over whether or not sentence completion tests elicit responses from conscious thought rather than unconscious states. This debate would affect whether sentence completion tests can be strictly categorized as projective tests.

A sentence completion test form may be relatively short, such as those used to assess responses to advertisements, or much longer, such as those used to assess personality. A long sentence completion test is the Forer Sentence Completion Test, which has 100 stems. The tests are usually administered in booklet form where respondents complete the stems by writing words on paper.

The structures of sentence completion tests vary according to the length and relative generality and wording of the sentence stems. Structured tests have longer stems that lead respondents to more specific types of responses; less structured tests provide shorter stems, which produce a wider variety of responses.

The data collected from sentence completion tests can usually be analyzed either quantitatively or qualitatively. Usually, sentence completion tests can be interpreted in two different ways: subjective-intuitive analysis of the underlying motivations projected in the subject's responses, or objective analysis by means of scores assigned to each completed sentence. Multiple themes can occur in a short test, which gives the examinee multiple opportunities to reveal underlying motivations about each topic during data analysis. Of course, most sentence completion tests are much longer-

anywhere from 40 to 100 stems-and contain more themes-anywhere from 4 to 15 topics.

- **TAT (Thematic Apperception Test):** The Thematic Apperception Test, or TAT, is a projective psychological test. Proponents of this technique assert that a person's responses to the TAT cards can provide information about his or her views of the self, the world, and interpersonal relationships. Historically, it has been among the most widely researched, taught, and used of such tests.

The TAT is popularly known as the *picture interpretation technique* because it uses a series of provocative yet ambiguous pictures about which the subject is asked to tell a story. The subject is asked to tell as dramatic a story as they can for each picture presented, including the following:

- what has led up to the event shown
- what is happening at the moment
- what the characters are feeling and thinking
- what the outcome of the story was

The complete version of the test contains 31 picture cards. Some of the cards show male figures, some female, some both male and female figures, some of ambiguous gender, some adults, some children, and some show no human figures at all. One card is completely blank and is used to elicit both a scene and a story about the given scene from the storyteller. Although the cards were originally designed to be matched to the subject in terms of age and gender, any card may be used with any subject.



Example of TAT Picture

Values Inventories:

Values Inventories measure work values and values associated with broader aspects of life. Examples include:

- **Work Values Inventory:** Competent vocational rehabilitation planning is generally understood to rest on a tripod of interests, skills or abilities, and values. Interests and skills or abilities have a long assessment history; assessment of work values has only recently emerged. One of the original assessment tools is Donald Super's Work Values Inventory (WVI).

Generally speaking, work values can be defined as the qualities that people seek in their work, occupation, or career. In contrast, interests may be defined as the activities through which valued qualities are realized. For example, valuing independence may call for one to be interested in managerial activities.

Super's inventory was devised originally as a research tool in the Career Pattern Study of the late 1940s. After extensive further development, the inventory was made available to the profession in 1970, though by 2000 it was virtually out of print. It assessed 15 values, such as achievement, prestige, esthetics, and economic returns, using a five-point scale to rate the importance of each to the respondent.

- **Work Environment Preference Schedule:** The Work Environment Preference Schedule was designed to measure a personality construct, "bureaucratic orientation", which reflects a commitment to the set of attitudes, values, and behaviours that are characteristically fostered and rewarded by bureaucratic organizations. High scores typify individuals who accept authority, who prefer to have specific rules and guidelines to follow, who prefer impersonalized work relationships, and who seek the security of organizational and in-group identification.

Neuropsychological Evaluations

Neuropsychological evaluation is a testing method through which a neuropsychologist can acquire data about a subject's cognitive, motor, behavioural, linguistic, and executive functioning. In the hands of a trained neuropsychologist, these data can provide information leading to the diagnosis of a cognitive deficit or to the confirmation of a diagnosis, as well as to the localization of organic abnormalities in the central nervous system (CNS). The data can also guide effective treatment methods for the rehabilitation of impaired patients.

Neuropsychological evaluation provides insight into the psychological functioning of an individual, a capacity for which modern imaging techniques¹³⁸ have only limited ability.

However, these tests must be interpreted by a trained, experienced neuropsychologist in order to be of any benefit to the patient. These tests are often coupled with information from clinical reports, physical examination, and increasingly, premorbid and post-morbid self and relative reports. Alone, each neuropsychological test has strengths and weaknesses in its validity, reliability, sensitivity, and specificity. However, through eclectic testing and new in situ testing, the utility of Neuropsychological evaluation is increasing dramatically.¹³⁹

Neuropsychological evaluation is useful for measuring many function categories, including the following:

- Intellectual functioning
- Academic achievement
- Language processing
- Visuospatial processing
- Attention/concentration
- Verbal learning and memory
- Visual learning and memory
- Executive functions
- Speed of processing
- Sensory-perceptual functions
- Motor speed and strength
- Motivation/symptom validity
- Personality assessment

Examples of Neuropsychological tests would include:

Intellectual functioning	Wechsler Adult Intelligence Scale Wechsler Intelligence Scale for Children Stanford-Binet Intelligence Scale
Academic achievement	Wechsler Individual Achievement Test (WIAT) Woodcock-Johnson Achievement Test
Language processing	Boston Naming Test Multilingual Aphasia Examination Boston Diagnostic Aphasia Examination Token Test
Visuospatial processing	Rey-Osterrieth Complex Figure – Copy condition WAIS Block Design Subtest Judgment of Line Orientation Hooper Visual Organization Test
Attention/ concentration	Digit Span Forward and Reversed Trail Making Tests Cancellation Tasks (Letter and symbol) Paced Auditory Serial Addition Test (PASAT)

Verbal learning and memory	Wechsler Memory Scale (WMS) Logical Memory I and II - Contextualized prose Verbal Paired-Associates WMS-III Verbal Memory Index Rey Auditory Verbal Learning Test - Rote list learning (unrelated words) California Verbal Learning Test - Rote list learning (related words) Verbal Selective Reminding Test - Selective reminding (unrelated words) Hopkins Verbal Learning Test
Visual learning and memory	WMS Visual Reproduction I and II WMS-III Visual Memory Index Rey-Osterrieth Complex Figure - Immediate and delayed recall Nonverbal Selective Reminding Test Continuous Recognition Memory Test Visuo-Motor Integration Test - Block design
Executive functions	Wisconsin Card Sorting Test Category Test Stroop Test Trail Making Test-B WAIS Subtests of Similarities and Block Design Porteus Maze Test Multiple Errands Test (MET)
Speed of processing	Simple and Choice Reaction Time Symbol Digit Modalities Test - Written and oral
Sensory-perceptual functions	Halstead-Reitan Neuropsychological Battery (HRNB) Tactual Performance Test and Sensory Perceptual Examination
Motor speed and strength	Index Finger Tapping Grooved Pegboard Task Hand Grip Strength Thurstone Uni- and Bimanual Coordination Test
Motivation	Rey 15 Item Test Dot Counting Forced-Choice Symptom Validity Testing
Personality assessment	Minnesota Multiphasic Personality Inventory (MMPI) Millon Clinical Multiaxial Inventory Beck Depression Inventory (BDI)

	Rorschach Test Thematic Apperception Test for Children or Adults

Work Samples Tests:

Work samples are an assessment approach whereby the client is observed performing a simulated or actual work activity. Work samples are designed to see whether the individual follows the procedures and uses the tools and materials involved in actual jobs appropriately. Work samples are used to measure a variety of constructs including vocational aptitudes, worker temperaments, vocational interests, hand dexterity, tolerance for standing or sitting, work habits and behaviours, learning style, and understanding of written and oral instructions.

For many clients, there is a need to extend the evaluation process beyond the occupational information and exploration stage. For those persons whose vocational history is minimal, or whose disabilities may have eliminated most of their previously demonstrated transferable skills, work samples become a viable method of assessing vocational potential. Work samples usually emphasize psychomotor skills rather than verbal abilities. They produce feedback from hands-on activities experienced by the client. A work sample may take as little as a few minutes, or as much as eight hours to complete.

Work samples represent an important component of the vocational evaluation process. They allow clients to experience activities which are obviously (to the client) work related. They provide the evaluator an opportunity to observe the behaviours of clients in job related situations, as well as to measure the client's physical tolerance, frustration tolerance, interests, temperaments and aptitudes for jobs and groups of jobs. They provide clients with an opportunity to experience work and to related worker traits to actual jobs.

- **McCarron-Dial Evaluation System:** This was developed to predict an individual's ability for community-based employment. A battery of tests consists of eight separate instruments that access five factors (verbal-cognitive, sensory, motor, emotional and integration). The basic battery takes about 3 hours to administer and the comprehensive battery takes 5 days to complete.
- **VALPAR:** The VALPAR Component Work Samples series is a collection of 18 work samples and functional capacity evaluations designed to measure worker characteristics. The 18 work samples meet such criteria as universality, efficiency, durability, marketability, flexibility and mobility. Designed for optimum evaluator efficiency, each work sample is recyclable, scored with ease, equipped for 100 administrations, uses a minimum of consumable supplies, and is portable and easily scored. The work samples are also designed so that the evaluatee's language and reading skills do not present barriers to vocational

assessment. All groups are recommended for these samples, including hearing and visually impaired.

- **Micro-Tower:** The Micro-TOWER System of Vocational Evaluation was developed in response to the need for a revision of the TOWER (Testing, Orientation, and Work Evaluation in Rehabilitation) System. The Micro-TOWER system of work sample tests measures the major aptitudes required for most semi-skilled and unskilled occupations. It may be used as a screening device, preceding more extensive evaluation. A variety of general vocational aptitudes are measured--verbal, numerical, motor, spatial, and clerical perception skills. These skills were originally chosen to parallel the Dictionary of Occupational Titles aptitudes, and include message taking, making change, bottle capping and packing, lamp assembly, blueprint reading, and mail sorting. The system has been field tested on a variety of populations, and is suitable for the physically handicapped, emotionally disturbed, and Spanish-speaking. Separate norms are available for a number of different groups. The test is administered, using a tape recorder, to a group of approximately five to ten clients at one time. At the beginning of each work sample, occupational information is presented.

4.18 Transferable Skills Analysis

Introduction: The TSA is an important concept for the vocational rehabilitation professional to understand. A Transferable Skills Analysis (TSA) is an effective, simple and cost-effective technique to assist in the vocational rehabilitation process. It is of particular value in aiding the vocational rehabilitation professional in assisting injured workers in determining alternative vocational goals.

Over the past number of years, numerous software packages have been developed for the vocational rehabilitation professional to make the TSA process easier. Many of these are great tools, which makes the job much easier. However, many organizations and individuals do not have the financial resources to avail themselves of such products. In addition, many have come to rely on the results of these computerized packages rather than the skill and expertise of the knowledgeable VRPM.

Transferability is a generalized process of identifying traits and skills (as demonstrated in previous jobs) that can be “matched” to similar traits and skill requirements in other jobs. In constructing a Transferable Skills Analysis the VR professional:

1. develops a profile of the worker’s past (e.g. pre-injury, illness or disabling condition) occupational/education history
2. modifies the profile to take into account the worker’s current functioning level
3. determines potential alternative occupational matches
4. labour market information on vocational alternative
5. assist the worker to determine new career direction

Advantages of a Transferable Skills Analysis: There are a number of advantages of doing a TSA that cannot be matched in any other form of assessment:

- Based on the proven employment/education history of the client. Transferable Skills Analysis relies solely on the client's past record, thus adding validity to the result.
- Reality versus clinical basis. Clinical assessments typically take place in a quiet room with artificial expectations. Some individuals do well on paper/pencil tests whereas others "freeze" at the very thought of being tested. Older workers who have been out of the education system for an extended period of time tend to have difficulties undertaking formalized assessments.
- Confounding variables: Clinical assessments usually measure for speed and power. That is, not only does the client have to be accurate in their answers, they also have to be fast. A clinical assessment can be negatively affected if the client is on medication, limited due to their injury, or even if they have had a poor night's sleep. The TSA bases its results on the workers work history, which could have been over many years and not a "one-shot" event.
- Cost: Dollar for dollar a Transferable Skills Analysis is probably one of the most effect tools a VR professional can have. After the purchase of the basic tools (NOC Career Handbook and an Internet connection) there are no further financial costs.

Disadvantageous of a Transferable Skills Analysis: Even though the TSA is an effective tool for the VR, it still has a number of disadvantages or pitfalls:

- Under/Over Employment: As the TSA is based on the worker's personal education/work history there is the possibility that the worker's aptitudes do not match their work history. The individual who gets a managerial job because they are married to the owner's child, or the taxi driver who has a PhD but can't find a job in his/her field, are two examples where a TSA may run into problems. These difficulties can be overcome with a thorough history taking, but can be a problem if unexamined.
- VR Professional Experienced Based: The value of a Transferable Skills Analysis is only as good as the VR professional who does it. It requires knowledge of job descriptions and duties, the labour market, ability to weight education/work variables, etc.
- Job Title Versus Job Description: There are many instances where an individual's given job title do not match the NOC description. If the job title is used, without consideration of the duties attached, there is a significant danger of producing a flawed Transferable Skills Analysis. Once again this requires a good history taking and experience on the part of the VRPM.
- Not to be used in Isolation: One of the greatest dangers is to produce a TSA either manually or with a computer software program and use it as a definitive answer to the client's VR needs. The Transferable Skills Analysis is only one tool and should be used in conjunction with clinical assessments, medical assessment, psychological assessments, interest tests, etc. If possible a clinical assessment should be

undertaken concurrently to a TSA. The results can be used to compare and contrast results, with the combination providing a much more accurate result.

Steps to a Transferable Skills Analysis: There are numerous types of Transferable Skills Analysis such as those based on job descriptions; materials handled, length of education, work traits, etc. For our purposes we will look only at the simplest of TSA which looks at the transferability of an individual's attributes as defined in the National Occupation Classification (NOC).

Step One - Information Gathering: This is perhaps the most important step in the TSA process. This requires the VRPM to get a complete and accurate description of the client's past education and work history. The vocational rehabilitation professional can facilitate the TSA by focusing more on work history in their interviews and information gathering. This information is obtained through interviews, file review, medical records, job description, etc. Also of value is an understanding of the individual's hobbies and volunteer experiences as they may shed light on any transferable skills.

Step Two – Pre-Accident/Illness Profile: The development of a pre-accident profile is done in two steps: obtaining the raw data which relates to work history and the development of an Unadjusted Profile. All information is taken from the *NOC Career Handbook*.

The Unadjusted Profile is the development of the client's predicted pre-accident or illness profile. This is where the VRPM needs the greatest skills and expertise. In making these predictions there is a myriad of considerations that must be taken into consideration: are the individual's past jobs a true indication of their skill level, are there any other confounding variables that must be taken into consideration, does the individual's education reflect the projected profile, which jobs should carry the most weight, was the client over/under employed, etc.

Example: You are undertaking a Transferable Skills Analysis on a 36 year old Motor Cycle Mechanic. He recently injured his lower back. You have received a Functional Capacity Analysis which indicates due to his injury he can only undertake "light" work. During an interview with the client you find out his only other job was as a "truck driver".

The first step is to consult the National Occupation Classification (NOC) to determine the specific NOC codes (<http://www30.hrsdc.gc.ca/NOC/English/NOC/2006/IndexOfTitles.aspx>) for his two jobs (motorcycle and truck driver). From this you learn: Motorcycle Mechanic (NOC – 7334) and Truck Driver (NOC – 7411).

The next step is to obtain from the NOC Career Handbook the job profile for each of the jobs and to determine the "Demonstrated Profile".

Aptitude Profile:

Job Title	NOC	Time	G	V	N	S	P	Q	K	F	M
Motorcycle Mechanic	7334	6 years	3	3	3	3	3	4	3	3	3
Truck Driver	7411	2 years	3	4	4	3	4	4	3	4	3
Demonstrated Profile			3	3	3	3	3	3	3	3	3

*Key:

G General Learning Ability

Q Clerical Perception

V Verbal Aptitude

K Motor Coordination

N Numerical Aptitude

F Finger Dexterity

S Spatial Aptitude

M Manual Dexterity

P Form Perception

1 = top 10% of the working population

2 = top 1/3 of the working population excluding the top ten percent

3 = middle 1/3 of the working population

4 = bottom 1/3 of the work population excluding the bottom ten percent

5 = bottom 10% of the working population

Physical Activities:

Job Title	NOC	Vision	Colour	Hearing	Body Position	Limb Coord.	Strength
Truck Driver	7411	4	1	1	1	2	2
Motorcycle Mechanic	7334	2	1	3	4	1	3
Demonstrated Profile		4	0	3	4	2	3

Key

<u>Vision:</u>	<u>Hearing:</u>	<u>Limb Coordination</u>
1. Close Visual Acuity	1. Limited	1. Not Relevant
2. Near Vision	2. Verbal Interaction	2. Upper Limb Coordination
3. Near and Far Vision	3. Other Sound Discrimination	3. Lower Limb Coordination
4. Total Visual Field		
<u>Colour</u>	<u>Body Position</u>	<u>Strength</u>
0. Not Relevant	1. Sitting	1. Limited
1. Relevant	2. Standing and/or Walking	2. Light
	3. Sitting/Standing/Walking	3. Medium
	4. Other Body Positions ¹²	4. Heavy

¹² Other Body Positions include bending, stooping, kneeling and crouching

The “Demonstrated Profile” is a reflection of a client’s aptitudes and physical attributes that he/she has shown in past job performance. There are some general principles in determine the client’s “Demonstrated Profile”:

- All things being equal the highest aptitude and physical activities is the one chosen as the “demonstrated profile”.
- If the client has advanced education which is not reflected in his/her job history, adjust the profile to reflect this. For example, if the individual has a university degree their G score should be a “2” regardless of their work history.
- In general, if the client was not successful in a job (e.g. got fired due to incompetence) or was at the job a short period of time (e.g. less than 6 months) it should not be considered in developing the demonstrated profile.
- If the client has undertaken an aptitude assessment (e.g. GATB) the scores can be used to verifying or modify the demonstrated profile.

Step Three – Residual Profile: The Residual Profile is the identification of the client’s current functioning level. The client’s skill profile may be directly affected by his/her injury/illness. Functional Evaluations are helpful in contributing to the residual profile. In many cases this will be a change in the individual’s physical functioning level. For example, in their pre-injury work they participated in “heavy” work, where now they are only able to undertake light or medium work. In general terms (except for illness/accidents that effect cognitive functioning), the client’s non-physical aptitudes (i.e. G, V, N, S, P and Q) should not change between pre and post injury.

Example: In the above example the client’s disability is a low back injury. As was noted the client is currently able to work at a “light” level. This is defined as work activities involved in handling loads of 5 kg but less than 10 kg.

Physical Activities:

Job Title	NOC	Vision	Colour	Hearing	Body Position	Limb Coord.	Strength
Truck Driver	7411	4	1	1	1	2	2
Motorcycle Mechanic	7334	2	1	3	4	1	3
Demonstrated Profile		4	0	3	4	2	3
Adjusted Profile		4	0	3	4	2	2

As can be seen the Demonstrated Profile for Strength has been reduced from a “3” (Medium) to “2” (Light).

There are some general principles in determine the adjusted profile of a client:

- Medical information, functional capacity evaluation, neuropsychological assessment etc. are all examples of information the VR Professional may receive which will give an indication of the client's functioning level.
- In general the cognitive aptitudes will not be affected in the adjusted profile except in instances of traumatic brain injury or some psychological impairment.
- There are instances where a client is on long-term medication which may have an impact on aptitudes and/or physical abilities.

Step Four – Alternative Occupations: Based upon the results from the Residual Profile, it is possible to determine alternative occupations that match the individual's aptitudes, interests and physical limitations. This is usually done by making a comparison to other occupations outlined in the *NOC Career Handbook* (HRDC also makes this services available through the Internet). This does not necessarily mean the client can undertake these jobs at the present time, but it does indicate those occupations which they could perform with adequate education or training. This listing is often effective as the basis for Occupational Exploration with the client.

Example: Using the above example the aptitude profile is put into the NOC Career Handbook site:

The screenshot shows the NOC Career Handbook website. The main content area is titled "Aptitudes" and includes a legend for aptitude levels (1 to 5) and a search table. The search table has columns for "From" and "To" values for various aptitudes. The "To" value for "M- Manual Dexterity" is set to 5.

Aptitude	From	To
G- General Learning Ability	3	5
V- Verbal Ability	3	5
N- Numerical Ability	3	5
S- Spatial Perception	3	5
P- Form Perception	3	5
Q- Clerical Perception	3	5
K- Motor Co-ordination	3	5
F- Finger Dexterity	3	5
M- Manual Dexterity	3	5

The next step would be to add the "physical activities". In this instance a "negative search" would be done to exclude all jobs in the "medium" and "heavy" range.

to identify occupations.

Specific Search
(select only one rating per activity - results include only those occupations that have all selected ratings)

Negative Search
(select unlimited ratings - results include occupations that do not have the selected ratings)

V - Vision

- ☐ 1 Close visual acuity
- ☐ 2 Near vision
- ☐ 3 Near and far vision
- ☐ 4 Total visual field

B - Body Position

- ☐ 1 Sitting
- ☐ 2 Standing and/or walking
- ☐ 3 Sitting, standing, walking
- ☐ 4 Other body positions

C - Color Discrimination

- ☐ 0 Not relevant
- ☐ 1 Relevant

L - Limb Co-ordination

- ☐ 0 Not relevant
- ☐ 1 Upper limb co-ordination
- ☐ 2 Multiple limb co-ordination

H - Hearing

- ☐ 1 Limited
- ☐ 2 Verbal interaction
- ☐ 3 Other sound discrimination

S - Strength

- ☐ 1 Limited
- ☐ 2 Light
- ☒ 3 Medium
- ☒ 4 Heavy

Environmental Conditions

Select any of the following factors and indicate the type of search you would like to perform to identify occupations.

Specific or Negative Search

The final step would be to do a “Search” with this adjusted profile. In this instance there was a listing of 308 occupations which match the client’s aptitudes and present physical functioning level.

Career Handbook

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Results: 308

- 0621 Retail Trade Managers
- 0631 Restaurant and Food Service Managers
- 0632 Accommodation Service Managers
- 0651 Other Services Managers
- 0712 Residential Home Builders and Renovators
- 1211 Supervisors, General Office and Administrative Support Clerks
- 1215 Supervisors, Recording, Distributing and Scheduling Occupations
- 1227 Court Officers and Justices of the Peace
- 1227.1 Court Officers
- 1227.2 Justices of the Peace
- 1233 Insurance Adjusters and Claims Examiners
- 1233.1 Insurance Adjusters
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- 1244 Court Recorders and Medical Transcriptionists
- 1244.2 Medical Transcriptionists
- 1411 General Office Clerks
- 1413 Records Management and Filing Clerks
- 1413.1 Records Management Clerks
- 1413.2 File Clerks
- 1413.3 Health Records Technicians
- 1414 Receptionists and Switchboard Operators
- 1414.1 Receptionists
- 1414.2 Hospital Admitting Clerks
- 1414.3 Medical and Dental Receptionists
- 1414.4 Switchboard Operators
- 1414.5 Answering Service Operators
- 1414.6 Front Desk Clerks (Except Hotel)
- 1422 Data Entry Clerks
- 1423 Desktop Publishing Operators and Related Occupations

Step Five – Labour Market/Training Information: This step can be undertaken either concurrent with Step Four or after some alternative occupations have been

determined. In this step the VR Professional and the client take into consideration such things as job availability, expected income, length and availability of training, size of labour market, etc. This information can be obtained through Government publications, StatsCan information, direct contact with employers/training organizations, and the Internet.

The Transferable Skill Analysis process is not a panacea for the vocational counselling process; however, it can provide the VR Professional another important tool in assisting his/her client in re-entering the labour market. Used with caution and as a part of a battery of services, the TSA can provide the basis of making effective decisions and determining appropriate vocational goals.

4.19 Situational Assessments

Situational assessments offer a work assessment approach where a client's job performance and work behaviours are systemically observed in a realistic and controlled working environment, such as a rehabilitation facility or sheltered workshop. The terms situational assessment, community-based situational assessment, job tryouts, on-the-job evaluation and supported employment evaluation are often used interchangeably. Situational assessments can provide insights regarding the client's general employability behaviours. It focuses on assessing the client's work potential in regard to factors such as ability to:

- Accept supervision
- Get along with co-workers
- Stay on task
- Sustain productivity for 8 hours and
- Tolerate frustration.

4.20 Testing levels (A, B, C)

In order to offer vocation evaluations the vocational rehabilitation professional, in most instances, require a specific level of education/training. Providing this type of service without the appropriate qualifications would be outside the individual's scope of practice, and therefore, a breach of ethics.

There are three levels of qualifications:

Level A – There are no special qualifications to purchase or administer this type of test. An example would be “*Career Decision Making System (CDMS)*”.

Level B - Tests may be purchased and administered by individuals with:

- A master's degree in psychology, education, occupational therapy, social work, counseling, or in a field closely related to the intended use of the assessment, and

formal training in the ethical administration, scoring, and interpretation of clinical assessments. Or

- Certification by or full active membership in a professional organization (such as ASHA, AOTA, AERA, ACA, AMA, CEC, AEA, AAA, EAA, NAEYC, NBCC) that requires training and experience in the relevant area of assessment. Or
- A degree or license to practice in the healthcare or allied healthcare field. Or
- Formal, supervised mental health, speech/language, occupational therapy, social work, counseling, and/or educational training specific to assessing children, or in infant and child development, and formal training in the ethical administration, scoring, and interpretation of clinical assessments.

Level C - Tests with a C qualification require a high level of expertise in test interpretation, and can be purchased and administered by individuals with:

- A doctorate degree in psychology, education, or closely related field with formal training in the ethical administration, scoring, and interpretation of clinical assessments related to the intended use of the assessment. Or
- Licensure or certification to practice in your state in a field related to the purchase. Or
- Certification by or full active membership in a professional organization (such as APA, NASP, NAN, INS) that requires training and experience in the relevant area of assessment.

E. Vocational Rehabilitation Reports and the Courts

4.21 Forensic Reports:

There are instances where the vocational rehabilitation professional is hired to produce a report which may be used within a court setting. The individual could be hired by either the plaintiff or the defendant. However, regardless of the source of the referral the VR professional is still required to be objective in their reporting. Their opinions must be based on facts, not on who is paying for vocational services/report.

There are two types of reports that may end up within a court setting:

- Reports where the VR professional is specifically asked for an opinion or
- Ongoing reports which become part of a court case

There are instances where a vocational rehabilitation professional may be asked to produce a report based on their opinion of a client's potential within the work force. Typically, this will involve not only their interactions with the client but also documentation received from other professionals. Great care must be taken to assure that the VR professional does not cross the line and give an opinion outside their scope of practice. For example it may be tempting to make a psychological diagnosis based on the client's behaviour; however, this is clearly outside the typical VR professional's knowledge and expertise.

The other type of report which may end up within a court setting are those ongoing reports which are normally produced during the vocational rehabilitation process. The VR professional should assume that every report which they compose may at some time end up within the legal process.

4.22 Reports to the court

As was noted there may be instances where the vocational rehabilitation professional may be asked to produce a report which will appear in court. In these instances, the VR professional may be considered an “expert” by the courts (see below).

If the individual is considered an expert by the court they can offer not just facts but also opinion. Areas which should be considered when writing a report for the court would include:

- Great care should be given to what information is provided in the report. If the individual is relying on the opinions of others, documentation as to these reports should be provided.
- The VR professional should indicate what third party information is being accepted as “fact”. For example the report could contain the phrase: “For the purpose of this report the following is accepted as fact;” After the statement there could be a listing of third party information that is being accepted. By doing this the individual does not have to defend statements outside of their area of expertise.
- Reports to the court should be in “first person”. For example the report should say “I did...” rather than “We did...” (Royal we). Unless more than one person was involved.
- For those deemed as experts by the court, opinions are not only allowed but expected. There needs to be great care that any opinion is based on solid facts and not conjecture.
- Never include anything in a report for the court that is based on undocumented third party “gossip”.

4.23 Expert witness

Forensic vocational reports, are based on the idea that the vocational rehabilitation professional would be considered an “expert” by the court. An expert is someone who, by experience, has acquired special or peculiar knowledge of the subject about which he undertakes to testify, whether such knowledge has been acquired by study, scientific works, or simply by practical observation. An expert does not need to have a PhD after their name. The only real consideration is whether the person has specialized knowledge beyond the normal understanding and experience of the judge or jury. An expert could literally be a “rocket scientist”, if the case required that type of expertise, or it could be a grizzled old trapper with a Grade 6 education, if the case needed that kind of expertise. Through an examination of the individual’s background, education, training, etc. the individual is deemed an expert by the court. It should be noted that even if an individual is deemed an expert by one court, this designation does not transfer to another court. Each time the vocational rehabilitation

professional appears in a court they will need to go through the same process to determine if they are to be considered an expert.

Review

1. What type of scale of measurement classifies, assigns numerals but does not distinguish size?
 - a. Ordinal
 - b. Interval
 - c. Nominal
 - d. Ratio
2. Any test in which the test is given in the same manner to all test takers, and graded in the same manner for everyone is a?
 - a. Nominal test
 - b. Standardized test
 - c. Valid test
 - d. Reliable test
3. A test that produces consistent results under consistent condition is said to be?
 - a. Reliable
 - b. Valid
 - c. Inclusive
 - d. Standardized
4. The Crombach's Alpha Test is one of the measurements used to examine:
 - a. External consistency validity
 - b. Transferability of data
 - c. Standardization of norms
 - d. Internal consistency reliability
5. Which of the following is not measure test validity:
 - a. Content validity
 - b. Concurrent validity
 - c. Productive validity
 - d. Face validity
6. In the measure of central tendency the middle score in a set of scores that have been ranked in numerical order is called?
 - a. Median
 - b. Mean
 - c. Mode
 - d. Ordinal
7. It has been found that two variables have correlation of $-.90$. This would indicate:
 - a. A moderate correlation
 - b. No correlation
 - c. Low correlation
 - d. Strong correlation

8. A client earns a percentile rank of 60 on a particular test; this means
- The client got 60% on the test
 - The client scored as well or better than 60% of the other students
 - The client got 60 questions correct
 - The client made 40 errors on the test
9. In looking at test scores, how many “quartiles” are there?
- 4
 - 5
 - 2
 - 3
10. What is a Z-score?
- It measures how many standard deviations from the mean our observations are
 - It measures the test's standard error of measurement
 - It measures the variance of a test to determine validity
 - It measures the percentile ranking of test-takers
11. Which of the following has a range of 1 – 9, a mean of 5 and a standard deviation of 2?
- T score
 - Standard deviation
 - Correlation
 - Stanine score
12. Which of the following estimates how repeated measures of a person on the same instrument tend to be distributed around his or her “true” score?
- Standard error of means
 - Standard error of measurement
 - Standard error of variability
 - Standard error of distribution
13. The statement being tested is called:
- The valid hypothesis
 - The evidence hypothesis
 - The null hypothesis
 - The criterion hypothesis
14. A test was found to have a $p < 0.10$. This means:
- The data evidence against the hypothesis would happen no more than 10 times in 1,000
 - The data evidence against the hypothesis would happen no more than 10 times in 100
 - The data evidence against the hypothesis would happen no more than 1 time in 100
 - The data evidence against the hypothesis would happen no more than 1 time in 1000

15. An example of an intelligence test is:
- Holland Assessment
 - Stanford-Binet
 - Canadian Work Capacity Inventory
 - Strong Assessment
16. Which kind of test measures past performance:
- Interest test
 - Achievement test
 - Aptitude test
 - Intelligence test
17. A client was given the General Aptitude Test Battery. For the V (Verbal) she scored a "2". This would mean:
- The client's score was in the bottom 20%
 - The client's score was in the bottom third of the population excluding the bottom 10%
 - The client's score was in the top third of the population excluding the top 10%
 - The client's score was in the top 20%
18. If a variable is extreme on its first measurement, it will tend:
- To move to the greater extreme on the second measurement
 - Stay the same on the second measurement
 - Move closer to the average on its second measurement
 - Move to the opposite extreme on the second measurement
19. Strong Interest Inventory uses:
- Stanford-Binet Codes
 - Canadian Inventory Codes
 - Differential Testing Codes
 - Holland Codes
20. Valpar is an example of:
- Interest test
 - Work samples test
 - Intelligence test
 - Aptitude test
21. A test is determined to be a "Level A" test, this means:
- There are no special qualifications to purchase or administer this type of test.
 - Tests may be purchased and administered by individuals with a master's degree in psychology or similar qualifications.
 - Tests may be purchased and administered by individuals with a PhD degree in psychology or similar qualifications
 - Tests may be purchased and administered by individuals with specialized training

Answers

1. Nominal – 4.7
2. Standardized test – 4.8
3. Reliable - 4.10
4. Internal consistency reliability – 4.10
5. Productive validity – 4.11
6. Median – 4.12
7. Strong correlation – 4.13
8. The client scored as well or better than 60% of the other students – 4.13
9. 3 – 4.13
10. It measures how many standard deviations from the mean our observations are - 4.13
11. Stanine score – 4.13
12. Standard error of measurement – 4.13
13. The null hypothesis – 4.13
14. The data evidence against the hypothesis would happen no more than 10 times in 100 – 4.13
15. Stanford-Binet – 4.16
16. Achievement test – 4.16
17. The client's score was in the top third of the population excluding the top 10% - 4.13
18. Move closer to the average on its second measurement 4.14
19. Holland Codes 4.15
20. Work samples test – 4.16
21. There is no special qualifications to purchase or administer this type of test. 4.19

Domain Five

Diversity and the Vocational Rehabilitation Professional

One of the major distinctions within all professions over the past number of years is the understanding of the diversity of our clients. This domain examines the various diverse groups (e.g. gender, cultural, racial, sexual orientation, etc.) and the implications for the vocational rehabilitation process.

A. Diversity and Legislation

Multiculturalism in Canada in the sense of equal acceptance of races, religions and cultures was adopted as the official policy of the Canadian government during the prime ministership of Pierre Elliot Trudeau in the 1970s and 1980s.¹⁴⁰ The Canadian government has been described as the instigator of multiculturalism as an ideology because of its public emphasis on the social importance of immigration.¹⁴¹ The Canadian Royal Commission on Bilingualism and Biculturalism is often referred to as the origin of modern political awareness of multiculturalism.¹⁴²

Canadians have used the term "multiculturalism" both descriptively (as a matter of fact) and normatively (as an ideal). In the first sense "multiculturalism" is description of the many different groups of religions and cultures that make up the population in Canada. The nation consists of people from all racial origins and is open to cultural pluralism as it is believed to be advantageous to the Canadian society as a whole. Canada has experience continual mass immigration since the nineteenth century, and by the 1980s almost 40 percent of the population were of neither British nor French origins (the two largest groups, and among the oldest). In the past, the relationship between the British and the French has been given a lot of importance in Canada's history. But by the early twenty-first century, people from outside British and French heritage composed the majority of the population, with an increasing percentage of those from "visible minorities".

Multiculturalism is reflected in the law through the Canadian Multiculturalism Act and section 27 of the Canadian Charter of Rights and Freedoms and is administered by the Department of Canadian Heritage. The Broadcasting Act of 1991 asserts the Canadian broadcasting system should reflect the diversity of cultures in the country.

5.1 Canadian Multiculturalism Act

In 1984, the Special Parliamentary Committee on Visible Minorities produced its well known report *Equality Now!* And in 1985 a House of Commons Standing Committee on Multiculturalism was created. In 1987, the committee issued an extensive report that called for the enactment of a new policy on multiculturalism and the creation of the Department of Multiculturalism.

A new multiculturalism policy with a clearer sense of purpose and direction came into effect in 1988 when the *Canadian Multiculturalism Act* was adopted by Parliament. Canada was the first country in the world to pass a multiculturalism law. The Act acknowledged multiculturalism as a fundamental characteristic of Canadian society with an integral role in the decision-making process of the federal government. Directed toward the preservation and enhancement of multiculturalism in Canada, the Act sought to assist in the preservation of culture and language, to reduce discrimination, to enhance cultural awareness and understanding, and to promote culturally sensitive change at the federal level.

5.2 Canadian Human Rights Act

The Canadian Human Rights Act is a statute passed by the Parliament of Canada in 1977 with the express goal of extending the law to ensure equal opportunity to individuals who may be victims of discriminatory practices based on a set of prohibited grounds such as sex, disability, or religion. It applies throughout Canada, but only to federally regulated activities; each province and territory has its own anti-discrimination law that applies to activities that are not federally regulated.

The Canadian Human Rights Act created the Canadian Human Rights Commission that investigates claims of discrimination as well as the Canadian Human Rights Tribunal to judge the cases.

Before a case can be brought to the Tribunal it must go through several stages of investigation and remediation by the Commission. After this process has been completed, if the parties are not satisfied, the case will go to the tribunal.

Section 25 of this Act enshrines multiculturalism: *This Charter shall be interpreted in a manner consistent with the preservation and enhancement of the multicultural heritage of Canadians.*

The profession of vocational rehabilitation is shaped by Western cultural values such as independence, work, achievement and self-sufficiency. VR professionals need to consider whether these values are consistent with those from different, non-majority cultures and incorporate these values and beliefs into VR planning.

B. Gender, Disability, Sexual Orientation and Aging

5.3 Gender impact on entering, maintaining or re-entering employment

Gender roles and stereotypes are important variables for vocational rehabilitation professionals to consider in response to the disability process. VR programs were initially developed to serve returning World War I veterans, and thus, were originally designed for men. When working with women, VR professionals should be conscientious of vocational aspirations by understanding their knowledge of occupations, work values and career goals. Restrictions often result from:

- The nature and type of disability
- Socialization that may restrict range of career to traditional jobs held by women and
- Limited opportunities of mentors or role models.

In addition, VR professionals should be cognizant of the following psychosocial implications when working with women clients:

- Woman may consider themselves incapable of succeeding in a male-dominated occupations
- Women may question their ability to successfully balance family, home and career
- Woman may experience double discrimination (being a woman and seen as fragile with a disability may heighten stereotypes)
- Women may experience loss as an assault to themselves that leads to greater loss of identity
- Women may experience higher rates of depression and grief, which is further compounded with the present disability and
- Women usually have more favourable attitudes toward individuals with disabilities than their counterparts.

Vocational rehabilitation professionals should also be aware of the following psychosocial implications when working with male clients:

- Society values and rewards physical capacity and the loss of functioning can be significantly challenging for men
- Men often define themselves through their vocation or career, thus, men no longer able to participate or perform in their chosen career may experience a loss of identity
- Men equate their masculinity with the ability to have intercourse; thus, men who are unable to get an erection due to a disability may feel emasculated
- Men often cope with sadness and grief through distraction such as playing sports or through physical fitness activity; those unable to use these coping methods because of the disability may be at greater risk for depression due to this additional loss
- In most cultures, men are the providers for their families; those unable to work because of a disability may feel as though they are disappointing or failing their families.

Patterson¹⁴³ et al suggested that men and women respond differently to various disabilities. For example, in the area of spinal cord injury, men experience greater difficulties around sexual functioning than women, resulting in feelings of loss of “manhood” or “masculinity”. In regards to HIV/AIDS, women are more socially isolated than men because of cultural backgrounds commonly associated with women with HIV/AIDS, and because rates of transmission of the disease are less and different in mode. In addition, women with HIV/AIDS experience issues related to pregnancy including the potential transmission from mother to child. With respect to myocardial infarction, men return to work sooner than women and typically participate in physical activity to cope with the stressors related to the condition. Rehabilitation programs are commonly geared toward this type of coping style, which is advantageous for men, yet not for women.

The VR professional should not assume that gender stereotyping occurs only in cross-gender counselling situations (e.g. men counselling women or vice versa). Specifically, gender stereotypes, values and attitudes are not based solely on the vocational rehabilitation professional’s gender. For example, both men and women VR professionals are at risk for possessing stereotypic values and beliefs about women. Sociocultural context informs different expectations of men and women and their opportunities and rewards (i.e. men are expected to hide their feelings). Men and women with disabilities, as well as VR professionals, are equally prone to possessing gender-based expectations for the type of rehabilitation services sought after and provided.

Vocational rehabilitation professionals need to take the following self-evaluation steps to prevent stereotyping:

- Evaluate attitudes (i.e. awareness, feelings and actions) and gender stereotypes possessed and
- Examine behaviour through self-examination questions, such as, “Is it as important for a woman to have a career as it is for a man?” “What are my feelings about men or women having non-traditional jobs (i.e. woman machine operator; man registered nurse)?” “What are my feelings regarding non-traditional family unit gender norms (i.e. stay-at-home dad with the mom as the family provider)?”

5.4 Disability impact on entering, maintaining or re-entering employment

Disability varies significantly across and within conditions. According to Smart¹⁴⁴ there are 10 disability factors that influence response to disability including:

- Time of onset (congenital, acquired)
- Type of onset (insidious versus acute)
- Course of disability (direction, pace of movement and degree of predictability)
- Functions impaired (meaning of functioning, degree of intrusiveness, residual functioning and assistive technology)
- Severity of the disability (number of disabilities experienced and areas of functioning affected)

- Treatment necessary
- Degree of stigma directed at the individual),
- Visibility of the disability of the disability,
- Degree of disfigurement and
- Prognosis

In addition, VR professionals should be aware of the sociocultural factors related to being an individual with a disability and how these may influence response to disability. For example, clients may have histories of stigmatization, prejudice and discrimination. In addition, individuals may have internalized stigma based on years of being stereotyped as incapable and deficient.

5.5 Sexual Orientation impact on entering, maintaining or re-entering employment

Sexual orientation must be considered in vocational rehabilitation planning. Persons who identify as/with sexual orientations such as lesbian, gay, bisexual, transgender, queer, questioning, intersex and asexual (LGBTQQIA) are vulnerable to stereotypes, bigotry, abuse, bullying and violence. Studies report the following negative consequences associated with those identifying as/with LGBTQQIA:

- Higher rates of mood, anxiety and substance abuse disorders,
- Societal oppression and greater risk for internalized homophobia, biphobia and transphobia
- Adolescent suicide rates that are two to three times higher in sexual minority populations and
- Low self-esteem and poor self-identity development among adolescents.

To increase the effectiveness of vocational rehabilitation services for those identifying as LGBTQQIA, VR professionals should be aware of the following:

- Heterosexism and its role in societal expectations of gender-appropriate norms
- Their own heterosexist attitude, whether they are heterosexual
- Multiple identity factors and developmental tasks, ethnic and cultural aspects; socioeconomic status; gender role differences and generational differences.

LGBTQQIA individuals with disabilities are subject to a complex array of prejudices by the mainstream population including facing double prejudices for equal rights, experiencing higher rates of marginalization and discrimination, confusion in navigating identity development and being seen as asexual and enduring a myriad of messages that they are not suitable sexual partners.

For the VR Professional there is a need for a comprehensive understanding of the following to navigate working with the LGBTQQIA population:

- Sexual orientation/identity development models

- The coming out processes
- Same-sex relationships
- What it means to be seropositive (HIV+)
- Parenting and familial concerns
- Unique experiences of LGBTQQIA ethnic minorities and
- Religious and/or aging issues.

VR professionals are advised to be knowledgeable of LGBTQQIA-affirmative therapists in their area so that they can make appropriate counselling referrals for clients.

5.6 Aging impact on entering, maintaining or re-entering employment

The chance of disability increases with age, and today's workforce is working later in life due to increased costs of living. Thus, VR professionals can expect to work with an increased number of older adults.

Aging well requires effective interaction, adaptation, accommodation and adjustment to one's environment to navigate age-related changes successfully. Moreover, variability in health issues exists due to genetics, environment, past illnesses and injuries, socioeconomic status and behavioural problems. Older adults face multiple life transitions in later life, including changes in health, roles, work, housing, social support, transportation, monetary and economic position, utility, and loss of spouse, friends and other supports. The most common stressors for older adults are health-related issues due to chronic illness, diminished functioning (e.g. having to use a hearing aid) and role strains (e.g. living with a child that is substance dependent). Loss of independence issues such as the loss of ability to drive, taking up residence in an assisted living community or nursing facility as well as having to depend on others in general for help in matter they once enjoyed handling themselves are additional stressors. Older adults also experience high rates of psychological problems. Specifically, there are high rates of depression and depressive symptoms among older adults; older white men are at greater risk of suicide, dementia increases with age and 80% of mental health issues are associated with chronic illness or disabilities, of which older adults experience at a high rate.

Western society values youthfulness and society perpetuates ageism and stereotypes of older adults as senile, sick, frail, asexual and a burden on their families as well as financially burdening the countries entitlement programs (e.g. CPP, OAS). Ageism is often combined with other prejudices and biases, such as gender, race, sexual orientation and disability. VR professionals are cautioned not be prejudicial by setting inappropriate VR goals based on an older adult's age as opposed to their interests and abilities and to examine their own fears, stereotypes and biases about aging and the older adult population.

C. Cultural Awareness

5.7 Developing awareness

Cultural awareness is important to help members of a multicultural team or workings with individuals from another culture identify where things may be going wrong or how to best leverage their differences.

Cultural differences manifest in many ways. A person's cultural background will impact how they act and behave. There will be differences in areas such as communication, attitude to towards conflict, approaches to task completion and decision making styles. Unless people come to realise these differences between them through cultural awareness, problems can continue and even intensify.

In providing VR services the professional should be sensitive to cultural differences. Cultural backgrounds of clients should be sensitively identified for a number of reasons:

- For some English may be a second language. This can become a significant issue in training, job search, supervising and safety issues.
 - What may be accepted as “normal” in one culture may not have the same meaning in another. For examples standing very close to another individual when speaking may be a normal behaviour in some cultures; where Western cultures tend to stand at least three feet away when speaking to others.
 - Religious observance is often central to cultural identity. This may mean requests for changes in scheduling due to needing to attend religious observances.

One of the areas where cultures and ethnic groups may differ is in regards to disability and return to work. For example:

- Disability vocabulary. Western concepts regarding disabilities and their effects impact how they are perceived and the services provided. For some employees there may be no precise word in their language for a particular disability, or the disability may not be one that is accepted as legitimate in their home country.
- Perception of independence: In some cultures, independence may include relying on family, friends, the community or the aid of strangers – utilizing informal human support, while new workers to Canada may experience a less self-directed approach. Culturally, it is common for family members to provide services such as a sighted guide for a sibling who is blind, or a cousin may assist with note-taking in classes, as opposed to assistive technology like a white cane or Braille machine that may be more common in Canada, unmarried women with disabilities may be accompanied by an elder brother or uncle for cultural or religious reasons in some countries.
- Understanding how a disability may be viewed by a given culture. Some types of disabilities may not be easily accepted as legitimate in the employee’s home country. In some communities, people with visible disabilities are deterred from participating in the

life of the community by social, institutional and infrastructural restrictions while other disabilities may be regarded as a blessing or gift (for example: in some cultures, people with epilepsy are considered gifted because they are believed to communicate with ancestors during seizures, other cultures may consider people who are blind more religiously affiliated or divined).

- Differences in approach to accommodations. Many countries in the non-Western world do not have legislated and formal procedure for requesting disability-related accommodations. Accommodations are arranged through community services, person-to-person, or by family members versus through legal processes according to law.
- Speaking about oneself: Many countries and cultures feel that speaking highly about oneself is a form of immodesty. This can impede the relationship between the vocational rehabilitation professional and the client as the client may feel that relaying anything positive about themselves is inappropriate.

Work environments today have a greater number of employees from different countries than ever before. If employees are not properly prepared for this workplace reality, misunderstandings and tension can occur within the workplace. For example, cultural groups may tend to "stick together," causing others to feel rejected and/or snubbed. Also, different communication styles may lead to misunderstanding and negative assumptions on the part of different cultural groups towards one another.

In order to create an inclusive work environment with minimal tension and misunderstanding, the awareness level of all employees must be raised. An education program should focus on the following:

- What culture is and how it affects everyday interactions with co-workers/clients
- Cultural assumptions and biases
- How culture impacts key issues such as communication style and teamwork
- Nonverbal communication (e.g. eye contact, body language, facial expression, gestures, personal space, finger tapping, jingling coins) between Canadians/Americans and other nationalities, and how these may cause conflict, confusion, etc.
- How to ensure everyone feels at home within their workplace, regardless of their cultural background

Members of the ethnic and cultural diversity groups within the workplace should be centrally involved in any sensitivity training/education.

The actions and behaviours of the vocational rehabilitation professional should be a model of open respect and patience with different ethnic and culturally different groups. A number of steps the vocational rehabilitation professional could take to increase cultural sensitivity could include:

- Develop awareness: take a look at your own biases and prejudices, become aware of cultural norms, attitudes, and beliefs, and value diversity;

- Don't allow cultural differences (preferences) to become the basis for criticism and judgements. Differences are neither good nor bad – it is what we do with them that makes a difference;
- Build friendships of mutual respect and a desire for understanding;
- Be yourself and show that you care about the person and that you honestly want to help;
- Take time to listen. If you don't understand, or you are not being understood, take the time to find out why. Explain or ask questions. For example, "Would you help me understand?"
- Acquire knowledge about other cultures by attending classes or seminars, reading books or watching movies about other cultures, and attending cultural events/festivals.

The vocational rehabilitation plan and process is often a difficult experience even for those individuals born and raised in Canada. For those clients who come from other ethnic or cultural backgrounds it can be an overwhelming experience. In order to be of assistance to the client and his/her family it is often of value to have an interpreter. Family members can often be of assistance in this area.

5.8 Cultural Tunnel Vision

Cultural tunnel vision is a perception of reality based on a very limited set of cultural experiences. Every individual is raised and educated within a very specific cultural group and from this group we all learn how to view the world. Our perceptions of reality, our values, and even our behaviours are a reflection of what we have absorbed. It is out of this limited sense of reality we make our ethical decisions. Gilbert Wrenn, one of the pioneers in the counselling profession, characterized a culturally encapsulated individual as having the following traits:

- defines reality according to one's cultural assumptions
- shows insensitivity to cultural variations among individuals
- accepts unreasoned assumptions without proof or ignores proof because that might disconfirm one's assumptions
- fails to evaluate other viewpoints and makes little attempt to accommodate the behaviour of others
- is trapped in one way of thinking that resists adaptation and rejects alternatives

In all likelihood a vocational rehabilitation professional would never display overt racism or cultural bias. However, there are instances when inadvertent prejudice can occur within the work setting. For example, a VRP may refer to themselves as colour blind. Sue and Sue regard colour blindness as a form of racial microaggression. When a worker reports feelings of alienation in the workplace because she is the only person of colour employed there, a colour-blind vocational rehabilitation professional might minimize her concerns and say: "I think you are being paranoid. We should emphasize similarities not people's differences." This statement conveys that race is not a critical variable that affects people's lives and that it has no sociopolitical relevance.

Individuals who say they are colour blind usually are trying to communicate that they do not discriminate and they treat others equally; however, in doing so they are ignoring a vital part of an individual's identity. The statement gives the impression that those who benefit from racial privilege are closing their eyes to the experiences of others. This concept of colour-blindness can extend beyond race to other areas of cultural differences. It could mean overlooking a client's gender, sexual identity, ethnicity, or any other important dimension in a person's life. Cultural blindness will often detract from the effectiveness of the vocational rehabilitation professional. Cultural tunnel vision can have a significant impact when a vocational rehabilitation professional confronts an ethical dilemma. If unaware of potential cultural differences, the VRP would be prone to look for answers that are culturally appropriate for his/her culture.

5.9 Full inclusion

Full inclusion means that all students, regardless of handicapping condition or severity, will be in a regular classroom/program full time. All services must be taken to the child in that setting.

5.10 Cultural assumption

A cultural assumption is a common set of beliefs about a particular group. Cultural assumption may be positive, such as "all Asians are good at math" or negative, such as "all Asians are poor drivers". It is making a universal statement about a particular group that may or may not be true about an individual in the group.

One of the common cultural assumptions that many have is that all indigenous people avoid eye-contact in social settings. When meeting with a client of indigenous heritage it may be easy for the vocational rehabilitation professional to make the assumption that non-eye contact is "part of their culture". Rather, non-eye contact could be due to a variety of subjective reasons (e.g. shyness, fear of authority, avoiding, etc.).

5.11 Acculturation

Acculturation is the process of social, psychological, and cultural change that stems from blending between cultures. The effects of acculturation can be seen at multiple levels in both the original (native) and newly adopted (host) cultures.

Historically *speaking*, acculturation is a direct change of one's culture through dominance over another's culture through either military or political conquest.

At this group level, acculturation often results in changes to culture, customs, religious practices, diet, healthcare, and other social institutions. Some of the most noticeable group level effects of acculturation often include changes in food, clothing, and language.

At the individual level, the process of acculturation refers to the socialisation process by which foreign-born individuals adopt the values, customs, norms, attitudes, and behaviours of the dominant host culture. This process has been linked to changes in daily behaviour, as well as numerous changes in psychological and physical well-being. As enculturation is used to describe the process of first-culture learning, acculturation can be thought of as second-culture learning. Since approximately one in four children in the Canada live with at least one immigrant parent, this topic is worthy of understanding and discussing.

5.12 Ethnicity

In common use, ethnicity is used as a euphemism for the sensitive term *race*, but with identical meaning: group ancestry and physical characteristics, such as skin color, as in “ethnic Chinese”. In careful use, it refers to any common characteristic or identity, particularly linguistic, national, regional, or religious groups, and can cut across race, such as Hispanic/Latino; or be a subgroup of a racial group, as in German Texan, Chinese Indonesians, Nuyorican (New York Puerto Rican), etc.

5.13 Prejudice

Prejudice is an affective feeling towards a person or group member based solely on their group membership. The word is often used to refer to preconceived, usually unfavorable, feelings towards people or a person because of their sex, gender, beliefs, values, social class, age, disability, religion, sexuality, race/ethnicity, language, nationality, beauty, occupation, education, criminality, sport team affiliation or other personal characteristics. In this case, it refers to a positive or negative evaluation of another person based on their perceived group membership.

Prejudice can also refer to unfounded beliefs and it may include "any unreasonable attitude that is unusually resistant to rational influence". Gordon Allport defined prejudice as a "feeling, favorable or unfavorable, toward a person or thing, prior to, or not based on, actual experience".

5.14 Stereotyping

A widely held but fixed and oversimplified image or idea of a particular type of person. This is an uncritical generalization about individuals who are identified by belonging to a specific group.

5.15 Mores

This refers to social norms that are widely observed and are considered to have greater moral significance than others. Mores include an aversion for societal taboos, such as incest. The mores of a society usually predicate legislation prohibiting their taboos. Often, countries will

employ specialized vice squads or vice police engaged in suppressing specific crimes offending the societal mores.

5.16 Cultural Values

Cultural values are the core principles and ideals upon which an entire community exists. This is made up of several parts: customs, which are traditions and rituals; values, which are beliefs; and culture, which is all of a group's guiding values.

5.17 Bias

Cultural bias is the phenomenon of interpreting and judging phenomena by standards inherent to one's own culture. The phenomenon is sometimes considered a problem central to social and human sciences, such as economics, psychology, anthropology, and sociology.

5.18 Explicit culture

Explicit culture are those aspects of a culture that are easily observable. For example: clothing, music, dance, language spoken, etc.

5.19 Invisible (Implicit) culture

Implicit values of a culture typically operate "under the surface" (values, family dynamic, masculinity and femininity, manners, etc.).

5.20 Ethnocentrism

Ethnocentrism is judging another culture solely by the values and standards of one's own culture. Ethnocentric individuals judge other groups relative to their own ethnic group or culture, especially with concern for language, behaviour, customs, and religion. These ethnic distinctions and subdivisions serve to define each ethnicity's unique cultural identity. Ethnocentrism may be overt or subtle, and while it is considered a natural proclivity of human psychology in everyday life, it has developed a generally negative connotation.

5.21 Cultural Norms

Cultural norms are the agreed-upon expectations and rules by which a culture guides the behaviour of its members in any given situation. Of course, norms vary widely across cultural groups. Canadians, for instance, maintain fairly direct eye contact when conversing with others. Asians, on the other hand, may avert their eyes as a sign of politeness and respect. Sociologists speak of at least four types of norms: *folkways*, *mores*, *taboos*, and *laws*.

5.22 Worldview

A world view or worldview is the fundamental cognitive orientation of an individual or society encompassing the whole of the individuals or society's knowledge and point of view. A world view can include natural philosophy; fundamental, existential, and normative postulates; or themes, values, emotions, and ethics.

5.23 Cultural diversity:

The existence of a variety of cultural or ethnic groups within a society. This refers to the spectrum of differences that exist among groups of people with definable and unique cultural backgrounds.

5.24 Diversity:

Means understanding that each individual is unique, and recognizing our individual differences. It refers to individual differences on a number of variables that place the individual at risk for discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, social orientation, disability, language or socioeconomic status.

5.25 Pluralism:

When smaller groups within a larger society maintain their unique cultural identities, and their values and practices are accepted by the wider culture provided they are consistent with the laws and values of the wider society. This is a perspective that recognizes and values the diversity of beliefs and values.

5.26 Stereotype:

A widely held but fixed and oversimplified image or idea of a particular type of person. This is an uncritical generalization about individuals who are identified by belonging to a specific group.

5.27 Racism:

Prejudice, discrimination, or antagonism directed against someone of a different race based on the belief that one's own race is superior. This is any pattern of behaviour that, solely because of race or culture, denies access to opportunities or privileges to members of another racial or cultural group.

5.28 Microaggression:

A statement, action, or incident regarded as an instance of indirect, subtle, or unintentional discrimination against members of a marginalized group such as a racial or ethnic minority. These are persistent verbal, behavioural and environmental assaults, insults and invalidations that often occur subtly and are difficult to identify.

5.29 Workplace Culture:

Of importance to the vocational rehabilitation profession is the culture at the workplace. The concept of a workplace culture encompasses many different characteristics of an organization. Culture has visible components in the way that a business looks and how employees dress, but it really thrives in the attitudes of employees, in the setting of goals and in the communication of business values to workers and customers. The organization's leadership sets the pace for creating, defining and refining the company culture. Workplace culture is the collection of unwritten rules, codes of behaviour and norms by which people operate in the workplace.

Review:

1. The *Canadian Multiculturalism Act* is applicable to:
 - a. All Canadian organizations
 - b. Federal departments and organizations
 - c. Federal and provincial governments
 - d. Only those organizations with more than 20 employees.
2. Gender stereotyping occurs only in:
 - a. Cross-gender vocational rehabilitation counselling situations
 - b. Same-gender vocational rehabilitation counselling situations
 - c. Male dominated occupations and employment situations
 - d. Any vocational rehabilitation counselling situation regardless of gender
3. You are providing vocational rehabilitation services to a client with a disability who reveals that they are gay. How can this impact the VR process?
 - a. It will likely have no impact as the Canadian Human Rights Act prevents discrimination.
 - b. It will likely have minimal impact as most jobs are gender-neutral
 - c. It will likely have no impact as all employers must have a gender-neutral worksite.
 - d. It will likely have an impact as the individual may face prejudice due to their sexual orientation and disability.
4. The frequency of disabilities during the working years:
 - a. Stay the same as the employee ages
 - b. Rises as the employee ages
 - c. Decreases as the employee ages
 - d. Seldom impacts employment
5. Perception of independence:
 - a. Changes from one culture to the next
 - b. Stays the same across all cultures
 - c. Is not an issue for the vocational rehabilitation professional
 - d. Should not be reflected in any service the VR professional provides
6. Defining reality according to our own cultural assumptions is:
 - a. Cultural blindness
 - b. Inclusion
 - c. Cultural tunnel vision
 - d. Exclusion
7. “All Asians are good at the sciences” is an example of:
 - a. Cultural assumption
 - b. Cultural delineation
 - c. Cultural authority
 - d. Cultural bias

8. The socialization process by which foreign-born individuals the values, norms, customs, attitudes and behaviours of the dominant host culture is called:
 - a. Cultural assumption
 - b. Dependency
 - c. Acclimatization
 - d. Acculturation
9. Social norms that are widely observed and are considered to have greater moral significance than others is termed:
 - a. Biases
 - b. Prejudices
 - c. Mores
 - d. Values
10. In talking to a person of colour the vocational rehabilitation professional states: "I'm colour blind". This could be an example of:
 - a. Microaggression
 - b. Bias
 - c. Prejudice
 - d. Mores

Answers:

- 1 Federal departments and organizations – 5.1
- 2 Any vocational rehabilitation counselling situation regardless of the gender of those involved – 3.3
- 3 It will likely have an impact as the individual may face prejudice due to their sexual orientation and disability. 5.5
- 4 Rises as the employee ages 5.8
- 5 Changes from one culture to the next 5.7
- 6 Cultural tunnel vision 5.9
- 7 Cultural assumption – 5.10
- 8 Acculturation – 5.11
- 9 Mores – 5.15
- 10 Microaggression – 5.29

Domain Six

Job Development and Placement

Assisting an individual with a disability into or back into the workforce, is one of the main goals of the vocational rehabilitation professional and this Domain is at the heart of what many undertake on an ongoing basis. This Domain examines: understanding limitations/restrictions, understanding job demands, hidden job market, resume construction, interview skills, locating a job placement, job club, job coaching, co-worker model, monitoring, job development, etc.

A. Occupation Information

6.1 National Occupation Classification (NOC)

The National Occupational Classification (NOC) is probably the most widely used job identification manual by Canadian vocational rehabilitation professionals. It was preceded by the Canadian Classification and Dictionary of Occupations (CCDO). The NOC is designed to classify occupational information from statistical surveys. It is also used in a range of contexts to compile, analyze and communicate information about occupations. Occupational information is of critical importance for the provision of labour market and career intelligence, skills development, occupational forecasting, labour supply and demand analysis, employment equity and numerous other programs and services. It provides a standardized framework for organizing the world of work in a manageable, understandable and coherent system.

The basic principle of classification of the NOC is that of kind of work performed. Occupations are identified and grouped primarily in terms of the work usually performed, this being determined by the tasks, duties, and responsibilities of the occupation. Factors such as the materials processed or used, the industrial processes and the equipment used, the degree of responsibility and complexity of work, as well as the products made and services provided, have been taken as indicators of the work performed when combining jobs into occupations and occupations into groups.

An occupation is defined as a collection of jobs, sufficiently similar in work performed to be grouped under a common label for classification purposes. A job, in turn, encompasses all the tasks carried out by a particular worker to complete their duties.

Structure of NOC 2011

The National Occupational Classification 2011 is a four-tiered hierarchical arrangement of occupational groups with successive levels of disaggregation. It contains broad occupational categories, major, minor and unit groups.

10 broad occupational categories

- Each broad occupational category has a unique one digit code number and is composed of one or more major groups.

40 major groups

- Each major group has a unique two-digit code number and is composed of one or more minor groups. The first digit of this code indicates the broad occupational category to which the major group belongs.

140 minor groups

- Each minor group has a unique three-digit code number and is composed of one or more unit groups. The first two digits of this code indicate the major group to which the minor groups belong.

500 unit groups

- Each unit group has a unique four-digit code. The first three digits of this code indicate the major and minor groups to which the unit group belongs.

The broad occupational category code, designated by a single digit, is repeated at all levels. Major group codes are created by adding a second digit. This digit appears in the second position at all lower levels in the structure. Minor group codes add a third digit. Finally, the 4-digit unit group codes contain the digit identifying the broad occupational category, followed by the digit identifying the major group and the digit identifying the minor group and a last digit identifying the unit group.

There are approximately 40,000 occupational titles classified in the 500 unit groups of the NOC 2011. Some of these titles are clearly occupations, such as librarian and chef, while others reflect specializations within an occupational area, such as music librarian and pastry chef. Still others represent a range of jobs, such as furniture assembler and sawmill machine operator.

These titles are used to describe the work performed by many individuals holding similar jobs within an occupational area. The list of titles in the NOC is not meant to be exhaustive, but attempts to cover the most commonly used and universally understood labels that identify work in the labour market.

The first digit of the NOC relates to one of ten “skill types”:

Skill Type	Occupation
0	Management occupations
1	Business, finance and administration occupations
2	Natural and applied sciences and related occupations
3	Health occupations
4	Occupations in education, law and social, community and government services
5	Occupations in art, culture, recreation and sport

6	Sales and service occupations
7	Trades, transport and equipment operators and related occupations
8	Natural resources, agriculture and related production occupations
9	Occupations in manufacturing and utilities

The second digit of the NOC Code relates to “Skill Level”:

Skill Level	Nature of Education/ Training
0 or 1 (Level A)	University degree at the Bachelor, Masters or Doctoral level
2 or 3 (Level B)	Two to three years of post-secondary education at a community college, institute of technology or CEGEP <i>or</i> Two to five years of apprenticeship training <i>or</i> Three to four years of secondary school and more than two years of on-the-job training, specialized training courses or specific work experience.
4 or 5 (Level C)	Some secondary school education, with up to two years of on-the-job training, training courses or specific work experience.
6 or 7 (Level D)	Short work demonstration or on-the-job training <i>or</i> No formal educational requirements.

Management occupations are treated slightly differently compared to other occupations. Management occupations classified as Skill Type 0, span all other Skill Types from 1 through 9 of the classification structure, and are found in all areas of the labour market. All NOC codes that begin with a zero represent management occupations. When the second digit is also zero, this represents "senior" management occupations. To identify all other management occupations, the second digit (1 through 9) corresponds to management within each Skill Type.

National Occupation Classification – Career Handbook:

The structure of the Career Handbook is identical to that of the NOC with one modification. In many cases, the NOC unit group has subgroup descriptions of Main Duties. In order to help users identify the differences between subgroups, the Career Handbook provides a unique occupational profile for each subgroup with a digit after a decimal point. For example, NOC unit group 5121 Writers, has three subgroups in its Main Duties section – Creative Writers, Technical Writers and Copywriters. In the Career Handbook, each of these subgroups has its own occupational profile – 5121.1 Creative Writers, 5121.2 Technical Writers and 5121.3 Copywriters. As a result, the Handbook contains 923 distinct groups derived from the 520 in NOC 2001.

The NOC Career Handbook provides the vocational rehabilitation professional with a wide range of information about each occupation. This information includes:

Occupation Code, Title and Introductory Statement: The **occupation code** appears at the top of both pages of an entry. It is either identical to the four-digit NOC unit group code, or it has a digit added after a decimal identifying it as a subgroup of the original NOC unit group.

The **title** of the group follows the code on the first page. The titles are either those of the original NOC unit group or are taken from the Main Duties subgroup descriptions.

The **introductory statement**, which provides a general overview of the occupation, is taken from the lead statement of the NOC unit group. When there are subgroups, this same pattern is followed.

Examples of Job Titles: The NOC and the Career Handbook do not provide an exhaustive list of job titles. The list provided in the group indicates the most commonly used titles in an occupation across the country.

This list also presents a conceptual boundary around an occupation by identifying the range of job titles contained within a group.

Profile Summary: This section identifies all the ratings in an abbreviated alphanumeric format, providing vocational rehabilitation professionals with a quick overview of the nature of the occupation.

A Synopsis of Descriptors and Labels as well as Descriptor Definitions provide detailed information on the factor ratings, their labels and levels.

Descriptors Definitions:

Aptitudes: An individual's **overall capacity** to learn the skills needed to perform job duties is based on his or her **specific aptitudes** for acquiring information and transforming it into action.

To describe aptitude levels, the Career Handbook uses the following scale based on the normal curve representing the Canadian labour force. For example, 1 indicates the level of aptitude that applies to the top 10 percent of the working population.

- 1 The highest 10 percent of the working population
- 2 The upper third, exclusive of the highest 10 percent
- 3 The middle third of the working population
- 4 The lowest third, exclusive of the lowest 10 percent
- 5 The lowest 10 percent of the working population

Nine aptitude factors are rated according to the above scale to provide the aptitudinal profile needed to perform the work of an occupation. The Aptitudes Scale is based on the General Aptitude Test Battery (GATB).

- **General Learning Ability (G):** Ability to “catch on” or understand instructions and underlying principles; to reason and make judgments.
- **Verbal Ability (V):** Ability to understand the meaning of words and the ideas associated with them, and to use them effectively; to comprehend language, to understand relationships between words and to understand the meaning of whole sentences and paragraphs; to present information or ideas clearly.
- **Numerical Ability (N):** Ability to carry out arithmetical processes quickly and accurately.
- **Spatial Perception (S):** Ability to think visually about geometric forms and comprehend the two-dimensional representation of three dimensional objects; to recognize the relationships resulting from the movement of objects in space. May be used in such tasks as blueprint reading and in solving geometry problems. Frequently described as the ability to “visualize” objects of two or three dimensions.
- **Form Perception (P):** Ability to perceive pertinent detail in objects and in pictorial and graphic material; to make visual comparisons and discriminations and to see slight differences in shapes and shadings of figures and widths and lengths of lines.
- **Clerical Perception (Q):** Ability to perceive pertinent detail in verbal or tabular material; to observe differences in copy, to proofread words and numbers, and to avoid perceptual errors in arithmetical computation.
- **Motor Co-ordination (K):** Ability to co-ordinate eyes, hands and fingers rapidly and accurately when required to respond with precise movements.
- **Finger Dexterity (F):** Ability to move the fingers and manipulate small objects with the fingers rapidly and/or accurately.
- **Manual Dexterity (M):** Ability to move the hands easily and skillfully; to work with the hands in placing and turning motions

The Canadian Work Preference Inventory:

The Canadian Work Preference Inventory (CWPI) measures five occupational interests:

- **DIRECTIVE:** Directive persons like to take charge and control situations. They like to take responsibility for projects that require planning, decision making and co-ordinating the

work of others. They are able to give direction and instructions easily. They enjoy organizing their own activities. They see themselves as independent and self-directing.

- **INNOVATIVE:** Innovative persons like to explore things in depth and arrive at solutions to problems by experimenting. They are interested in initiating and creating different ways to solve questions and present information. They enjoy scientific subjects. Innovative persons prefer to be challenged with new and unexpected experiences. They adjust to change easily.
- **METHODICAL:** Methodical persons like to have clear rules and organized methods to guide their activities. They prefer working under the direction or supervision of others according to given instructions, or to be guided by established policies and procedures. Methodical persons like to work on one thing until it is completed. They enjoy following a set routine and prefer work that is free from the unexpected.
- **OBJECTIVE:** Objective persons enjoy working with tools, equipment, instruments and machinery. They like to repair and/or fabricate things from various materials according to specifications and using established techniques. Objective persons are interested in finding out how things operate and how they are built.
- **SOCIAL:** Social persons like dealing with people. They enjoy caring for and assisting others in identifying their needs and solving their concerns. Social persons like working and co-operating with others. They prefer to be involved in work that requires interpersonal contact.

Data, People and Things:

- **Data/Information (D):** Non-tangible information, knowledge and concepts related to data, people and things that are obtained by observation, investigation, visualization and mental creation. Written data take the form of numbers, words and symbols. Other data are ideas, conceptualization and oral verbalization.
- **People (P):** Human beings; also includes animals dealt with on an individual basis.
- **Things (T):** Tangible and/or virtual objects that include the body, substances, materials, machines, tools, equipment, products and/or systems.

Physical Activities:

- **VISION:** The use of sight in the work performed. The levels are organized in terms of the visual field involved in the performance of the work.
 - Close visual acuity
 - Near vision

- Near and far vision:
- Total visual field
- **COLOUR DISCRIMINATION:** The use of colour discrimination to identify, distinguish and match colours and different shades of the same colours.
 - Not relevant
 - Relevant
- **HEARING:** The use of hearing in the work performed. The levels are organized in terms of the type of auditory discrimination involved in the performance of the work.
 - Limited
 - Verbal interaction
 - Other sound discrimination
- **BODY POSITION:** Primary type of posture or body movement involved in performing the work. These postures or body movements range from simple to complex and from sedentary to mobile
 - Sitting
 - Standing and/or walking
 - Sitting, standing, walking
 - Other body positions
- **LIMB CO-ORDINATION**
 - Not relevant
 - Upper limb co-ordination
 - Multiple limb co-ordination
- **STRENGTH:** The use of strength in the handling of loads such as pulling, pushing, lifting and/or moving objects during the work performed.
 - Limited: Work activities involve handling loads up to 5 kg.
 - Light: Work activities involve handling loads of 5 kg but less than 10 kg.
 - Medium: Work activities involve handling loads between 10 kg and 20 kg.
 - Heavy: Work activities involve handling loads more than 20 kg.

Environmental Conditions

- **Location:** The work performed is carried out indoors in a regulated environment, indoors in an unregulated environment, outdoors or in a vehicle. In many occupations, the Main Duties may be performed in more than one location.
 - Regulated inside climate: A normal controlled environment such as an office, hospital or school.
 - Unregulated inside climate: An inside work environment where the temperature or humidity may be considerably different from normal room conditions. In some

groups, the nature of the duties affects the temperature or humidity of the work environment.

- Outside: An outdoor work environment where the worker is exposed to variations in weather conditions and seasonal weather patterns.
- In a vehicle or cab: An interior space in any form of vehicle or in the cab of heavy equipment operated by the worker.

Hazards:

Potential hazards to which the worker may be exposed. The codes provide an indication of the type(s) of hazard(s) most likely to be present in the workplace environment. They are not a measure of frequency, duration or degree of exposure to hazards, but an indication of the presence or absence of a particular hazard in the work environment.

- Dangerous chemical substances
- Biological agents
- Equipment, machinery, tools
- Electricity
- Radiation
- Flying particles, falling objects
- Fire, steam, hot surfaces
- Dangerous locations

DISCOMFORTS:

Work conditions that create disturbances but are not hazardous. In general, these conditions create discomfort, but are not direct sources of injury. In extreme instances, however, these conditions might cause injury.

- Noise
- Vibration
- Odours
- Non-toxic dusts
- Wetness

EDUCATION/TRAINING INDICATORS:

Education/Training Indicators incorporate both educational and training requirements. These indicators consist of eight education or training types and two factors. The two factors are included in the rating where applicable. They represent requirements for entry into occupations that either cannot be objectively measured or are additional (+), and that are characterized as regulatory (R).

Each occupation is given multiple ratings, when applicable, to indicate all possible educational/training paths. In an occupation where high school and another type of training are

required, the rating for high school completion has been dropped because a high school education is not sufficient for entry into that occupation.

- No formal education or training requirements
- Some high school education and/or on-the-job training or experience
- High school
- Course work, training, workshops and/or experience related to the occupation
- Apprenticeship, specialized training, vocational school training
- College, technical school (certificate, diploma)
- Undergraduate degree
- Post-graduate or professional degree

Essential Skills Profile (HRSDC):

Essential skills profiles describe how workers in an occupation use each of the nine essential skills: reading, document use, writing, numeracy, oral communication, thinking, digital technology (originally, computer use), working with others and continuous learning.

These nine essential skills are seen as "building blocks" because people build on them to learn all other skills. They are needed for work, learning and life, and allow people to grow with their jobs and adapt to changes in the workplace. The essential skills profiles describe the skills workers need, as well as the level of difficulty required to perform their jobs successfully.

Essential skills profiles are an important source of information in building a workforce that includes all kinds of skilled workers. The profiles have many purposes and can influence workers and learners in different ways, while helping prepare them for success at work. They can be used directly with individuals, and can also help build research, standards and curriculum. For example:

- Course, training and curriculum developers use the profiles to create learning programs, tools and activities to prepare people for work;
- Researchers use the profiles to study work, literacy (i.e., reading, writing, document use and numeracy) and skill levels in Canada, and evaluate how teaching and learning opportunities relate to the essential skills required in the workplace;
- Trainers and teachers use the profiles to help youth and adults understand how their learning applies to different occupations;
- Guidance and career counsellors use the profiles to give advice on career options and learning plans;
- Employers use the profiles to develop or choose the right kind of training for their employees and/or create job advertisements, interview questions and job evaluations;
- Parents, mentors and advisors use the profiles to help students plan for their future; and
- Job-seekers, workers and learners use the profiles to understand how their own skills measure up to those needed in different occupations.

All essential skills profiles are developed based on the approach described in the essential Skills Research Project (ESRP). The Employment and Skills Development Canada (ESDC) database currently houses more than 350 essential skills profiles, some of which were developed in the mid- 1990s.

6.2 Dictionary of Occupational Titles (DOT)¹³

Even though the DOT was produced for American users many Canadian vocational rehabilitation professionals also find it useful in assisting their clients. The revised fourth edition of the Dictionary of Occupational Titles was published by the U.S. Department of Labor (1991). It is one of the most comprehensive occupational information resources that cover over 12,000 jobs representative of the labour market. The DOT uses a nine-digit code to classify occupations with each digit bearing a specific meaning. The first digit provides information on one of the nine broad *Occupational Categories* (see below). *Occupational Divisions* (83 divisions) within each of the occupations are denoted by the first two digits, whereas the *Occupational Groups* (564 groups) within each of the divisions are defined by the first three digits. The middle three digits provide information on the worker function (functional demand) ratings for tasks performed in the occupation. The fourth digit refers to worker functions in relation to *Data*; the fifth digit refers to worker functions in relationship to *People*; and the sixth digit refers to worker function in relationship to *Things*. The numerical assignments for each of these relationships are shown in columns 2 to 4.

Categories of Occupations and Worker Function Rating

Category (1 st digit)	Data (4 th digit)	People (5 th digit)	Things (6 th digit)
0/1 Professional/ Technical/ Managerial	0 Synthesizing	0 Mentoring	0 Setting Up
2 Clerical and Sales	1 Coordinating	1 Negotiating	1 Precision working
3 Service	2 Analyzing	2 Instructing	2 Operating – controlling
4 Agricultural, fishery, forestry and related	3 Compiling	3 Supervising	3 Driving – operating
5 Processing	4 Computing	4 Diverting	4 Manipulating
6 Machinery trades	5 Copying	5 Persuading	5 Tending
7 Benchwork	6 Comparing	6 Speak – signaling	6 Feeding-off bearing
8 Structural work	7 Serving	7 Handling	
9 Miscellaneous		8 Talking instructions- helping	

¹³ The DOT is no longer being update. It has been replaced by O*NET, which is not as comprehensive in detail for vocational rehabilitation services.

Finally, the last three-digit set aids in discriminating among closely related jobs within the same occupational group. Note that there are no two occupations having the same nine-digit code. Each occupation in DOT is analyzed based on job analysis. DOT variables are analyzed in terms of necessary or desirable characteristics of the worker that derived from job analysis schedules which include:

- Worker functions
- Vocational aptitudes
- Temperaments
- Interests
- Physical demands
- Working conditions
- General education development and
- Specific vocational preparation

The physical demands factor is particularly important in job matching as it provides information on the extent of how impairments/functioning can affect job performance and the kinds of accommodations needed to enable the person with a disability to perform the essential functions of a particular job. There are seven basic parts to an occupational definition which present data about a job in a systemic fashion. The parts are listed in order in which they appear in every definition:

- Occupational Code Number
- Occupational Title
- Industry Designation
- Alternate Titles (if any)
- Body of the Definition
- Undefined Related Titles (if any) and
- Definition Trailer

Vocational Aptitudes and Temperaments

Vocational Aptitude	Temperament
(G) General learning aptitude	(D) Directing, controlling or planning activities of others
(V) Verbal aptitude	(R) Performing repetitive or short-cycle work
(N) Numerical aptitude	(I) Influencing people in their opinions, attitudes and judgments
(S) Spatial aptitude	(V) Performing a variety of duties
(F) Form perception	(E) Expressing personal feelings
(Q) Clerical perception	(A) Working alone or apart in physical isolation from others
(K) Motor coordination	(S) Performing effectively under stress
(F) Finger dexterity	(T) Attaining precise set limits, tolerances and standards
(M) Manual dexterity	(U) Working under specific instructions
(E) Eye-hand-foot coordination	(P) Dealing with people
(C) Color discrimination	(J) Making judgements

Sample DOT Code and Its Coding Structure

Example of DOT Code and its Coding Structure – 045.107.042 – Voc. Rehab Counsellor						
Category	Division	Group	Data	People	Things	Alphabetized Order
0	4	5	1	0	7	042

First three digits describe a Category, Division and Group (045)

Middle three digits describe tasks along Data-People-Things category (107)

Last three digits alphabetizes the order of titles within six-digit code set (042)

6.3 North American Industry Classification System

The North American Industry Classification System or NAICS is used by business and government to classify business establishments according to type of economic activity (process of production) in Canada, Mexico, and the United States of America. It can be used by the vocational rehabilitation professional to determine occupations related to specific industries. For example, vocational rehabilitation professionals (NAICS: 624310) are related to such occupation as: Technical and Trade Schools (NAICS: 61151); Elementary and Secondary Schools (NAICS: 61111) and Education Support Services (NAICS: 611710).

B. Labour Market Information:

The employment rate for individuals with disabilities continues to be unacceptably low. A recent Statistics Canada report estimated the employment rate of individuals with disabilities to be 41% compared to 76% for people without disabilities. For workers with disabilities, the unemployment rate of 26% is over five times greater than those individuals without disabilities¹⁴⁵. The recent recession has a disproportionate impact on workers with disabilities, with the number of employed workers with disabilities declining at a rate more than three times that of workers without disabilities and the unemployment rate rose dramatically to levels exceeding that of other workers. Without a doubt, lack of employment opportunities excludes people with disabilities from full community participation, significantly affecting the quality of their lives.

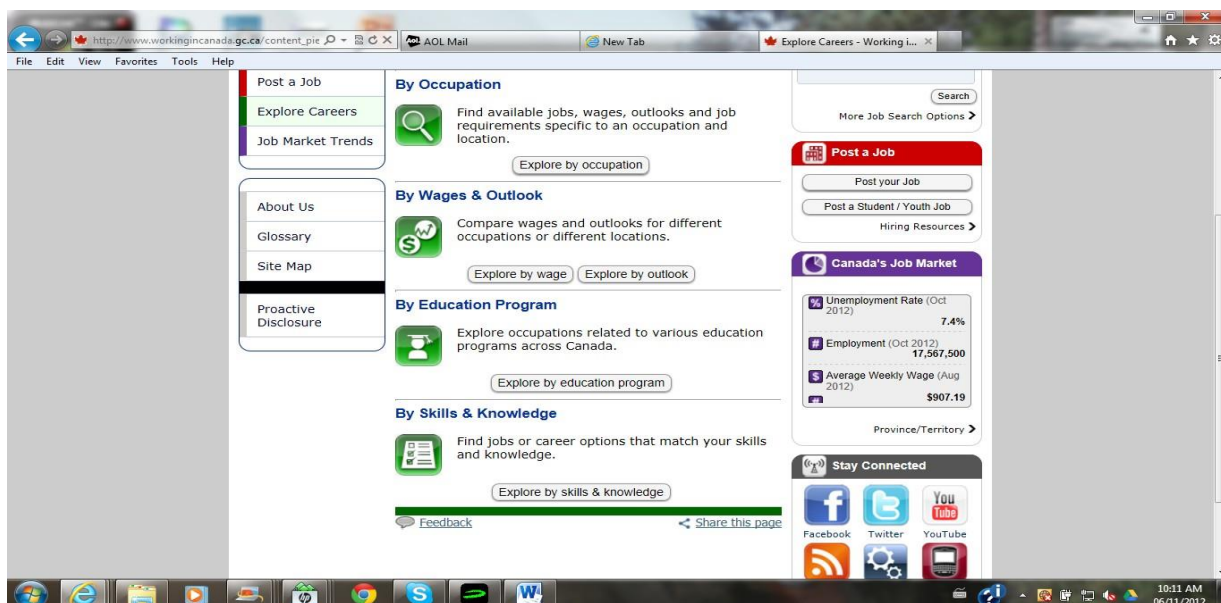
Job placement should be viewed as a program goal instead of a discrete set of activities (helping clients find jobs) that occur in the final stage of the vocational rehabilitation process. Vocational rehabilitation professionals must be familiar with labour market information, job requirements and employer demands to help clients develop appropriate vocational goals consistent with their job performance and capacity early in the VR process. Importantly, employment demand is changing and projected to shift due to fundamental structural economic changes. The organizational structures of Canadian companies are also changing.

The organizational chart is now flatter and team based, and the emphasis is on flexibility, productivity and workplace socialization skills. Therefore, vocational rehabilitation professionals also must have a thorough understanding of the real concerns of employers about hiring and retention of individuals with disabilities and be able to address their concerns and needs. Helping people with disabilities develop flexible, versatile and adaptable work skills that meet employer expectations and requirements for jobs in the new economy will improve their odds of obtaining employment.

Employers are less risk adverse in occupations where the demand is high and the supply of qualified workers is low. Preparing people with disabilities for these occupations will increase their chance of being hired. As a result, a demand-side employment approach is gaining considerable attention in vocational rehabilitation. To improve employment rates and employment quality for individuals with disabilities, vocational rehabilitation professionals must be able to identify the largest and fastest growth areas of employment opportunities and be knowledgeable about the skill sets needed for these demand occupations. It is important for VR Professionals to be familiar with occupational information and analysis.

6.4 Working in Canada – Government of Canada Job Bank

This is a Federal Government internet website that provides a range of information of jobs throughout Canada (<https://www.jobbank.gc.ca/content/pieces-eng.do?cid=01>). The *Explore Careers* section of this website provides specific information on occupations, wages and outlook, education programs and skills and knowledge.



By Occupation: Information can be obtained on specific occupation and locations.

The screenshot shows the 'Working in Canada' website with the 'Explore Careers by Occupation' page. The page has a header with the Government of Canada logo and navigation links. The main content area features a search form with fields for 'Occupation' (containing 'truck driver') and 'Location or Postal Code' (containing 'Winnipeg, Manitoba'). There are buttons for 'Search' and 'Explore Careers'. The 'Explore Careers' section has three sub-options: 'By Wages & Outlooks', 'By Education Program', and 'By Skills & Knowledge'. The page also includes a 'Date Modified: 2012-08-07' and a 'Top of Page' link.

This search produces a “Job Market Search” which lists the number of jobs available in the location, the wage range, outlook and education and requirements.

The screenshot shows the 'Job Market Search' results for 'TRUCK DRIVERS (NOC 7411)' in the 'WINNIPEG REGION'. The page displays a table of job postings with columns for 'Date Posted', 'Job Title', 'Location', and 'Source'. The results show 31 job postings in the Winnipeg Region, with a wage range of 18.50 \$/hr. The table lists several job titles, including 'Long distance truck driver (Bulk Liquid)', 'Truck driver, tractor-trailer (Class-1 Company Driver)', and 'Tow truck driver'. The locations are all in Winnipeg, and the source is Job Bank.

Date Posted	Job Title	Location	Source
2012-11-05	Long distance truck driver (Bulk Liquid)	Winnipeg	Job Bank
2012-11-05	Truck driver, tractor-trailer (Class-1 Company Driver)	Winnipeg	Job Bank
2012-11-05	Truck driver, tractor-trailer	Winnipeg	Job Bank
2012-11-05	Truck driver, tractor-trailer	Winnipeg	Job Bank
2012-11-05	Truck driver, tractor-trailer	Winnipeg	Job Bank
2012-11-05	Truck driver, tractor-trailer	Winnipeg	Job Bank
2012-11-02	Tow truck driver	Winnipeg	Job Bank
2012-11-01	Flatbed truck driver	Winnipeg	Job Bank

6.5 Provincial Labour Market Information

A number of Provinces also have websites which reflect job availability in their area.

- [British Columbia](#)
- [Alberta](#)
- [Saskatchewan](#)
- [Manitoba](#)
- [Ontario](#)
- [Quebec](#)
- [Prince Edward Island](#)
- [New Brunswick](#)
- [Nova Scotia](#)
- [Newfoundland](#)

6.6 Cold Calls

Perhaps one of the most effective ways to obtain labour market information is to make cold calls to employers. These types of interviews can provide information on wages, specific education, employment trends and job openings. Contacting employers can be the most effective and accurate information the vocational rehabilitation professional can get on labour market information in their area.

C. Vocational Planning

6.7 Developing a vocational rehabilitation plan

The vocational rehabilitation plan (also called individual vocational rehabilitation plan or written vocational rehabilitation plan) is probably the most important step in delivering services to a client. This plan puts together all the gathered information about the client, developed vocational goals, and the matching of the client's attributes (e.g. skills, restrictions, etc.) with recommendations regarding further steps to assist the client enter or re-enter the work force (e.g. job search training, direct placement, etc.) The development of a vocational rehabilitation plan should always be done in collaboration with the client. There are a number of steps involved in developing a vocational rehabilitation plan:

- **Information gathering:** The initial phase of developing a vocational rehabilitation plan is to gather a range of information about the client. This information typically comes from two sources:
 - Third party information: Depending on a number of factors, the vocational rehabilitation professional could receive a wide range of third party information. This information could include:

- Client limitations/restrictions
- Client diagnosis and prognosis
- Medical practitioner(s) and specialist(s) report
- Neuropsychological assessment
- Psycho-vocational assessment
- Job demands analysis
- Education records
- Employment records, etc.
- Subjective information: Typically this information would come from the vocational rehabilitation professional's interaction with the client. The most significant information would be derived from the initial intake interview.

There may also be disagreement between the client's understanding of their limitations/restrictions and what is found in the medical reports. Ideally, in situations such as this a case-conference is held to clarify the situation and attempt to assure that all parties have a clear understanding.

- **Return to work hierarchy:** If the client was employed at the time of the onset of illness or accident, the vocational rehabilitation professional should consider the implications of the return to work hierarchy. The principle of this hierarchy is to look at jobs which are the closest to the individual's pre-disability job, before considering other options. There are some variations in the wording depending on the jurisdiction, but the most common return to work hierarchy is:
 - Return to pre-disability job
 - Return to alternative job with same employer
 - Return to alternative job in same industry (different employer)
 - Return to work in any job
 - Retraining¹⁴
- **Occupational exploration:** Many clients have limited knowledge of the variety of occupations within the labour market. Some are entering the job market for the first time; whereas, others have been in the same occupations for years and have little idea about options.
- **Job matching:** Working with the client various occupational choices are explored. The focus is meeting the needs of the client regarding: limitations/ restrictions, transferable skills, interests, potential income, long term employability, and other salient issues.
- **Settings goals:** Up to this point the development of a vocational plan is relatively "mechanical". In the final step consideration not only has to consider the jobs that fit the client's strength, restrictions, etc. but also any psycho-social barriers to employment. Typically, goal setting is both for the short term and the long term.

¹⁴ There are some jurisdictions that add "self-employment" as a final step.

Short term goals could be such things as: completing a GED program, securing child care, anger management class, job search training, etc. Longer term goals would be the end point of the plan which would typically include permanent employment.

D. Job Placement and Development

6.8 Stigma:

Stigma is a strong lack of respect for an individual because they are perceived as different from the rest of society. Due to the nature of job placement/development there is always the possibility that the very act of assisting a client into the work force can cause stigma to occur. This can occur especially with such techniques as job coaching where the vocational rehabilitation professional is at the job site with the client.

6.9 Job seeking skills

In looking for employment an individual needs two specific skill areas:

- Generalized (soft) skills: working as a member of a team, following instructions, planning, decision making, processing information, etc.
- Specific (Hard) skills: these are the specific skills related to a job (e.g. welding, bookkeeping, hair styling, etc.)

There are instances where the vocational rehabilitation professional and the client focus solely on the “hard skills” the individual needs to enter the workforce. However, the individual’s “soft skills” are as important (if not more important).

6.10 Understanding client restrictions/limitations

Even though work restrictions and work limitations are often used interchangeably there is a distinct difference between the two:

- A **limitation** is a reduction of the individual's capacity to perform job-related tasks as a result of a disabling condition. The person can still do their job from a physical or psychological point of view, though with reduced capacity e.g. the worker is slower, less productive, less efficient, or can do the work activity for a shorter duration – but they can still do that activity.
- A **restriction** is a clinical prescription to avoid an activity due to immediate likelihood of significant harm that arises out of a disabling condition. If the worker participates in the work activity, there is a significant probability of immediate harm. Even if the worker stated they wanted to do the activity, the clinician would advise against it.

6.11 Understanding job demands

In those instances where a worker is returning to employment after the onset of an illness or an injury, they will progress through medical diagnosis and treatment and be back to work within a short period of time. However, there are instances where the worker's injury or illness may call into question whether or not they can return to their own job. In these cases a comparison needs to be made between the functional abilities and the worker's job demands.

The job demands of any particular occupation can include the:

- physical demands (i.e., musculoskeletal strength and cardiopulmonary endurance) including the need to lift, bend, push, pull, carry, climb, sit or stand for prolonged periods
- cognitive and psychological demands (i.e., concentration, memory, stress, need to multitask)
- potential hazardous exposures (i.e., chemical or biological hazards, radiation, extreme heat or cold)
- requirements for the use of personal protective equipment such as wearing a respirator

The worker may also be required to:

- monitor displays
- communicate with others
- perform a variety of complicated tasks

The vocational rehabilitation professional needs to be especially vigilant at this point in the return-to-work process, as there is often confusion with physicians regarding the actual job demands versus perceived job demands. Ideally, the workplace will have a job demands analysis completed on every position at their worksite.

A job demands analysis usually is completed by kinesiologists, occupational therapists and like professionals. However, for some companies it is not possible, either due to lack of professionals in the area or funding, to complete a job demands analysis for every job at the worksite. For these organizations, it is possible for the vocational rehabilitation professional to undertake the analysis.

These evaluations document the job's physical demands, including strength, endurance and coordination, as well as communication, visual, audiometric and environmental factors. They also attempt to classify the educational, vocational, intellectual and psychological factors that are significant in the successful accomplishment of tasks involved in that particular job.

The final outcome of each job demands analysis should be a comprehensive list of the tasks required for a specified job title. A complete understanding of these tasks will guide the physician's efforts to return the patient to the workplace. If questions arise as to the accuracy of the job demands analysis or if opinions differ between the patient and the employer

regarding requirements for the job, the vocational rehabilitation professional should invite the physician to visit the place of work and observe the demands of the job. The physician may have to be paid for the site visit. This task may also be delegated to another health professional such as an occupational therapist.

Another source of information is the National Occupation Classification (NOC), which lists the physical demands of most job titles in Canada. The NOC groups jobs into occupations based on their similarities and defines the structure and content of all listed occupations.

The National Occupation Classification further delineates each occupation's vocational, educational and physical demands, and incorporates a guide for occupational exploration. The physical demands for each occupational title are broken down into a variety of tasks and subtasks (e.g., standing, walking, lifting, and climbing). The ability to successfully execute these tasks defines the minimal physical requirements for a specific occupational title. The most significant drawback for the use of the NOC is that the physical activities are broad generalities and may not be specific to the worker's actual job.

Whatever manner the workplace uses to obtain a job demands analysis this should be forwarded as promptly as possible to the worker's treating physician. This will allow the medical doctor to make an accurate comparison between the workers' diagnosis and the demands that will be placed on them at the worksite.

6.12 Work conditioning:

A post-acute, work related, intensive, goal oriented treatment program specifically designed to restore an individual's systemic, neurological, musculoskeletal and cardiopulmonary functions.

- Most often performed by a single discipline – Physical Therapy or Occupational Therapy
- Two (2) to four (4) hours per day
- Most often 5 times per week of treatment
- Strengthening, conditioning and job/ work simulation components

This process prepares the injured worker for return to work, job search or job retraining by providing an intensive, active, rehabilitation program that addresses the worker's physical needs.

The purpose of work condition is to:

- Maximize Patient's Physical and Functional Abilities to Return to Work
- Work Relevant, Intensive, Goal Oriented Program Designed to Restore Work Performance
- Emphasize Active Management Techniques through Work Simulation and Work Conditioning

6.13 Work hardening

Work hardening is:

- An occupational rehabilitation program that is focused on assisting the injured worker to return to the job while minimizing the risk of re-injury.
- This is a program with a sound vocational direction with measurable outcomes.
- A rehabilitative approach performed by a multidisciplinary team of professionals.
- Services such as physical therapy, occupational therapy, or vocational rehabilitation and/or social/psychological services are included in a work hardening program.
- Uses real or simulated work activities designed to restore physical, behavioural and vocational functions.
- Work hardening addresses the issues of productivity, safety, physical tolerances and worker behaviours.

Work hardening addresses the issues of:

- Physical tolerances
- Job Specific Physical Rehabilitation
- Productivity
- Work Place Safety
- Job Performance and Injury prevention
- Worker Behaviours

6.14 Direct job placement

To obtain and retain competitive employment in integrated settings, individuals with disabilities must develop appropriate specific employability, general employability and place-ability skills.

Specific employability skills are job specific and vary from one job class to another. Vocational behaviour and skills in specific employability are important in predicting job performance.

Conversely, *general employability skills*, also known as general work personality, are not job specific. General employability skills are required in every job. Examples of these behaviours include grooming and hygiene, attendance, punctuality, safety consciousness, interpersonal relationships, frustration tolerance, work stamina, productivity, etc. General employability behaviours and skills are important in the predication of job maintenance behaviour.

Placeability is often referred to as the degree of sophistication in job-acquiring skills. Although placeability has little to do with the person's ability to perform a job, it is an important factor to evaluate in rehabilitation, because it addresses a person's ability to obtain a job. Job-seeking behaviours are evaluated in terms of the client's resourcefulness, motivation, skills in writing resumes and cover letters, interview behaviour, etc. As a process, job placement is referred to as a set of activities involved in locating a suitable job for VR clients and getting them hired for the job. Specifically, job placement assistance include job-seeking skills training, direct placement, supported employment and demand-side job placement.

Selective placement is defined as the precise and detailed matching of the person's abilities with the work environment and the requirements of the job. Direct placement intervention requires the aggressive marketing of the benefits of hiring people with disabilities to employers and the ability to supply employers with qualified candidates with disabilities using selective placement. Job analysis is essential to successful selective placement and is used to determine person-job fit and the modifications that can be used to enhance the appropriate fit.

6.15 Supported employment

The supported employment model is a wide-ranging selective placement approach. This type of placement highlights job preparation for individuals with significant disabilities in competitive employment settings and continued follow-up of services through the course of employment. Supported employment's focus on on-job training, advocacy, long-term job retention and follow-up service is what distinguishes this work model from other job placement approaches. The supported work approach places clients who do not have all the needed work and social skills necessary for immediate job success, which is a noteworthy variation from conventional placement approaches that involve that before placement can occur, the client must be job ready. For example, a client may want to enter an occupation which may exceed their limitations. It may be possible to use supported employment with a host employer to make a determination if the individual has the capacity to undertake the job.

There are a number of variations of the supported employment model. Among the most prevalent are the train-place-train-follow-up and the place-train-follow-up. The TPTF is composed of four major parts:

- Surveying potential employers to establish significant vocational and social survival skills that require training
- Training individuals with the purpose of performing such tasks
- Placing trainee clients in competitive employment settings and
- Supplying long-term follow-up training.

The first part of this approach stresses the identification of prospective job placements within the community and conducting a job analysis for the available positions. The second part focuses on training by means of time-limited pre-employment training programs. Individuals are placed within community-based training programs in local industries, for a period of time no longer than six months, where they learn the necessary and required skills for competitive employment. The third part of the approach, placement, provides the clients with the necessary services to transition from training to competitive employment. The last part of this approach centres on providing follow-up services after placement and is characterized by being shorter in duration and more intense than the training phase.

The PTF approach is composed of four major components:

- Job placement
- Job-site training

- Ongoing assessment and
- Job retention

Each component of this approach involves particular activities that must be performed by staff. In job placement, staff activities should include:

1. Structuring job search attempts for the client and matching his or her strengths to the job's needs
2. On behalf of clients, interacting with employers
3. Arranging transportation for travel related to training and
4. Encouraging the involvement of client's families to assist in identifying suitable jobs.

During job-site training, staff activities should include:

- Providing clients with training in behavioural skills and social skills at the job site as needed
- Working with the client's employer and coworkers to provide help to the client and
- Aiding the client and coworkers in their adjustment to each other.

In ongoing assessment, staff activities should include:

- Attaining feedback on the client's development from the employer
- Supervising the client's progress in learning the job through direct observation and
- Occasionally assessing the client and the client's family satisfaction with the program.

In this last component, job retention, staff activities should include:

- Systematically fading the staff intervention at the job placement
- Following-up with the client's employer and
- Helping the client to find a new job if needed.

In both the approaches discussed above, as well as for all other approaches with a selective placement orientation, job analysis plays a fundamental role. The TPTF approach emphasizes job training before placing the client in a permanent competitive job; whereas, the PTF approach centres on placing the client at a specific job setting where she or he can attain on-the-job training and can also expect long-term employment.

6.16 Sheltered workshop

A sheltered workshop that provides employment opportunities for individuals who are developmentally, physically, or mentally impaired, to prepare for gainful work in the general economy. These services may include physical rehabilitation, training in basic work and life skills (e.g., how to apply for a job, attendance, personal grooming, and handling money), training on specific job skills, and providing work experience in the workshop.

Due to criticism of being exploitive environments, sheltered workshops have fallen out of favour and very few exist in Canada. However, over the years thousands of individuals with disabilities have gone through these types of programs.

6.17 Enclave model

Although not used extensively, the enclave mode is a small group of people with disabilities (no more than 5 people) who are trained and supervised among employees who are not disabled at the host company's work site. Persons in the enclave work as a team at a single work site in a community business or industry. Initial training, supervision, and support are provided by a Vocational Rehabilitation Professional who may work for the host company or private agency. Another variation of the enclave approach is called the "dispersed enclave." This model is used in service industries (e.g., universities, restaurants, and hotels). Each person works on a separate job, and the group is dispersed throughout the company. This can be considered a type of mainstreaming where the unique needs of the individual is met within a normalized setting.

6.18 Job coaching model

The responsibilities of the job coach are varied, with primary emphasis on insuring the delivery of whatever work and work-related assistance individuals need to become employed and maintain their jobs. This includes addressing issues on and away from the jobsite, such as transportation, case management, benefits, interpersonal relationships, skill training, grooming, lunch and breaks, supervision, and career advancement. The individualized nature of the model in the delivery of needed supports have been the major reasons why supported employment has been so widely accepted and promoted.

6.19 Co-worker model

The co-worker model is very similar to the job coaching model, with one important difference. Rather than the vocational rehabilitation professional serving as the on-the-job trainer, a co-worker fulfills part of this role. This type of model would be utilized in those jobs where there is a technical aspect beyond the VR Professionals skill level. For example if the client is returning to worker as a welder, the vocational rehabilitation professional may not have knowledge of this area. In this instance the VR Professional would work with a co-worker on the technical aspects of the job, while they fulfill the other aspects of a job trainer.

6.20 Work trial

A work trial allows a client with a disabling condition to work with an employer for a defined period of time. In some instances a work trial is utilized as part of the rehabilitation process in order to make a determination on the capabilities of a client in an actual work environment. In

other instances work trial are utilized when a client is entering the work force for the first time or after an extended period of time off work as a form of occupational exploration

A work trial helps an employee to:

- rebuild work skills and self confidence
- establish work routines following if entering the work force for the first time or returning from an injury and absence
- take part in a work hardening program to improve physical or psychological tolerance at work
- learn new work skills—this is beneficial if an employee needs new skills to improve their employability

6.21 Job shadowing

Job shadowing can be used to assist a client in their occupational exploration process. This entails the individual follows a worker while they perform job tasks. There are times when a client has an image of a job which may be different from reality. This allows them to have a better understanding of what is done in performing an occupation.

6.22 Training on the job (TOJ)¹⁵

For a variety of reasons a client may not have formalized education/training in a particular job. In these instances a training on the job alternative may be the best solution to assist them into a job or returning to the work force. A TOJ allows a client to learn the job at the worksite.

6.23 Job bundling

Job bundling is a unique type of job placement/development. There are occasions when a worker cannot return to their pre-disability job and there is a desire to find alternative work with the same employer. In those instances where there is no available single job with the employer, job bundling could be utilized. This would require taking tasks from a number of job to make one job. These tasks could come from different areas of the department or even the organization. The attempt is to create a job which the client could undertake in consideration of their strengths and limitations/restrictions.

6.24 Social enterprise

Social enterprises are organizations that address a basic unmet need or solve a social problem through a market-driven approach. Social enterprises can be structured as a for-profit or non-profit, and may take the form of a co-operative, mutual organization, a social business,

¹⁵ Sometimes called On the Job Training (OJT)

a benefit corporation, a community interest company, a company limited by guarantee or a charity organization. They can also take more conventional structures. What differentiates social enterprises from other organizations is that their social mission is as core to their success as any potential profit

There are a number of organizations across the country which use the social enterprise model to hire and train individuals with disabilities.

E. Job Placement

Selective placement is defined as the precise and detailed matching of the person's abilities with the work environment and the requirements of the job. Direct placement intervention requires the aggressive marketing of the benefits of hiring people with disabilities to employers and the ability to supply employers with qualified candidates with disabilities using selective placement. Job analysis is essential to successful selective placement and is used to determine person-job fit and the modifications that can be used to enhance the appropriate fit.

6.25 Hidden job market

The hidden job market is a term used to describe jobs that aren't posted online or advertised in any other way. Employers might not post jobs for a number of reasons – for example, they might be trying to save money on advertising, or they might prefer getting candidates through employee referrals. In attempting to locate a job placement for a client the vocational rehabilitation professional should use not only those job banks that are readily accessible but also look to the hidden job market. It is estimated that at least 60% of job openings are found in the hidden market.

6.26 Cold calls

In undertaking job placement, one of the most effective methods is to make “cold calls” to prospective employers. The purpose of these cold calls could be to locate a specific job for a client or to build a job bank. In the latter instances, the vocational rehabilitation professional would be attempting to develop a relationship with an employer(s) in order to provide a placement when they have a client that matches the needs of the employer.

6.27 Employer negotiations

Employers may believe a number of myths concerning individuals with disabling conditions. In attempting to make a job placement the vocational rehabilitation professional may need to enlighten the employer as to the reality of hiring an individual with a disability:

- People with disabilities are reliable employees and have an overall higher job retention rate.
- Employees with disabilities are less likely to have an occupational injury.

- Business who hire individuals with disabilities may be eligible for wage subsidies and other benefits.
- Workers with disabilities have use fewer “sick days” compared to others.
- Workers with disabilities increases the diversity of the organization.
- Workers with disabilities are as capable as anyone.

6.28 Job analysis/job matching

When considering a specific job placement, the vocational rehabilitation professional may undertake a job analysis in order to determine if it is appropriate for the client. Job analysis is a systematic study of the worker in terms of what the worker does, the methods and techniques one employs, the resulting products or services on produces, and the traits necessary to accomplish the job. It is an important skill set used by vocational rehabilitation professionals to analyze the essential functions of a job to determine transferrable skills, job accommodation needs, and job placement of individuals with disabilities. Job analysis involves breaking the total job down into tasks and/or subtasks, determining how the job is performed, what is accomplished, where it is performed and why it is performed. It also involves determining the tools, equipment, machines, work aids and materials used in performing the job. The analysis also involves determine the physical requirements, environmental conditions and special vocational preparation required to perform the job. Specifically, a comprehensive job analysis involves a careful analysis of the following factors that are associated with performing the job well:

- Purpose
- NOC data
- Hiring requirements
- Salary
- Tasks and elements
- Vocational aptitude
- Temperaments
- Physical demands
- Interests
- Working conditions
- General educational development
- Specific vocational demands
- Architectural barriers.

The vocational rehabilitation professional compares this information with the client’s limitations/restrictions, skills, aptitudes, etc. to determine if there is a match.

6.29 Monitoring

In developing a vocational rehabilitation plan, one of the most important component is “monitoring”. When the plan is developed there should be an understanding of:

- Who will be doing the monitoring – will it be the vocational rehabilitation professional, a supervisor, or some other individual?
- What type of monitoring will occur – will it be a written/verbal report?
- How will the monitoring take place – will it be a daily “check-in”, will it be formalized, will it rely on the client’s report or some other method?
- When will the monitoring take place – will it be daily, weekly, bi-weekly or variable? Will it change over time (e.g. intensive at the beginning and lessening over time)?
- Where will the monitoring take place – will it be at the job site?
- Why will the monitoring occur – will it be to monitor the worker’s fatigue or some other physical issue, productivity or quality of work?

Monitoring a job placement allows the vocational rehabilitation professional to:

- Determine the ongoing success of the placement
- Determine if client is staying within their workplace limitations
- Address issues before they become a difficulty at the workplace
- Make modifications to the plan

One of the main functions of monitoring is to have the opportunity to deal with problems before they threaten the job. If a difficulty arises at the job site, the first thing a vocational rehabilitation should do is to speak directly to the client.

6.30 Documentation

Documentation is very important when assisting a client with a job placement. All contacts with the client, the employer and other parties should be documented, dated and signed.

F. Job Search

6.31 Resume construction

If the client is involved in a job search, a resume will probably be needed. In constructing a resume there are three major types:

- **Chronological Resume:**
A chronological resume starts by listing out the client’s work history, beginning with their most recent position first and continuing in reverse chronological order. To supplement each position listed, key accomplishments and qualifications are included to give potential employers a sense of the kind of work they have done in the past and what they are capable of doing. An Education section follows, including the schools they attended and when, certificate(s) earned, and any honors or awards received. In addition, they will typically also include a Skills section which will include computer skills, laboratory skills or languages spoken, etc.

Employers typically prefer this type of resume because they can easily scan which jobs they have held, when they held them, and what they accomplished there. Chronological resumes benefit job seekers with a strong work history and may create difficulties for clients who have been out of the work force for an extended period of time, or entering the labour market for the first time.

- **Functional Resume:**

A functional resume focuses on the individual's skills and experience, rather than on their chronological work history. Instead of having a "work history" section at the top of the resume, it could have "professional experience" or "accomplishments" section that lists various skills that the individual has developed over the years.

A functional resume also sometimes includes a resume summary or headline at the top, which details a person's skills and achievements. A functional resume might not include one's employment history at all, or might have a concise list of work history at the bottom of the resume.

Functional resumes are used most often by people who are changing careers or who have gaps in their employment history. It is also useful for people who are new to the workforce, have limited work experience, or who have a gap in their employment. By highlighting skills rather than work history, one can emphasize that he or she is qualified for the job.

- **Combination Resume:**

A combination resume is a mix between a chronological resume and a functional resume. At the top of the resume is a list of one's skills and qualifications. Below this is one's chronological work history. However, the work history is not the focus of the resume, and typically does not take up much space on the resume.

With this type of resume, the individual can highlight the skills they have that are relevant to the job they are applying for, and also provide their chronological work history.

This kind of resume helps the individual highlight what makes them the best fit for the job, while still giving the employer all the information he or she wants.

- **Problem Areas:**

- **Gaps between jobs.** For many clients, their being off work an extended period of time is due to their rehabilitation process. When employers see gaps of unemployment (of longer than a few months), they wonder what happened during that time. Did the individual leave the previous job with nothing lined up, and if so, why? Were they fired? Were they working somewhere that they have

deliberately left off their résumé, and if so, what are they hiding? Gaps in the person's work history can raise significant questions.

It is difficult for the client to explain a long gap in their work history on their resume. A short explanation on the cover letter may be of some assistance, such as: "Due to an injury I had to leave my last job. However, at this time I am fully recovered and eager to return to work." However, even these types of statements can be misinterpreted. The client should be fully prepared to explain any gaps in employment history if they do obtain an interview.

- **If the client had a number of jobs over a short period of time they may look like a "job-hopper".** If the client's résumé shows a pattern of leaving jobs quickly – meaning that they have repeated stays of less than two years – this is going to raise alarm bells for most employers. They'll assume the individual won't stay long with them either, and they'll wonder why the client was unable or unwilling to stay in one place for a more typical amount of time.

First, if any of those short stays were designed to be short from the beginning, like an internship, temp job or contract work, make sure that the client's résumé indicates that. Note "contract job" or another explanation next to the job title. But if the individual is a true job hopper and those jobs that they left early were intended to be longer term, this is a harder problem to fix. They might need to rely on convincing hiring managers that (a) they are ready for stability and want to find a company they can commit to for longer, and (b) they are so great at what they do that they will be worth investing in.

- **The client was fired from a job in the recent past.** This is a problem because employers will want reassurance that whatever caused the client to be fired won't be repeated if they work for them.

Once again, this is difficult to deal with on a resume. However, if they obtain an interview they should practice an answer that briefly explains what they learned from the situation and what they would do differently now as a result.

- **The client doesn't have much experience.** While the client might be able to do the job if given a chance, the reality is that employers have plenty of experienced candidates who have already worked in their field. As a result, they don't have much incentive to take a chance on someone untested.

This is where a well thought out cover letter can really help. That means a cover letter that doesn't just regurgitate the individual's résumé but instead really speaks to why they want this particular job and why they would excel at it. In addition, try fleshing out the résumé with volunteer work, to establish a track record for employers to look at

6.32 Cover Letter

In addition to a resume the individual should also have a “cover letter” when they are looking for work. The cover letter is a tool to help introduce themselves in a memorable, personal way during a job application. A well-crafted cover letter goes over information on the resume and expands this information for the reader, taking them on a guided journey of some of their greatest career and life achievements. When starting to write any cover letter, it is always best to plan the content of your letter based on the requirements of the job they are applying for.

A cover letter should contain three things:

- How a candidate’s work experience meets job requirements.
- How a candidate’s skills meet job requirements.
- Why a candidate wants to work at the organization.

6.33 Interview skills

Many of the clients a vocational rehabilitation professional is providing services to, have not participated in a job interview for an extended period of time. For others, this may be the first time they have ever undertaken such a venture. In assisting the client there are a number of suggestions which may prove helpful:

- **Practice and Prepare:** There are a number of typical questions that are asked in almost every interview (e.g. what are your strengths, what are your weaknesses, tell me about your past jobs, etc.). The client should practice answer to these type of questions, to become comfortable when they are asked. The individual can either do this by themselves, or in a role-play with the vocational rehabilitation professional or some other individual.
- **Research the Company and the Position:** Often an employer may ask: “What do you know about this company and/or job?” The client should be prepared to give a complete answer for this type of question. Employers look for individuals who have done their “homework” and have taken initiative prior to the interview. It is also a good idea to know/remember the name of the interviewer and use it to build rapport.
- **Get Ready Before Hand:** By preparing and getting ready for the interview in advance, it will decrease the level of nervousness while in the interview. This also means having the clothes ready, getting a haircut or other similar activities.
- **Be on Time (Means being early):** Being on time for an interview is very important (should be there 10 minutes early). Typically, the interviewer will be interviewing a number individuals back to back. If someone is late, it can throw out the interviewer’s schedule – which is never a good idea. The client should also be there in time to use the restroom and get prepared for the meeting.
- **Try to Stay Calm:** This is probably the most difficult suggestion to follow. However, there is a greater chance that this can occur if the other suggestions have been followed.

- **Follow Up:** After the interview it is typically a good idea to follow up with the interviewer. A thank-you note may be appropriate which reiterates the individual's positive qualities. Follow-up should be done within 24 hours of the interview.

6.34 Job search techniques

In providing service to a client who is undertaking a job search, the vocational rehabilitation professional can offer a number of suggestions:

- **Walk-Ins** - this is when the individual goes to the employer's location and ask to be hired. It works best for hands-on jobs that pay by the hour, like dishwasher or non-union carpenter. It's generally not used for other jobs.
- **Cold Calling** is when the client phone complete strangers — people who have never heard of the individual and to whom they have no introduction — to set up an appointment to see them. It requires a good script and considerable persistence. Along with direct mail, it might be worth 5 to 10 % of their job hunting time.
- **Direct Mail** is sending letters or e-mails to complete strangers, people who have never heard of the client and to whom they have no introduction. It is possible to find a job this way, but it requires very large numbers of letters or e-mails. Along with cold calling, it might be worth 5 to 10 % of your time.
- **Completing Applications** is most important in government hiring and for some entry-level jobs. For other salaried jobs, it's not a strong technique. Many people fill out the application after they get hired, not before. Employers sometimes use applications as a polite way to get rid of unwanted applicants: "Fill out the application, and we'll let you know."
- **Responding to Job Postings on the Internet** If the person can find postings for the kind of work and the resume is suitable for them, they should definitely respond. It is doing well if the individual gets one interview for every 50 resumes they send out in response to specific postings. If they can find ads for their kind of work and their resume is suitable for them, they should definitely try it.
- **Networking**, or just plain talking to people, is how the majority of people find jobs. However, it's often confused with information interviewing or mixed up with things that's not networking at all, like networking parties or network marketing or aggressive sales techniques. Some books actually tell individuals that networking is the same as cold calling, or even suggest that it includes tricking people or stretching the truth. Suggestions from family, friends and associates are typically the most useful way to find a job.

6.35 Job club (Azrin)

One of the most successful job-seeking training programs is the "job club" (Azrin) approach. In addition to providing clients with typical job seeking skills training, the job club approach seeks to enhance motivation by using techniques such as a buddy system, family support, role models

and ample practices in completing job application, writing resumes and performing job interviews. Azrin and Philips reported that in their experimental study, 95% of the job club members were employed compared with 28% of the rehabilitation clients in a traditional job-seeking skills program.

Review:

1. The first digit in an NOC code relates to one of ten:
 - a. Managerial positions
 - b. Skill types
 - c. Interests
 - d. Aptitudes
2. In the NOC Career Handbook's Aptitude section a "Q" score pertains to:
 - a. Spatial Perception
 - b. Form Perception
 - c. Clerical Perception
 - d. Motor Co-ordination
3. The Canadian Work Preference Inventory: measures:
 - a. Values
 - b. Interests
 - c. Aptitudes
 - d. Education
4. Work activities involve handling loads up to 5 kg is classified as:
 - a. Light
 - b. Medium
 - c. Heavy
 - d. Limited
5. Some Canadian vocational rehabilitation professionals use the DOT to assist in determining the applicability of occupations for their clients. "DOT" stands for
 - a. Dictionary of Occupational Titles
 - b. Dictionary of Occupations and Trades
 - c. Department of Transportation
 - d. Dictionary of Other Trades
6. Which of the following is used by business and government to classify business establishments according to type of economic activity:
 - a. International Industry Code
 - b. Tri-partite Manufacturing Classification
 - c. North American Industry Classification System
 - d. Industrial Classification System
7. You are providing vocational rehabilitation services to a client who is interested in being a "trucker". You want to find out the wages and outlook for this occupation. Where could you look?
 - a. Working in Canada – Government of Canada Job Bank
 - b. Information Canada – Job Outlook
 - c. Dictionary of Trades
 - d. Canadian Job Statistics Information
8. The first step in developing a vocational rehabilitation plan is:
 - a. Writing the initial vocational rehabilitation plan
 - b. Consider the return to work hierarchy
 - c. Occupational exploration
 - d. Information gathering

9. You are working with a client who cannot return to their pre-disability job. In considering the return to work hierarchy what is the next step which should be considered?
- Return to alternative job in same industry
 - Retraining
 - Return to alternative job with same employer
 - Return to any job in any industry
10. What is termed a reduction of the individual's capacity to perform job-related tasks as a result of a disabling condition?
- A restriction
 - A limitation
 - A disability
 - A handicap
11. In order to undertake a "job match", the vocational rehabilitation professional needs to understand the client's physical limitations and _____?
- Worker's job demands
 - Worker's education
 - Worker's aptitudes
 - Worker's employment history
12. A post-acute, work-related, intensive, goal oriented treatment program is called:
- Work treatment
 - Work conditioning
 - Work strengthening
 - Work re-entrance
13. The model which has a small group of people with disabilities who are trained and supervised among employees who are not disabled at the host company's work site, is called?
- Incorporation model
 - Full inclusion model
 - Assistive model
 - Enclave model
14. The model that uses a vocational rehabilitation professional providing assistance at the job site for a client entering or re-entering the work force is called:
- Job coaching model
 - Assistive model
 - Co-worker model
 - Enclave model
15. A client cannot do all the tasks related to their pre-disability job. Pieces of a number of jobs, that the client can perform, are put together into one job. This is called:
- Job unification
 - Job structure
 - Job bundling
 - Job melding
16. A resume that focuses on the client's skills and experience, rather than on their chronological work history is called:
- Chronological resume
 - Functional resume
 - Operational resume
 - Experience resume

17. A job finding model that uses the “buddy system” is called:
- a. Job Teaming
 - b. Job Group
 - c. Job Gang
 - d. Job Club

Answers

- 1 Skill types – 6.1
- 2 Clerical Perception – 6.1
- 3 Interests – 6.1
- 4 Limited – 6.1
- 5 Dictionary of Occupational Titles – 6.2
- 6 North American Industry Classification System – 6.3
- 7 Working in Canada – Government of Canada Job Bank – 6.4
- 8 Information gathering – 6.7
- 9 Return to alternative job with same employer – 6.7
- 10 A limitation – 6.10
- 11 Worker's job demands – 6.11
- 12 Work conditioning – 6.12
- 13 Enclave model – 6.17
- 14 Job coaching model – 6.18
- 15 Job bundling – 6.22
- 16 Functional resume – 6.31
- 17 Job Club – 6.34

Domain Seven

Case Management and Disability Management

Case management is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual's health, social care, educational and employment needs, using communication and available resources to promote quality cost-effective outcomes. **Disability management** (also referred to as return to work programs) can be defined as a pro-active, employer-based approach to: a) prevent and limit disability; b) provide early intervention for health and disability risk factors; and c) foster coordinated disability management administrative and rehabilitative strategies to promote cost effective restoration and return to work

A. Case Management

Case management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet the client's needs through communication and available resources to promote safe and timely return-to-work. It is using internal and external resources to assure the client is receiving the services he or she needs, when needed. Case Management starts at the moment of an injury or onset of an illness through to closing the file after a return-to-work. The principals of case management is that it needs to be individualized, have strong communication with all stake holders, is goal focused and is cost effective.

7.1 Case management process

- **Initial medical treatment**

It is often assumed that treatment starts when the injured worker enters the medical doctor's office for an assessment. However, for on-the-job injuries, medical treatment starts with the workplace first aid attendant. In either case, it is imperative that, as soon as possible after the onset of an illness or an injury, the worker receive prompt medical attention. The individual involved, either the first aid attendant or medical doctor, should be able to evaluate the worker's illness or injury, determine whether they are fit to return-to-work or whether further exploration or medical treatment is required.

The role of the vocational rehabilitation professional is to ensure that the injured or ill worker obtains a prompt response to the onset of any illness or injury that has a potential for long-term consequences. Although the vocational rehabilitation professional may advocate for prompt treatment and rehabilitation, many factors related to the speedy delivery of services are outside their control. The company's

return-to-work program needs to have written policies and procedures regarding early contact and intervention with the ill or injured worker.

- **Understanding worker's job demands**

In the majority of instances the worker will progress through medical diagnosis and treatment and be back to work within a short period of time. However, there are instances where the worker's injury or illness may call into question whether or not they can return to their own job. In these instances a comparison needs to be made between the functional abilities and the worker's job demands.

The job demands of any particular occupation can include the:

- physical demands (i.e., musculoskeletal strength and cardiopulmonary endurance) including the need to lift, bend, push, pull, carry, climb, sit or stand for prolonged periods
- cognitive and psychological demands (i.e., concentration, memory, stress, need to multitask)
- potential hazardous exposures (i.e., chemical or biological hazards, radiation, extreme heat or cold)
- requirements for the use of personal protective equipment such as wearing a respirator

The worker may also be required to:

- monitor displays
- communicate with others
- perform a variety of complicated tasks

The vocational rehabilitation professional needs to be especially vigilant at this point in the return-to-work process, as there is often confusion with physicians regarding the actual job demands versus perceived job demands. Ideally, the workplace will have a job demands analysis completed on every position at their worksite.

A job demands analysis usually is completed by kinesiologists, occupational therapists and like professionals. However, for some companies it is not possible, either due to lack of professionals in the area or funding, to complete a job demands analysis for every job at the worksite. For these organizations, it is possible for the vocational rehabilitation professional to undertake the analysis.

These evaluations document the job's physical demands, including strength, endurance and coordination, as well as communication, visual, audiometric and environmental factors. They also attempt to classify the educational, vocational, intellectual and psychological factors that are significant in the successful accomplishment of tasks involved in that particular job.

The final outcome of each job demands analysis should be a comprehensive list of the tasks required for a specified job title. A complete understanding of these tasks will guide the physician's efforts to return the patient to the workplace. If questions arise as to the accuracy of the job demands analysis or if opinions differ between the patient and the employer regarding requirements for the job, the vocational rehabilitation professional should invite the physician to visit the place of work and observe the demands of the job. The physician may have to be paid for the site visit. This task may also be delegated to another health professional such as an occupational therapist.

Another source of information is the National Occupation Classification (NOC), which lists the physical demands of most job titles in Canada. The NOC groups jobs into occupations based on their similarities and defines the structure and content of all listed occupations.

The National Occupation Classification further delineates each occupation's vocational, educational and physical demands, and incorporates a guide for occupational exploration. The physical demands for each occupational title are broken down into a variety of tasks and subtasks (e.g., standing, walking, lifting, and climbing). The ability to successfully execute these tasks defines the minimal physical requirements for a specific occupational title.

The most significant drawback for the use of the NOC is that the physical activities are broad generalities and may not be specific to the worker's actual job.

Whatever manner the workplace uses to obtain a job demands analysis this should be forwarded as promptly as possible to the worker's treating physician. This will allow the medical doctor to make an accurate comparison between the workers' diagnosis and the demands that will be placed on them at the worksite.

- **Referral(s) to Third Party**

In the course of case management, the vocational rehabilitation professionals needs to be aware of changing needs of the client. There may be occasions when a referral to a third party should occur. Referrals to third parties should never be made without the full understanding and consent of the client and involved stakeholders.

- **Return-to-work determination**

Once the health care provider understands the patient's workplace tasks, responsibilities and environment, a return-to-work determination can often be made. Often the patient can return-to-work with initial duty limitations. It is imperative that the health care provider document meaningful and objective limitations. The National Occupation Classification divides physical work into four specific categories (limited,

light, medium, heavy) that quantify exertion and duration. These strength factor categories can be used for generalized limitations; in addition, the health care provider should be requested to prescribe more specific and detailed limitations (e.g., no working above shoulder level, no climbing on stairs or ladders, no operating heavy equipment, no forceful gripping.) Limitations should also address the need for special equipment and restricted hours of work. Finally, the time period during which the restrictions apply should be documented.

As the worker's limitations immediately following an injury or illness are very likely temporary in nature, the worker should have regular contact with his health care provider to monitor changes throughout the healing process.

It is on the basis of the medical limitations that the vocational rehabilitation professional can provide accommodated work in a safe and timely manner. A comparison is made between the worker's limitations and the available accommodated positions. In many instances the worker will be able to undertake all the tasks assigned to their position, but not for a full work day. In these cases a graduated return-to-work may be called for. This entails bringing workers back to their own job for a limited number of hours per day or week. As their physical abilities improve, there can be a corresponding increase in the number of hours at the worksite.

In other instances, workers' medical limitations may preclude them from performing part of the job. In these cases workers may be assigned only those tasks within their restrictions and receive assistance for those areas of the job they cannot perform. Caution should be taken to ensure that co-workers are not being assigned all of the heavy tasks with the injured/ill worker performing the lighter tasks.

In some cases the worker cannot do any part of their job and requires temporary alternative work. For example, if workers' own jobs are entirely in the 'heavy' range of physical activity but they are medically restricted to only 'light' work, alternative work must be located. It is very important that any alternative work is productive and meaningful.

The key for the vocational rehabilitation professional and the return to work process is to match the worker's accommodated or modified work with their current medical limitations. As the medical limitations change, the type and duration of work needs to change.

- **Documentation**

Well documented case management records should contain at least the following notations:

- written permission to release information, signed by the client,
- written and signed informed consent

- relevant historical and demographic information on the client,
- results of the initial assessment and periodic reassessments of the client, including data on the client's psychosocial, behavioural, and physical status (if appropriate),
- the vocational rehabilitation plan and specified goals, interim objectives and time frames, and schedules and procedures for monitoring progress toward accomplishment of goals and objectives,
- the outcomes for a client,
- referrals to other agencies or resources, including follow up and feedback from or recommendations by outside agencies or individuals, and
- reason for termination of services

7.2 Adjudication

Adjudication is the insurance process where a determination is made regarding the individuals eligibility for benefits. Based on the organization's insurance policy, the adjudicator evaluates the client's medical evidence and makes a decision regarding the eligibility for such benefits as long term disability benefits.

There are typically three types of disability/sick benefits in many organizations:

- **Sick Leave:** usually this is a few days or weeks in length. Usually, no adjudication takes place; rather a doctor's note is provided to the supervisor/HR department.
- **Short Term Disability** – this benefit typically begins when sick leave runs out. Most short term disability plans pay a percentage of the individual's wages (e.g. 70%) and runs for a defined period of time (e.g. 15, 26 or 52 weeks). There is often an adjudicator involved in this process.
- **Long Term Disability** – This benefit begins when short term disability benefits end. Typically, long term disability is paid for two years at which time a determination is made regarding the individual's ability to return to work. Some policies end at this time if the individual can return to "any job". Other policies allow benefits to continue if the individual cannot return to their "own job".

B. Disability Management

7.3 Disability management models¹⁶

- **Medical model:** The medical model looks at a person's impairment first and focuses on the impairment as the cause of disabled people being unable to access goods and services or being able to participate fully in society.¹⁴⁶ For the vocational rehabilitation profession this model would place their services within the

¹⁶ This section is also covered in Domain 1

rehabilitation phase. The client's diagnosis and prognosis are the central (and sole) consideration for assisting the person's entering or re-entering the work force.

Managed care is an example of a type of medical model. Managed care is often used by insurance systems, where a person's disability is compared to the "typical" individual with the same disabling condition. Prognosis is then delineated on "what would be expected" in similar circumstances. Typical manuals to assist in this process include: *Official Disability Guidelines*, published by the Work Loss Data Institute (Corpus Christi, TX); *Medical Disability Advisor — Workplace Guidelines for Disability Duration*, published by the Reed Group Ltd. (Boulder, CO); The *Health Management Guidelines*, published by Milliman & Robertson (Seattle, WA); and the *ACOEM Guidelines*, published by OEM Press (Beverly, MA).

- **Environmental/Social model:** This model identifies the problems faced by disabled people as a consequence of external factors. For example, in the way organisations produce information (not offering a variety of formats such as Braille, large text etc.), or inaccessible venues.¹⁴⁷ For the vocational rehabilitation profession, this model places emphasis on external variables that can be modified so that the individual can fully function with their home or work life.
- **Forensic model:** Forensic vocational rehabilitations major focus is on the medico-legal aspects of disabilities. The goal of this model is not necessarily to assist the individual with a disability in entering the work force; rather the goal is to make a determination of the person's employability, future earning capacity, etc.
- **Biopsychosocial model:** The biopsychosocial model is in some respects a combination of the medical and the social models of disability. The vocational rehabilitation profession needs to focus attention on the individual's environment that can be changed to accommodate the disabling condition. They also need to focus on supporting the person's medical condition and working through the rehabilitation process. The biological, psychological and social issues which create barriers to entering or re-entering the work force are important considerations.

7.4 Disability management program

Research and experience has demonstrated that effective disability management programs have a number of key characteristics including:

Management/Labour Support and Cooperation

The foundation of Disability Management is the joint commitment of labour and management. Examples which demonstrate this commitment could include:

- Letter of Understanding or part of general contract

- Disability Management Committee
- Education and support by union leadership and management
- Joint development of policies, procedures and education program

There is considerable experience and a general consensus that joint management-labour initiatives in Disability Management Programs is the most effective.

It has been found that for a Disability Management Program to be successful, it must be supported at all organizational levels: executive, managers, supervisors, workers and worker representatives.

Central to the philosophy of the labour movement has been the concept of “improving the lives” of workers.¹⁴⁸ Studies have demonstrated that the ideals of the labour movement match the ideals of the philosophy of Disability Management.^{149,150} Moreover, union representatives often possess an in-depth understanding of the workplace, including knowledge of specific tasks, and responsibilities associated with a variety of jobs. Union representatives also have firsthand knowledge of labour policies affecting many core issues related to rehabilitation, including disability prevention, safety and health and accommodation.

The foundation of worksite Disability Management is joint labour-management support and empowerment. Both union representatives and managers are key contributors in the Disability Management process when they participate cooperatively as decision-makers, planners and coordinators of interventions and services. Research has shown that, without joint support, worksite Disability Management initiatives often falter and adversarial relationships between injured workers and employers emerge.¹⁵¹

Perhaps the key feature of an organization which has joint labour/management support is the Disability Management Committee. Typically, this committee has equal number of management and labour representatives and oversees the DM program. There are three types of Disability Management Committees:

- Advisory: This type of committee provides overall guidance to the program. It typically does not become involved in day-to-day operations but sets the parameters and policies for the program. It is responsible for assuring that the program is monitored and evaluated on a regular basis.
- Administrative: This type of committee falls between the advisory and operational committees. It is more deeply involved in the administration of the program, but does not have hands-on responsibilities. This type of committee not only sets the policies and parameters of the program, but is provided on-going reports on the activities and costs of the program.
- Operational: This type of committee is deeply involved in the day-to-day operations of the program. Each case comes before the committee for discussion and assistance in the return to work process. In some ways it provides the services of the vocational rehabilitation professional.

Supportive Policies:

Supportive policies provide the framework for an effective Disability Management Program.

Program policies should include:

- Roles and responsibilities (management/supervisors, union, worker, co-workers, and return-to-work coordinator) There is strong evidence that Disability Management is more effective if all players recognize their role in the return-to-work process, take responsibility and play their parts when appropriate.^{152,153}
- Eligibility (should include all disabilities (e.g. physical, emotional, congenital, etc.) no matter their source (i.e. occupational and non-occupational). Particularly supportive programs allow provide for preventative Disability Management and
- Process (each step of the Disability Management process should be clearly outlined. These steps should outline how the program is changed depending on the complexity of the case. A flow chart is often included in the manual). Research has shown that a “stepped” approach provides an optimal framework which appropriately and efficiently meets the needs of the client. In essence this type of approach delivers what is needed by the individual, rather than a “one-size-fits-all” approach^{154,155}

Supportive Benefits:

Supportive benefits mean:

- Seamless between last day of work and return to regular pay. There are no significant time gaps for the client in receiving ongoing pay/benefits.
- Ability to change the contract as the need arises. The organization should be able to work with the insurance company to change their contract as needs arise; rather than waiting for the end of the contract.
- Supports timely and safe return-to-work. Program benefits should support, rather than impede safe and timely return-to-work. A program too “rich” in benefits may create a situation where the workers do not return-to-work in a “timely” manner. Benefits which create a significant financial hardship may create a situation where a client returns to work too quickly and not in a “safe” manner.
- Supports vocational rehabilitation. There are occasions when workers cannot return to their previous occupation nor can they transition into another accommodated position within the organization. Due to their disability they need to look at an alternative career path. Ideally, the organization’s benefits would cover the assessments; employment counselling and training a worker would need to successfully enter an alternative career path.

Coordinated Approach:

A coordinated approach to illness and injury would include:

- Interdisciplinary approach involving medical, social, ergonomics: to ensure that all issues that affect workers with disabilities are addressed There is strong evidence that multidisciplinary interventions that address health, personal and workplace factors (a

biopsychosocial approach) and that are linked to the workplace are effective and cost-effective for improving occupational outcomes.^{156,157}

- Early contact with client. A classic example of this is from research done in the late 1980's¹⁵⁸. When workers were off work with back injuries their supervisor phoned to say: "How are you? We were thinking about you. You are vital to our team. Your work is important and your job is waiting for you." That simple message and the company culture it reflected, cut the number off long-term disability benefits from 7.1% to 1.7%
- Early intervention – assuring the worker is receiving timely diagnosis and/or treatment. Referral to community resources if appropriate. There is strong research evidence that early intervention can be effective and cost-effective for increasing return-to-work rates and reducing the number of individuals who go to long-term disability.^{159,160}
- Ideally organizations should introduce prevention programs that assess the risk of disability in the workplace and put in place interventions to eliminate or minimize this risk. When injuries occur rehabilitation services should commence as soon as possible. Early referral for rehabilitation services is strongly correlated with early return-to-work, reducing the time taken to return-to-work and increasing the likelihood of return-to-work.^{161,162} Early intervention includes a range of components: (a) maintaining communication with workers who are absent from the workplace,^{30,32,163} (b) appropriate medical treatment,^{30,164} (c) immediate contact with the treating physician to obtain return-to-work restrictions, and provide information about job demands and the availability of transitional work (physicians should only be providing worker's restrictions to employer and not a diagnosis) and (d) implementation of a clearly defined return-to-work program that may include modifications.

An Effective Return-to-Work Program:

An effective return-to-work program involves:

- Return to work planning (and written plan) involves all key stakeholders (e.g. client, worker representative, supervisor, medical practitioner, vocational rehabilitation professional, etc.) and should be signed-off by key stakeholders.
- Systematic approach to determining workers restrictions (i.e. limitations), job demands and matching the two.
- Ongoing follow up to assure worker is progressing and staying within restrictions.
- Return-to-work jobs are productive and meaningful.

Effective Communication Strategy:

An effective communication strategy is key to the ongoing success of a Disability Management Program. Examples of effective communication strategy include:

- Orientation and at least yearly information session with all employees
- Brochures, mail outs, website, bulletin board information.

- Training sessions for management and union leadership
- Jointly developed with labour and management.

Research has shown that there is strong evidence that improved communication between all key stakeholders leads to faster return-to-work and less sickness absence overall, and is cost-effective^{165,166,167}

Stakeholder Education:

Stakeholder education and involvement could involve:

- Information package to all third party providers (e.g. medical professionals, occupational therapists, physiotherapists, etc.).
- Invitation to third party providers to worksite.
- Formal and ongoing support of union leadership and management for education and committee involvement.

Collaboration involves education of all employees about the philosophy and objectives of the Disability Management Program, as well as their role and rights. Furthermore, it is about promoting communication among all participants in the return-to-work process, which can include the injured worker, co-workers, physician, other health professionals, case manager, supervisor, union representative and claims manager.

Performance Measurement and Management:

Integral to an effective Disability Management Program is the measurement of key performance indicators.

- The program needs to set measurable targets (objectives). A target, to be valid, must be something that can be measured. For example a target of “increase employee happiness”, maybe laudable but would be impossible to measure. A target such as “decrease workplace accidents by 10%” is something that can be monitored and tracked.
- The organization not only needs to set targets, but has to track them. For some targets this could be on a monthly basis (e.g. time to first contact); whereas others would be measured on a longer term basis (e.g. decrease Workers Compensation Assessment rate).
- Internal targets should be set on such areas as: accident/injury reduction, claims duration, time on transition work, number of transition plans, time to first contact etc.
- In addition to internal targets there should be targets and monitoring of external providers (e.g. insurance providers, third party providers, occupational therapists, physiotherapists, etc.). These targets could include: effectiveness of the provider, time to see worker, costs, worker satisfaction, etc.
- The responsibility of meeting internal targets should be included in the supervisor’s and the return-to-work personnel’s key performance indicators (KPI).
- It is very important that not only are targets set and measured, but this information is made available to all the key stakeholders (e.g. senior management, union leadership, etc.). This

information should be made available for management meetings, annual meetings, union meetings, etc.

- The total cost of injury and illness to a workplace can be elusive as it has been shown that the hidden costs of disability such as recruitment, orientation, lost productivity, administrative costs, etc., add significantly to the direct disability related costs such as medical and wage replacement costs. Effective collection and analysis of disability cost data is pivotal to not only maximizing the effectiveness of Disability Management Programs, but in the evaluation and continuous improvement of Disability Management Programs. It is also essential to gather Disability Management cost data to ensure that benefit programs are optimized to achieve both the social and economic objectives of the program.

Ideally, the organization should use software that provides access to detailed costs for individual claims (for example, broken down by wage loss replacement, healthcare, vocational rehabilitation and other costs). The system also provides aggregate claim costs, with the ability to view aggregate costs for different periods (for example, monthly, quarterly, yearly) and compare to equivalent prior periods. Software should also be able to analyze benefit data and trends and to generate cost benefit ratios.

Both direct and indirect (overtime, training, hiring of additional staff to cover for the person who is away) disability costs should be used when forecasting budgetary expenditures. Workplace representatives should review the total disability costs for the past year, compare costs to prior years to determine if they are going up, down, or staying the same, and predict if current trends will continue. They also consider the number of people away during the year due to accidents/illness, and predict overtime or replacement staffing needs based on current trends. These factors are then used to help forecast disability costs for the following year.

It has been found that in most successful return-to-work programs satisfaction surveys are given to all workers whether they have participated in the return-to-work process or not. Results of the surveys are tracked to aid in program planning. Every worker is surveyed at least once every two years, and workers with a disability who have participated in the return-to-work process are surveyed on completion of the plan. This process provides the organization with information concerning employees "subjective" view of the program. As long-term success is dependent on the cooperation and support of all stakeholders, satisfaction surveys are an important tool for assessing the perceptions of the program and providing information for ongoing improvement.

Injury and Illness Prevention:

It has been often said that the easiest disability to rehabilitate is the one that does not occur. Organizations need effective injury and illness prevention programs. These programs should address health and safety issues both on the job and off the job. Indications of a good injury and illness prevention program would include:

- Safety program
- Dealing with hazards

- “Orders” against company
- Part of supervisors performance review
- Ongoing safety education
- Number of individuals trained in CPR and first aid.
- Wellness program

7.5 Fear of re-injury

Fear of re-injury is one of the most significant indicators for an individual successfully returning to work. The client could have had a significant injury at the workplace and experienced significant pain during their recovery. The memory of this pain can create a situation where the individual has intense fear of aggravating their injury. This can become a major concern in assisting the worker back to work.

7.6 Return to work options

- **Graduated return to work (GRTW))**

The term ‘graduated return to work’ embraces the idea of returning to work gradually, in stages, before an employee can complete all of their normal tasks and/or is able to work all their allotted hours and days. It is the most commonly used accommodation in assisting an individual return to work. It includes any level of work, from a couple of hours, to a few days a week, but relies on an agreement between the employer and employee. Each employee’s situation is different, so solutions need to be flexible and well planned, including regular reviews of the arrangement and an agreed date to return to their normal hours/duties.

An ideal graduated return to work should include:

- A gradual build up towards the employee’s usual hours and duties that begins with hours of work that are manageable for the employee at the current stage of their recovery.
- A timeframe that may be as little as one week, and not usually more than 4-6 weeks, unless the employee has a condition with long-term fatigue issues.
- Consideration of work timings that may support a return to work where there is some flexibility, for example hours that allow an employee to avoid a commute in rush hour traffic.
- Duties during the graduated return that are beneficial to the organisation but that allow the employee to be confident in their return (an example of this may be removing the requirement for business travel initially, or direct customer facing work depending upon the health issues).
- Review timeframes so that the line manager and employee can adjust, where necessary, or ensure all is on track.

- **Temporary Job Accommodation**

Canada's Employment Equity Act enshrines in law a commitment to equality in the workplace. This law means employers cannot deny anyone an employment opportunity or benefits for reasons unrelated to ability. Sometimes the rules and policies an organization uses to run its businesses unknowingly exclude a person or group from employment. Organizations should take proactive measures to remove these systemic barriers before requests for accommodation occur.

An area that is often contentious is the extent of information that the worker needs to supply the employer in regards to their disabling condition. In general terms the employee only needs to provide the employer medical information that is related to their limitations or restrictions. In order to enhance the possibility of a successful accommodation, the worker should provide the disability management program sufficient information to determine accommodation options.

Step 1 - Determine Current Functional Abilities

To determine an employee's capabilities and limitations, conduct a functional abilities assessment. Completed by a health care provider, this evaluation is a written assessment of an individual's mental and/or physical abilities. It helps the employer determine which duties the employee can perform. Specifically, the assessment indicates:

- restrictions that may prevent an employee from performing his or her job duties;
- whether the restrictions are permanent or temporary;
- the degree to which the individual's limitations will decrease;
- the time needed for improvements to take place; and
- any existing impairments and barriers preventing an employee from using equipment

To conduct a thorough functional abilities assessment, the health care provider needs the employer to provide as much detail as possible about the job's requirements. The employer can fill out a physical demand form and give it to the health care provider.

The vocational rehabilitation professional also needs to take into account the worker's desire/motivation to return to work. The most significant indicator of a successful return to work is whether or not the client had a high pre-disability job satisfaction.

Step 2 - Clarify functional needs of essential duties

The employer should conduct a functional needs analysis to support a request for accommodation. The employer may conduct this evaluation before receiving a request if the employer sees that an employee might have a condition that limits his or her

ability to perform tasks. A functional needs analysis describes a position in detail, including requirements related to:

- safety;
- certification;
- hours of work;
- the skills needed;
- the equipment used to perform the work; and
- the work environment, such as the premises and their accessibility

To clarify the functional needs of a position, the employer should identify the:

- job title;
- pay rate;
- location;
- classification;
- department or division; and
- the position's reporting structure

This analysis will help the employer identify any bona fide occupational requirements and develop potential accommodation scenarios. During the evaluation, the employer should try to answer some practical questions:

- How does the position fit within the organization?
- Why does the position exist?
- What are the expected results from the position?

Both labour and management can provide useful perspectives on work processes, the work environment and barriers that decrease the likelihood of a person returning to work. Gather input from many sources, including:

- a human resources representative;
- the direct supervisor;
- the employee representatives; and
- current and past employees who held the position

Give the functional needs analysis to the health care provider at the time of the functional abilities analysis. The needs assessment helps the health care provider understand the workplace context and requirements.

Step 3 - Compare and rationalize functional needs vs. abilities

When an employee is unable to perform work-related tasks, the employer may have to accommodate. If the employee cannot perform the essential duties—or the bona fide occupational requirements (BFORs)—of the position, the employer may not have to accommodate. BFORs are tasks that must be performed in a position. They are the reason the position exists. Follow the assessment process to find out if accommodation is required or is not feasible due to BFORs.

When a specific accommodation request is made, the employer compares the functional abilities of the employee with the functional needs of the position. The employer and employee will review the employee's limitations and find possible accommodation options that would enable the employee to do the job.

The employer and the employee should share information with employee representatives. Through discussions, all parties can agree on alternatives that are suitable for both the employer and the employee, and decide which aspects of the work should be modified.

The employer may insist that specific tasks are bona fide occupational requirements (BFORs)—practices essential to the position. Without them, the position is useless. The following three criteria should be used to decide if the BFOR definition applies:

1. The employer has established a rational connection between the practice and the job.
2. The practice was established in good faith.
3. The employer has established that the modification required by the employee would cause undue hardship. Undue hardship means accommodation is impossible without causing serious negative safety, health or cost effects for the employer.

BFORs may seem daunting, but if the employer discusses the situation with the employee and employee representatives, together they may find a solution that satisfies all parties.

Step 4 - Identify Immediate Health Needs

An employer, insurance board or workers' compensation board may require a medical or a functional abilities assessment when an employee requests accommodation. The employer needs medical information to determine the validity of an employee's absence and eligibility for leave benefits. The medical information will also help the employer think of potential accommodation options and ensure that the employee is able to return to work.

Medical and functional abilities assessments should be done by qualified health care providers who treat the type of medical condition in question. An insurance or workers' compensation board may also have one of its own qualified medical experts complete an assessment.

The goal of the medical assessment is to identify what the employee can and cannot do given the nature and extent of the employee's condition.

The health care provider's role includes:

- identifying the functional abilities of the employee;
- recommending work restrictions;

- providing risk-management strategies; and
- specifying other measures such as the need for specialized equipment

If the employer offers the employee a new or modified job, the employer should give the health care provider a written description of the position's duties. This description enables the health care provider to offer the employer useful information.

The employee should fully participate in the assessment by attending the scheduled appointment and providing the necessary information. The employee should also follow the health care provider's advice relating to abilities and restrictions, using assistive devices, and steps to follow for recovery.

Employee representatives should be aware of the medical needs of the employee and the measures taken to address them. With this information, the representatives can consider potential issues with the collective agreement and give expert advice.

Step 5 - Generate and Assess Creative Accommodation Options

When the need for accommodation arises, the employee should inform the employer of his or her requirements. The employee can do this during his or her absence, or when he or she is ready to return to work.

The key to accommodation is individualization. There is no set formula. Each person may have unique needs. Accommodation involves customizing work to meet the specific needs of an individual, considering the organization, the work environment, and the worker's physical and psychological condition.

Think proactively about accommodation. Consider all employees who have conditions that limit their abilities to perform tasks—not only employees who wish to return to work following injuries, but also employees still on the job.

Depending on the accommodation needed, the employer will assess and propose various options. These possible solutions can consist of one or many changes: training, a new schedule, a temporary transfer of duties, or specialized equipment, for example.

All parties have roles to play. The employer will discuss options with the employee, health care providers and employee representatives to get information and input. Workers' compensation and insurance boards can help, too. They may have work-reintegration programs, rehabilitation specialists who can give expert advice, and other useful resources.

Employee representatives should help find alternatives and not block accommodation. The collective agreement should not be used as a reason to disregard an accommodation option. However, the accommodation of one employee should not unnecessarily strain other employees.

Recognize the difference between what the employee wants and what he or she needs. The employee should accept reasonable accommodation and not expect perfect accommodation. Accommodation is reasonable if:

- it meets the individual's disability-related needs;
- it enables the employee to perform work duties adequately; and
- the employee enjoys the same benefits and privileges as before and experienced by others

Step 6 - Assess Medical Impact

The health care provider (HCP) plays an important role in the accommodation or return-to-work process. After the employer has identified accommodation options, the employer can ask the HCP to review the options and advise on their feasibility.

Using the functional abilities analysis, the HCP will recommend how each option can benefit or affect the employee. The HCP will advise if any modifications relating to the plan are necessary or if any of those changes might risk the employee's health.

When evaluating how accommodation affects the employee's health, the HCP can also advise on when the employer should reassess each accommodation option. Consider how the accommodation could affect the health and safety of other employees. Use advice from health care providers to assess each accommodation option.

Prior to the implementation of any workplace accommodation the vocational rehabilitation professional needs to involve the client in any evaluation and equipment purchase.

Step 7 - Assess Workplace Impact

Accommodation can help an organization retain employees and attract new hires with needed skills. Accommodation supports the organization's positive public image.

Accommodation also affects employees. It may change their duties, schedules and the people with whom they work. The employer and employee representatives should tell employees about any changes that will affect them while ensuring the privacy of the employee who needs the accommodation.

Inform employees about the accommodation policy and how it meets the obligations of the Canadian Human Rights Act and the Employment Equity Act. With this information, employees will understand the need for accommodation and may react less negatively when coworkers make accommodation requests.

Step 8 - Finalize Accommodation Plan

The employer develops a detailed accommodation plan and provides it in writing to the employee. The plan consists of the best option that will not cause undue hardship, yet allows the employee to continue working with the same advantages and benefits as before the illness or injury. The plan may include steps to be implemented and information about how the employer and employee might change the plan over time.

Despite best efforts, the employee may not be satisfied with the accommodation plan. The employer should have an appeal process that enables all parties to discuss and develop accommodation that meets everyone's needs. The appeal process should be clearly stated in the accommodation policy.

The employer may avoid employee dissatisfaction by involving the worker in accommodation planning. Throughout that process, the employer must respect the employee's privacy and should not disclose medical information to other parties without the employee's consent.

All parties involved should be aware of the final accommodation plan. The plan describes the chosen option with information including:

- job title;
- location;
- schedule;
- supervisor;
- rate of pay;
- date of return; and
- job description.

The employer may implement the accommodation for a trial period and modify the plan if necessary.

- **Permanent accommodation**

Despite adequate medical treatment, occupational rehabilitation and accommodated/modified work, some individuals reach the point of maximal medical improvement but are unable to return to their full duties. In these instances the vocational rehabilitation professional needs to look at permanent accommodation of the worker. The vocational rehabilitation professional works with the Disability Management committee, the worker's supervisor, and the health care professionals to determine appropriate long-term work accommodations within the worker's medical restrictions. This may entail modifying the worker's job to take into account the medical restrictions or a new job that allows the worker to perform all the tasks assigned.

Another approach to finding work for an individual who requires permanent accommodation is commonly referred to as '**bundling**.' By reorganizing tasks from a number of existing positions, it may be possible to create a brand-new job that accommodates the abilities of the employee with a disability.

7.7 Legal requirements¹⁷

- **Canadian Charter of Human Rights and Freedoms**

Due to the nature of some injuries or constraints in the workplace, it may not be possible to accommodate the worker in the original or modified job. If a worker is not medically fit to return to their job or any other modified/accommodated position within the organization, the requirements of the Canadian *Human Rights Act* must be followed carefully. The *Act* states:

15. (1) It is not a discriminatory practice if (a) any refusal, exclusion, expulsion, suspension, limitation, specification or preference in relation to any employment is established by an employer to be based on a bona fide occupational requirement;

For any practice mentioned in paragraph (1) (a) to be considered to be based on a bona fide occupational requirement and for any practice mentioned in paragraph (1)(g) to be considered to have a bona fide justification, it must be established that accommodation of the needs of an individual or a class of individuals affected would impose undue hardship on the person who would have to accommodate those needs, considering health, safety and cost.

This means that a worker can only be released from an organization if it can be shown that either their medical limitations cannot be accommodated within the workplace, based on a bona fide occupational requirement or the accommodation would create undue hardship.

There are instances where the worker's medical limitations are so significant or the organization so small that accommodation is not possible. In these cases alternative work outside of the worker's company may need to be explored.

In exploring other employment, consideration should initially be given to assisting workers in finding alternate employment within the same industry. This would allow them to be able to use the skills and knowledge they have gained in their previous occupation. If alternate employment cannot be found within the same industry, other jobs within other industries or retraining may be considered. Finally, self-employment may be an option, but great care should be taken if this direction is pursued due to the extremely high failure rate of starting a company

¹⁷ Also covered in Domain 1

If workers cannot return to their own job or an accommodated position with the company, the vocational rehabilitation professional may need the assistance of a vocational rehabilitation consultant. The consultant can provide expertise in vocational testing, occupational exploration, job search skills, and other aspects of finding alternative employment. This consultation is often done in conjunction with the insurance carrier.

It is the first priority of the return-to-work program to assist the injured or sick workers back to their own job or an accommodated position. However, in those rare cases when this is not possible, finding alternative employment outside the company is preferable to unemployment and the significant problems that could ensue

- **Duty to accommodate**

One of the key concepts of the Canadian Human Rights Act is the *duty to accommodate*. The duty to accommodate is the obligation to meaningfully incorporate diversity into the workplace. The duty to accommodate involves eliminating or changing rules, policies, practices and behaviours that discriminate against persons based on a group characteristic, such as race, national or ethnic origin, colour, religion, age, sex (including pregnancy), sexual orientation, marital status, family status and disability.

The duty to accommodate requires employers to identify and eliminate rules that have a discriminatory impact. Accommodation means changing the rule or practice to incorporate alternative arrangements that eliminate the discriminatory barriers.

Undue Hardship: The *Canadian Human Rights Act* requires that clients be accommodated up to the point of undue hardship. Undue hardship describes the limit, beyond which employers and service providers are not expected to accommodate. Undue hardship usually occurs when an employer or service provider cannot sustain the economic or efficiency costs of the accommodation.

There is no clear formula for deciding what costs represent undue hardship and there is no precise judicial definition of “undue hardship.” However, “undue hardship” implies that some hardship may be involved in the duty to accommodate. Employers and service providers are expected to exhaust all reasonable possibilities for accommodation before they can claim undue hardship. Some of the limits of undue hardship are:

- The financial costs of the method of accommodation
- The relative interchangeability of the workforce
- The possibility of substantial interference with the rights of other employees

- Safety
- The size of the operation
- The morale of other employees

Bona Fide Occupational Requirements: Discrimination against a client can occur if the employer can prove a legitimate business reason (as above). However, they must be able to demonstrate that the workplace rule, policy, standard or criteria relied upon is a “bona fide occupational requirement.”

The Supreme Court of Canada has established a three-step test for determining what seems like a discriminatory standard is instead a bona fide occupational requirement (BFOR). In order to prove that the standard is indeed a BFOR, the employer must demonstrate:

- that the employer adopted the standard for a purpose rationally connected to the performance of the job;
- that the employer adopted the particular standard in an honest and good faith belief that it was necessary to the fulfilment of that legitimate work-related purpose; and
- that the standard is reasonably necessary to the accomplishment of that legitimate work-related purpose

This approach is based on the need to develop standards that accommodate the potential contributions of all employees without imposing undue hardship on the employer. This is known as the employer’s “duty to accommodate.” Unless no accommodation is possible without imposing undue hardship, the standard at question is not a BFOR.

- **Canada Labour Code**

The Canada Labour Code is an Act of Parliament of the Canadian government to consolidate certain statutes respecting labour. Generally speaking, the code only applies to those industries in which the federal government has jurisdiction instead of the provinces. These industries include: broadcasting, telecommunications, chartered banks, postal service, airports and air transportation, shipping and navigation, interprovincial or international transportation (i.e. road, railway, ferry or pipeline). It also applies to businesses in the Territories, on First Nations reserves, and certain crown corporations. However, it does not apply to the Royal Canadian Mounted Police (RCMP) or military.

The Canada Labour Code is divided into three parts:

- i. Labour Relations – This part addresses collective bargaining, dispute resolution, strikes and lockouts.

- ii. Occupational Health and Safety – This part addresses maintaining health and safety of the worker at the workplace. It focuses on the recognition and prevention of hazards.
- iii. Employment Standards Act – This part deal with terms and conditions of employment concerning hours, wages, leave, holidays, and sexual harassment. It also sets the conditions for the termination of employment.

Provinces have similar legislation, which regulate labour relations, employment standards and workers health and safety.

7.8 Working with Unions

Research and experience has demonstrated that union involvement in a disability management program increases the likelihood of long-term success.

- **Role of union**

Unions play an important role in the workplace. Some of the key roles include being able to resolve workplace issues by being a voice for employees and acting as a representative during bargaining negotiations.

Other key features of unions include:

- Working with management to help resolve workplace issues
- Being an advocate for employees
- Ensuring employers are meeting their minimum obligations
- Looking into suspected breaches of
 - Workplace laws
 - Discrimination laws
 - Workplace safety laws

- **Shop steward**

Stewards maintain a sense of solidarity among union members and encourage collective activity to maintain the status of organized labor in the workplace. A steward assists co-workers in processing their employment grievances, and educates new and seasoned members on their responsibilities, union rules and expectations. Shop stewards act as liaisons between the company's management and its union workers to resolve labor-management issues before they escalate to matters that involve strikes or work stoppages. To be successful in this role, the shop steward must be familiar with the collective bargaining agreement and be able to interpret clauses that affect both labor and management actions.

A shop steward's primary job is the one they were hired by the company to perform. Employment by the company, is typically a shop steward requirement. For example, a construction company electrical worker who is also a shop steward must focus on installing electrical components. However, their secondary duties -- providing leadership and guidance to fellow union members -- are permissible during work time, which is usually a provision in the union contract.

The shop steward can be one of the greatest supports and advocate for the disability management program or can create significant difficulties. Their role is to advocate for the worker, and is extremely helpful that they see the disability management program as a benefit.

- **General Contract**

Typically unions and management sign a contract for a defined period of time which outlines a number of areas including:

- Wages
- Benefits
- Working conditions
- Job protection
- Time-off

Often the disability management program becomes part of the general contract as it is seen as a “benefit”.

- **Mediation/Arbitration**

Mediation and arbitration both involve finding a resolution to a dispute (usually over the interpretation or application of a written contract) and involve a third party (an arbitrator or mediator). However, the method by which resolution is reached is completely different in arbitration and mediation.

In mediation the parties (employer and union or other employee representative) to a labor-management dispute mutually select an impartial third party to help them reach agreement over a disputed issue or issues. The role of the mediator is to listen to the positions and interests of both parties, to make suggestions for resolution if appropriate, and to help them reach an agreement to which they can both commit. Mediation may be voluntary or imposed by legislation. The mediator has no authority to force the parties to come to an agreement and cannot impose his or her version of a good resolution upon them. Any suggestion he or she makes about what would be the “best” solution for the dispute is not binding upon the parties.

In arbitration the parties mutually select an impartial party to hear both parties’ positions and arguments, consider live witness (oral) testimony and documentary evidence if offered, and write an opinion and award resolving the issue in question.

The parties to arbitration generally agree in advance that the resulting award will be final and binding upon them. Most collective bargaining agreements contain a specific provision that addresses the arbitration of disputes. Sometimes an arbitrator will try to mediate a dispute prior to moving to arbitration. In such circumstances he or she tries to get the parties to resolve the dispute on their own without having a decision imposed upon them.

- **Grievance process**

Every Collective Agreement usually contains a grievance and arbitration procedure, though there are many variations in the actual process set out in each. The purpose of the procedure is to resolve disputes between employees and the union on the one side, and the employer on the other, in regards to matters covered by the Collective Agreement.

Essentially, the grievance process is the first process and arbitration is only pursued if the dispute is not resolved during the grievance process.

Grievance procedures usually have two or three *steps*, or *stages*, involving progressively higher levels of management and union representation. The grievance and arbitration clause will set out time limits for proceeding to each subsequent stage of the process.

Types of disputes

The most common dispute is whether a *discipline* or *discharge* was proper. Examples of other disputes that can be resolved using the grievance and arbitration procedure include a claim by an employee that the wage rate set out in the agreement has not been paid, that an overtime assignment was wrongly made, or that a safety shoe allowance has not been paid.

Employees are usually required to first discuss most complaints with their supervisor. If the supervisor cannot resolve the problem, then the dispute will proceed to higher levels of the grievance process in the search for a resolution.

In situations that impact many employees, unions usually have the right to submit a group complaint, often called a policy grievance. In a policy grievance no particular employee involved in filing the grievance is named.

Steps from grievance to arbitration

The right to go to higher levels in the grievance procedure and ultimately to arbitration is almost always the right of the trade union, not the employee. For various reasons, the union may decide not to pursue the employee's complaint.

If the matter is not resolved at some level of the grievance process, the union may take the matter to arbitration. Arbitration is a type of informal court. The arbitrator is the judge, but unlike the courts, this judge is paid for by both the union and the employer in equal amounts, regardless of who wins the case. The arbitrator can be selected by agreement or, if either the union or employer asks, the appropriate government agency.

Three person Boards of Arbitration were once popularly used. They consisted of the neutral arbitrator, an arbitrator appointed by the union and an arbitrator appointed by the employer. Not surprisingly, most decisions were two to one. Today, the use of a single arbitrator rather than a Board is common.

At an arbitration hearing, both sides present their case. Facts must be either agreed to, or proved by witnesses and other evidence such as documents. Following the hearing, which can take many days in complex situations, the arbitrator will usually take some time to consider the problem and then issue a written decision. The arbitrator's decision is legally binding and final.

- **Alternative dispute resolution**

This is a formalized process where the individuals involved in a dispute can resolve the issues (with the assistance of a neutral third party) prior to going to a formalized legal setting.

Review:

1. This is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual's health, social care, educational and employment needs, using communication and available resources to promote quality cost-effective outcomes.
 - a. Case management
 - b. Disability management
 - c. Psychotherapy
 - d. Counselling
2. Ideally, when should the case management process start:
 - a. At the point of maximum medical recovery
 - b. As soon after the onset of illness/injury as possible
 - c. At the point where the individual goes on short term disability
 - d. When fully ready to return to work
3. What is an insurance process where a determination is made regarding the individual's eligibility for benefits?
 - a. Claims processing
 - b. Claims intake
 - c. Claims adjudication
 - d. Claims certifying
4. The return to work model that focuses on the rehabilitation of the disabled worker is termed the:
 - a. Biopsychosocial model
 - b. Return to work model
 - c. Job matching model
 - d. Traditional (medical) model
5. The disability management model of return to work, promotes:
 - a. Solely the use of medical practitioners
 - b. Management/labour support and cooperation
 - c. Labour managed return to work
 - d. Management managed return to work
6. A disability management program's policies should include:
 - a. Roles and responsibilities
 - b. Eligibility
 - c. Process
 - d. All of the above
7. Return-to-work jobs should be:
 - a. Based on a listing of return-to-work jobs
 - b. Always in pre-disability job

- c. Productive and meaningful
 - d. Only be used in instances of minor disability
- 8. Intervention should only take place:
 - a. Early as possible
 - b. At time of full recovery
 - c. When the worker is ready to return to work
 - d. After diagnosis and/or treatment
- 9. Returning a disabled worker on a time-limited, part time or limited basis is referred to as:
 - a. Short term settlement
 - b. Permanent return to work
 - c. Auxiliary placement
 - d. Graduated return to work
- 10. The first step in developing an work place accommodation is:
 - a. Determine current functional abilities
 - b. Order assistive devices
 - c. Compare and rationalize functional needs vs. abilities
 - d. Generate accommodations options
- 11. According to the Canadian Charter of Human Rights and Freedoms, a Federally regulated organization needs to accommodate a disabled employee:
 - a. Only if there are more than 20 employees
 - b. Only in instances of severe injury/illness
 - c. Up to the point of financial hardship
 - d. Up to the point of undue hardship
- 12. A worker for the Federal government asks the vocational rehabilitation professional about the number of vacation days they should receive every year. The VRP could look at:
 - a. The Charter of Human Rights and Freedoms
 - b. The Canada Labour Code
 - c. The Canada Employment Code
 - d. The Canada Labour Relations Code

Answers

Case management – 7A
At soon after the onset of illness/injury as possible – 7.1
Claims adjudication – 7.2
Traditional (medical) model – 7.3
Management/labour support and cooperation – 7.4
All of the above – 7.4
Productive and meaningful – 7.4
Early as possible – 7.4
Graduated return to work – 7.6
Determine current functional abilities – 7.6
Up to the point of undue hardship – 7.7
The Canada Labour Code – 7.7

Domain 8

Ethical and Professional Conduct

Ethical and professional conduct should be at the heart of everything an individual does in their role as a vocational rehabilitation professional. This Domain examines the role that ethics play in the life of the individual and their interaction with their clients.

In order to make sound ethical decisions, the vocational rehabilitation professional needs to take care of their personal well-being. Poor decisions are made when the individual is tired, rushed or even hungry. Without careful consideration of one's physical and mental health they risk burnout, which causes damage not only to themselves but potentially their clients.

This Domain also looks closely at the entire field of ethics and how it intersects with the vocational rehabilitation profession. It examines history, schools of ethical thought and the specific ethical behaviours.

A. Personal Well-being

8.1 Personal well-being and impact on ethical decision making

Health and wellness promotion and the prevention of illness and injury are key concepts in vocational rehabilitation and should be maintained in day-to-day practice by setting an example or standard which workers and managers alike can emulate. By maintaining their own health and wellness, vocational rehabilitation professionals will be better able to manage the challenges faced each day related to complex issues, continuous change and variable workload.

Work life balance is also a concept that is spoken of often in most corporate wellness programs, and vocational rehabilitation professionals can again set an example by ensuring that they balance their work life demands with family time, social activities and a health regimen that includes healthy eating and regular exercise.

The vocational rehabilitation professional should develop a list of health and wellness goals for themselves and implement a plan to achieve each goal, with time lines and an outline of objectives to achieve each. This can be as simple as creating a journal to record daily activities, to joining social and exercise activities on a regular basis.

8.2 Burnout

Hard data on the prevalence of burnout is elusive since it's not yet a clinical term separate from stress. Some researchers say that as few as 7% of professionals have been seriously impacted by burnout. But others have documented rates as high as 50% among medical residents and 85% among financial professionals. A 2013 ComPsych survey of more than 5,100 North American workers found that 62% felt high levels of stress, loss of control, and extreme fatigue. Research has also linked burnout to many negative physical and mental health outcomes, including coronary artery disease, hypertension, sleep disturbances, depression, and anxiety, as well as to increased alcohol and drug use. Moreover, burnout has been shown to produce feelings of futility and alienation, undermine the quality of relationships, and diminish long-term career prospects.

There are three components to burnout:

- **Exhaustion:** comprises profound physical, cognitive, and emotional fatigue that undermines people's ability to work effectively and feel positive about what they're doing. This in turn makes positive ethical judgement difficult if not impossible.
- **Cynicism**, also called depersonalization, represents an erosion of engagement. It is essentially a way of distancing oneself psychologically from your work. Instead of feeling invested in your assignments, projects, colleagues, clients, and other collaborators, the individual feels detached, negative, and even callous. Cynicism can be the result of work overload, but it is also likely to occur in the presence of high conflict, unfairness, and lack of participation in decision making.
- **Inefficacy:** refers to feelings of incompetence and a lack of achievement and productivity. Vocational rehabilitation professionals with this symptom of burnout feel their skills slipping and worry that they won't be able to succeed in certain situations or accomplish certain tasks. It often develops in tandem with exhaustion and cynicism because people can't perform at their peak when they're out of fuel and have lost their connection to work. This could mean that the VRP begins to "second-guess" themselves in making ethical decisions.

It is imperative that the vocational rehabilitation professional self-identify when symptoms of burnout begin to occur. If identified there are a number of actions which can assist in either prevention or recovery:

- **Prioritize self-care.** It's essential to replenish physical and emotional energy, along with the capacity to focus, by prioritizing good sleep habits, nutrition, exercise, social connection, and practices that promote equanimity and well-being, like meditating, journaling, and enjoying nature.
- **Shift perspective.** While rest, relaxation, and replenishment can ease exhaustion, curb cynicism, and enhance efficacy, they don't fully address the root causes of burnout. The vocational rehabilitation professional should take a close look at their mindset and assumptions. What aspects of the situation are truly fixed, and which can you change? Altering perspective can buffer the negative impact of even the inflexible aspects.

- **Reduce exposure to job stressors.** The individual will also need to target high-value activities and relationships that still trigger unhealthy stress. This involves resetting the expectations of colleagues, clients, and even family members for what and how much they are willing to take on, as well as ground rules for working together.

8.3 Self-acceptance

Though related, self-acceptance is not the same as self-esteem. Whereas self-esteem refers specifically to how valuable, or worthwhile, we see ourselves, self-acceptance alludes to a far more global affirmation of self. When we're self-accepting, we're able to embrace *all* facets of ourselves--not just the positive, more "esteem-able" parts. As such, self-acceptance is unconditional, free of any qualification. We can recognize our weaknesses, limitations, and foibles, but this awareness in no way interferes with our ability to fully accept ourselves.

What Determines Our Self-Acceptance in the First Place?

In general, similar to self-esteem, as children we're able to accept ourselves only to the degree we feel accepted by our parents. Research has demonstrated that before the age of eight, we lack the ability to formulate a clear, separate sense of self--that is, other than that which has been transmitted to us by our caretakers. So if our parents were unable, or unwilling, to communicate the message that we were totally okay and acceptable--independent, that is, of our hard-to-control, sometimes errant behaviours--we were primed to view ourselves ambivalently. The positive regard we received from our parents may have depended almost totally on how we acted, and unfortunately we learned that many of our behaviours weren't acceptable to them. So, identifying ourselves with these objectionable behaviours, we inevitably came to see ourselves as in many ways inadequate.

Additionally, adverse parental evaluation can, and frequently does, go far beyond disapproving specific behaviours. For example, parents may transmit to us the overall message that we're selfish--or not attractive enough, smart enough, good or "nice" enough . . . and so on. As a result of what most mental health professionals would agree reflects a subtle form of emotional abuse, almost all of us come to regard ourselves as only *conditionally* acceptable. In consequence, we learn to regard many aspects of our self negatively, painfully internalizing feelings of rejection we too often experienced at the hands of overly critical parents. And this tendency toward *self-criticism* is at the heart of most of the problems that, as adults, we unwittingly create for ourselves.

In other words, given how the human psyche operates, it's almost impossible *not* to parent ourselves similarly to how we were parented originally. If our caretakers dealt with us in a hurtful manner, as adults we'll find all kinds of ways to perpetuate that unresolved pain onto ourselves. If we were frequently ignored, berated, blamed, chastised, or physically punished, we'll somehow contrive to continue this self-indignity. So when (figuratively, at least) we "beat ourselves up," we're typically just following our parents' lead. Having to depend so much on

them when we were young--and thus experiencing little authority to actually question their mixed verdict on us--we felt pretty much obliged to accept their negative appraisals as valid. This is hardly to say that they constantly put us down. But, historically, it's well-known that parents are far more likely to let us know when we do something that bothers them than to acknowledge us for our more positive, pro-social behaviours.

In fully comprehending our current reservations about ourselves, we also need to add the disapproval and criticism we may have been received from siblings, other relatives, teachers--and, especially, our peers, who (struggling with their own self-doubts) could hardly resist making fun of our frailties whenever we innocently "exposed" them. At any rate, it's safe to assume that almost all of us enter adulthood afflicted with a certain negative bias. We share a common tendency to blame ourselves, or to see ourselves as in some way defective. It's as though we all, to whatever degree, suffer from the same chronic "virus" of self-doubt.

8.4 Personal growth

In order to be an effective as a vocational rehabilitation professional, the individual must be able to reflect upon, recognize and develop their personal values and attitudes. Being able to identify how they think and feel about certain issues, for instance, those related to older people and people with disabilities will enable the individual to understand how their personal views might impact on their role. Being empathetic, unbiased and non-judgmental are essential attributes if you intend to work in this field. It is important to understand personal values and attitudes because it enhances the individual's professionalism and ethical work practice.

8.5 Purpose in life

By finding a 'purpose in life' the individual develops strong goal orientation and conviction that life holds meaning. This does not necessarily have a "religious" connotation, rather it means any central organization feature that gives the individual a purpose for his or her life. Those who have developed a purpose in life have a greater sense of personal well-being.

8.6 Environmental mastery

An individual who has environmental mastery makes effective use of opportunities and has a sense of mastery in managing environmental factors and activities, including managing everyday affairs and creating situations to benefit personal needs.

8.7 Autonomy

An individual who has a sense of autonomy is independent and regulates his or her behaviour independent of social pressures.

8.8 Positive relations with others

A positive relationship with other means the individual engages in meaningful relationships with others that include reciprocal empathy, intimacy, and affection.

B. Factors Influencing Unethical Behaviour

Every professional must sign a Code of Ethics and promise to follow them in the course of their work with clients. However, every year there are ethical complaints against vocational rehabilitation professionals who are not complying with these obligations. It could be assumed that for every formal ethical complaint there are probably dozens of unethical actions which are not reported. Are those who breach their ethical obligations “bad people” or are there other factors going on that create situations where good people do bad things. Often times unethical acts are not what is done but what is “not done” (nonfeasance). Over the past number of years research has been undertaken to make a determination of why good people can perform unethical behaviours. Some of the factors which create this type of situation include:

8.9 Self-Image:

It is clear that unless an individual is purposefully malevolent (e.g. the disposition to bring pain or misery to another) they do not wake up in the morning planning to make unethical decisions. Invariably we think of ourselves as ethical individuals who make well-reasoned and moral decisions. Researchers looked at how people’ expectations of themselves determined their behaviour¹⁶⁸. They looked at whether a change in self-image led to different behaviour. They also examined whether people saw themselves as “heteronomous” (a product of circumstance and lack free will) or “autonomous (immune to circumstances and possessing free will) were more susceptible to unethical behaviour.

They had participants take a math test on computers. The subjects were told that due to a software error the answers might appear on the screen. To prevent this, the participants were asked to press the spacebar immediately for each new question. In reality the researchers observed whether the participants secretly used the answers, instead of doing the calculations themselves. Before the participants took the test, the researchers also did something else. They used an established method to imprint an idea on the participants (a process known as *priming* in the literature), in this case a conviction regarding free will. Some of the students were required to read an article stating that science refutes the notion of free will and that the illusion of free will is a product of the biochemical make-up of the brain. Other participants did not receive this reading material. In reading the article the first group was more inclined to believe that free will does not exist.

The results were clear. Those with a weaker conviction regarding free will (and therefore the extent to which they could determine their own behaviour and future) were more inclined to cheat than those whose convictions were not influenced. The first group cheated approximately 45 percent more than the second group. If people see themselves as responsible, they will be more inclined to take responsibility and behave responsibly. If people can hide behind other factors, such as the idea that their will is preprogrammed and their behaviour is predestined, they are more likely to behave dishonestly. In a second experiment it became apparent that the participants primed beforehand with the idea that people have free will were less inclined to steal money.

It is therefore important to examine one's self-image. Whether we see ourselves as playthings (heteronomous) or as players (autonomous) makes a difference to our behaviour. If we see ourselves as heteronomous, we are more likely to succumb to pressure and temptation than if we see ourselves as autonomous. The same applies to vocational rehabilitation professionals who see themselves as a product of their environment bend with the wind and are unable to show any backbone. This then paves the way for unethical behaviour, as a reaction to declining referrals, because the fee-payer asks for it, or because the government issues incomprehensible laws. Ethical behaviour likewise begins with a self-image of autonomy.

Example: A vocational rehabilitation professional works for a large bureaucratic organization which has not only government laws overseeing its operation but regulations, guidelines and standards of practice. Each step of the vocational rehabilitation process is guided by innumerable rules and policies. The VRP in this type of system can come to believe that they have very limited freedom and are forced to follow the organization's directions. In these situations, without a perception of freedom, it is easier for the person to commit unethical acts and point to the organization as the reason. The VRP gives up their ethical decision as they see themselves as a "cog in the organization's machinery".

8.10 Personal Biases:

Another concept that impacts ethical decision making is an individual's personal bias. It is clear that personal "biases" play a significant role in making ethical decisions. Individuals can have a distorted view of reality, because they cannot observe reality objectively. A large body of research shows that the majority of people see themselves as above average. The majority of people, for example, think themselves more intelligent, better looking, funnier and better at driving than average¹⁶⁹. The majority also consider themselves more honest, more trustworthy, more ethical, more fair, more open and more helpful than average. When married couples are asked about their own share of the household chores, the estimates often come out well above 100 percent. When scientists are asked about their own contribution to a jointly written article, again the sum often easily exceeds 100 percent. It has been found that at least 90 percent of managers consider themselves to function above average. This effect of overestimation is also called the 'dodo effect', named after the passage in *Alice in Wonderland* in which the dodo, in

response to the question who of all the animals won a running race, replies that 'everyone won'. It is not uncommon for vocational rehabilitation professionals to be judgemental of the unethical behaviours of others, particularly in other organization. They see themselves as more ethical, more honest and more trustworthy compared to others.

Biases are stubborn things. Once we have approached information in a distorted way, it is difficult to reinterpret the same information more even-handedly. It is therefore important to be aware of the existence of biases. And especially the biggest bias of all: that we consider others more biased than ourselves.

8.11 Euphemisms:

A few years ago there was a news story about a man named Daniel who had been degraded and tortured by colleagues in a factory over a period of 10 years. Daniel was tied down on a pallet while a colleague pushed his genitals into his face. They locked him in a cage, poured 25 kilos of talcum powder over him and went to work on him with a pressure washer. His colleagues found this completely unremarkable. One of them Lucien, claimed it was "normal in the company." It happens frequently. That's why he filmed Daniel being mistreated. He thought of it as "joking around" rather than bullying.

What happened here is a common occurrence: the use of euphemisms strips unethical practices of their moral connotations. Bribery becomes 'oiling the wheels' or 'service costs', stealing becomes 'pinching' and 'freeloading' and sleeping at work (something 42 percent of workers admit to having done) becomes 'recharging' or 'having a quiet moment'. By labeling things differently we take the ethical sting out of them and make them acceptable, normal or even desirable. Bullying is wrong, but if it is defined as 'joking around' then it becomes a social activity. So, for the sake of being sociable, Daniel's colleagues tied him to a pallet, laughed about it and filmed him so they could enjoy it again later. According to Albert Bandura, who has written on this topic, euphemisms are a dangerous weapon. They close people's eyes and ears to what is morally questionable¹⁷⁰.

Euphemisms can be very subtle and may not raise "red flags" regarding unethical behaviour.

For example: Every Friday afternoon a vocational rehabilitation company had a staff meeting with their 10 VRPs. During this meeting each of the employees would go through the list of the clients they were working with and a one sentence statement regarding where they were in the process. No discussions were held about the client; rather it was solely a listing of names and status. At the end of the month these staff meetings were billed to the third party payer as "staff consultation". This euphemism would lead the funder to believe that the time being billed was spent discussing the client and the job entry process (as such seen as a legitimate charge). Rather the company billed for each staff member in the room when the client's name was brought up. As they billed in fifteen minute segments it added up to a considerable amount of billed time (10 employees X 15 minutes X hourly rate). In short they billed two and

one-half hours for an action that took less than 10 seconds. This activity went on for years, without it being raised as a concern by any of the VRP's.

8.12 Time Pressure:

We often think of "time pressure" in negative terms; but for some being under the gun is a positive thing. They get their most productive work accomplished when they are feeling the pressure of a due date. Unfortunately, there are also some negative aspects to time pressure.

An experiment was undertaken where the subjects were theology students who were assigned the task of giving a short sermon about the Bible story of the Good Samaritan. In this story a Jewish man on his way from Jerusalem to Jericho is attacked by robbers and abandoned. Various role models who stood for piety at the time, such as a priest and a Levite, saw the man lying there but passed him without helping. Then a Samaritan came along. Although Jews were the enemies of the Samaritans, the Samaritan cared for the Jewish man and brought him to a hostel, where he paid for his stay. The theme of the sermon was 'helpfulness'. After the students were finished with their preparations they were told that the sermon would be filmed in another building on the university campus. The theology instructor gave them directions. On the way to the other building they passed a man who needed help. This man, who was part of the researchers' plan, appeared to have collapsed in the doorway. His head was bowed and his eyes were closed. At the moment that the student passed him, he gave a well-practiced groan and coughed twice. Would the theology students help the man?

When the theology students received plenty of time to walk to the other building, they almost all helped the man, but when the researchers ensured that the students set off late, the proportion prepared to help fell to 63 percent. More than a third of the students did not stop for the man. But here's the real shock. When the instructor encouraged the students to get to the other building as fast as possible, because there was no time to lose, the percentage plummeted, only 10 percent still stopping to help. Of the theology students on their way to preach about helpfulness, 90 percent ignored a man in need of help. Some students even stepped over him.

Despite the best of intentions, under time pressure we can still end up ignoring people who need our help. We no longer even see that others need us. After all, we are busy doing important things. Time pressure causes moral blindness: we shut down our senses partially or completely, even as we preach that it is important to help others. Time pressure can also lead to tasks not being carried out well or being rushed. This leads us to make mistakes more easily¹⁷¹.

Example: Most VRP's are under considerable time pressure. They have an active case load of clients that demand their time, they have reports to prepare, job sites to visit, employers to placate, managers who want things done yesterday, phone calls to return, etc. etc. etc. In addition to their work responsibilities, many have full personal lives with all its demands. A

vocational rehabilitation professional with all these pressures could take short cuts to get their job done. Or rather than spending a few minutes with a client to figure out why they are resistant in returning to work; cut them off benefits due to “non-cooperation”.

8.13 Cognitive Dissonance:

Another manner in which individuals who commit unethical behaviours can justify their actions is through a psychological phenomenon called “cognitive dissonance”. Cognitive dissonance refers to the discomfort arising from holding conflicting cognitions. Cognitions are pieces of knowledge, ideas or convictions. Cognitive dissonance arises under a conflict between beliefs, or between belief and behaviour (believing one thing and doing another). These contradictory cognitions force our minds to seek out new thoughts or ideas, or to adjust our current beliefs to reduce the dissonance between the cognitions. For example, if we want to stop smoking (cognition) but are unable to resist the temptation to light up again (behaviour), this causes tension between cognition and behaviour. Cognitive dissonance irritates, causes stress and saps energy. It can even harm people’s positive self-image. We find it difficult to live with ourselves when we consider ourselves worthless. We want to see ourselves as rational and honest, so we think up reasons, often subconsciously, to reconcile the conflicting cognitions.

Research shows that chain smokers who tried to stop smoking failed because they managed to play down the risks of smoking to themselves. We call this ‘rationalization’: we come up with a reason for unreasonable behaviour. We talk black into white and vice versa. A great deal of research has been done on the rationalization and neutralization techniques people apply. Classic research among young offenders by Gresham Sykes and David Matza¹⁷² from the fifties illustrates five rationalizations. Denying one’s own responsibility (‘It’s not my fault’); denying the damage or disadvantage to the other party (‘No one will suffer for this’, ‘What they don’t know won’t hurt them’); denying a victim (‘They asked for it’, ‘You get what you deserve’); condemning those who condemn the misdemeanor (‘They should take a look at themselves’, ‘He started it’); and blaming their action on loyalty to another (‘I didn’t do it for myself’). Later research among other groups brought a number of other rationalizations to light. Often the image of a balance is raised (‘On balance I’ve done more good than bad’); people point to others (‘Everyone does it’); negative intentions are denied (‘It was only a joke’); and people call on relative acceptability (‘Others are worse than me’). If this kind of argument is used in the workplace, then it’s time to intervene to address the flimsiness of the arguments and ideas.

Leon Festinger was the founder of cognitive dissonance theory. A classic experiment by Festinger and Merrill Carlsmith¹⁷³ shows how quickly rationalizations occur and how quickly they lead to adjusted norms when people are unable to find external justifications. The participants were required to continually turn a number of pegs 90 degrees for 20 minutes. This was a pointless and boring exercise. The participants were subsequently asked to convince a new participant that this exercise was very interesting, to get this person to set to work too. Half the participants were given the prospect of earning 1 dollar for this, and the other half 20

dollars. Afterwards the participants were asked how interesting they actually found turning the pegs. What were the results? The participants who received 20 dollars found the exercise less interesting than the participants who received 1 dollar. This is surprising. Surely the participants all did the same exercise? What happened? The participants who received 20 dollars could justify lying to the other person by the high sum they received for it. The other group had no external reason strong enough to lie, so they had to convince themselves. They achieved this by telling themselves that turning the pegs was actually quite fun. This made them believe they were telling the truth to the newcomers.

Festinger and Carlsmith's experiment shows the danger of rationalizations. We can lie with dry eyes because we have made ourselves blind to the truth. We take a moral day off, as Sykes and Matza call it. Moral objections are swept under the table or temporarily switched off. The greater the cognitive dissonance, the greater the motivation to close this gap. People use rationalizations to build up protection against accusations, from themselves and others. This promotes moral blindness and opens the door to new transgressions. Morals are sent on vacation, and we continue to see ourselves as honest. As Bernard Ebbers said to his fellow church-goers, after the fraud at his company became known, 'I just want you to know you aren't going to church with a crook. No one will find me to have knowingly committed fraud.' In the end he was convicted of fraud and sentenced to 25 years in prison.

Example: Even though the profession's Code of Ethics and societal norms clearly point out that it is unethical for a vocational rehabilitation professional to have an intimate relationship with a client, there are occasions when this does happen. When this occurs the VRP knows that it is unethical (thought) but carries still undertakes the relationship (behaviour). Cognitive dissonance occurs between thought and behaviour, which creates psychological pain. In order to diminish this pain the individual can either stop the behaviour or change the thought process. If the behaviour continues the VRP could think such things as: "It was a consensual between two adults so there was nothing wrong." "You can't help loving another person no matter the setting." "It was the client's fault; I was seduced." Etc. By changing the thought process the dissonance disappears. Unethical behaviour can be rationalized to the point where a clear ethical violation may be seen as something neutral or in extreme cases "positive" (I was helping the client.).

8.14 Tired or Hungry:

Many organizations have started "Wellness Programs" over the last number of years as there is mounting evidence that an unhealthy life style diminishes productivity at the work place. Vocational rehabilitation professionals are known for their hard work and compassion; which occasionally leads to negative outcomes. Some VRP's are so focused on giving to others that they forget about their own health and wellbeing. Not surprisingly research has shown that tired or hungry individuals make poor ethical choices.

Tiredness is one of the reasons for the loss of self-control, resulting in increased chances of fraud and cheating. Nicole Mead and colleagues¹⁷⁴ established this in their research. They began by making half of the participants in their study mentally tired. They did this by getting the participants to write a short essay without the letters A and N. Because these are common letters, the task required a great deal of energy. The other half had it easy; they too were required to write a short essay, but in their case without the rare letters X and Z. The participants were then required to complete a math task of finding the pairs which added up to 10 exactly within five minutes. For every question answered correctly the participants received 25 cents. Half of each group was required to hand in their answer forms so that the researchers could check them. The other half could check their own answers and pay themselves.

The non-tired participants in the self-checking group claimed to have completed 25 percent more correct tasks than the group checked by the researchers. Among the tired participants, however, the difference was much larger: those who were permitted to determine their own score claimed to have correctly completed no less than 104 percent more tasks than those judged by the researchers. The experiment shows that mental fatigue leads to reduced self-control. We become too tired to be honest. Our moral muscle deteriorates, causing us to succumb more readily to moments of weakness.

Besides training, rest is important, as much for our moral as for our physical muscles. Research by William Killgore and colleagues¹⁷⁵ shows that lack of sleep leads to slower moral decision making. In their study the participants were required to pass judgment on the behaviour of others in a variety of difficult situations. Half of the group was well-rested; the other half had not been allowed to sleep for a long time. There was barely any difference in the time taken by the two groups to judge behaviour in practical dilemmas, but in moral dilemmas the sleep-deprived participants took considerably longer to come to a judgment than those who were rested. Killgore's explanation is that tiredness makes it more difficult to integrate emotion and cognition, and it is this integration which is important in moral dilemmas.

People who regularly get too little sleep due to their work, and who are confronted with a variety of moral dilemmas, as vocational rehabilitation professionals should therefore be extra alert to the risk of taking moral decisions more slowly and also differently from other people. The same goes for directors and managers who work long days and only get a short night's sleep. Even entire organizations can suffer fatigue, for instance from frequent reorganizations, and project and personnel changes. This fatigue comes at the cost of ethical decision making, as the decisions become too emotional and impulsive, or indeed too rational and detached.

Another thing that is important for our moral muscle is food. Research by Matthew Gailliot and Roy Baumeister¹⁷⁶ shows that, like physical effort, activities which require self-control lower blood sugar levels. Discipline requires energy from our brains, which is supplied in the form of sugar. The lower the glucose level, the lower the self-control. A great deal of research shows that criminals, frauds, vandals and traffic offenders, suffer more than average with hypoglycemia, low blood glucose. Sugar is therefore important for our self-control. When

Gailliot and Baumeister gave the participants in their research a sugary drink, their blood sugar levels increased, and subsequently their self-control and moral behaviour. This also explains the findings of another study, in which participants who skipped breakfast had less self-control. Not only is eating breakfast good, sugary food in the company canteen also helps to keep people on the straight and narrow (unless your goal is to lose weight).

Bertolt Brecht was therefore right. In his *Threepenny Opera* (Dreigroschenoper) the gangsters act like respectable businessmen and vice versa. The theme song is 'Erst kommt das Fressen, dann kommt die Moral' (Food first, then morality). So it is important to establish that organizations do not suffer from hypoglycemia as well as a lack of sleep.

Example: It is not uncommon for a VRP to have a desk-load of work to finish in a short time frame. In order to get ready to take a vacation a vocational rehabilitation professional wants to clean up all of the outstanding work prior to leaving. In order to do that he works late into the night for a few days and skips some meals. On the last night before his vacation he has only had 10 hours sleep over the past three nights and has not eaten since breakfast. He is tired and his sugar level is low. He needs to make decisions regarding the cases on his desk so he can leave the desk clean and be able to relax during his vacation time. He looks at a particularly complication file that would require a lot of thinking to set in the right direction. As he is hungry and tired he lacks the capacity to think clearly and thus makes rash decisions rather than well-thought-out reasoned decisions.

These are only a partial listing of the reasons why unethical decisions are made by good people. It is often thought that immoral behaviours are only done by individuals with defective moral compasses. This does not seem to be the case. Unless vigilant anyone can make a poor decision which directly impacts on not only their own credibility but could affect the lives of clients, their families, employers, insurers, and other key stakeholders.

C. Foundation of Ethical Conduct

8.15 Criteria for “professional”

For those in a work activity to be called a “profession” a number of criteria must be met:

- Academic education – there needs to be a common education obtained by all members. Typically, this education is provided in formalized higher education institutions such as colleges and university.
- Importance of service provided – society must recognize that the services provided are important.
- Professional degree – in most professions there is a requirement to obtain at least an undergraduate degree. Most senior professions require a masters or doctoral level degree from a recognized university.

- Professional association – those in a profession have an association that supports their field and assures that those practicing are provided avenues to ongoing education.
- Autonomy – in providing services the practitioner, even when working in a team, operates autonomously in fulfilling their roles.
- Ethical code – professionals also are required a “Code of Ethics” which comes from their professional association or college.

8.16 Differences Code of Conduct and Code of Ethics

A Code of Ethics is a document, usually issued by a board of directors that outlines a set of principles that affect decision-making. For example, a code of ethics might stipulate that XYZ Corporation is committed to environmental protection and green initiatives. The expectation is that individual employees, when faced with the option, will select the greenest solution. The Caux Roundtable, a business-ethics think tank, argues for Codes of Ethics by noting that, "The self-interested pursuit of profit, with no concern for other stakeholders, will ultimately lead to business failure and, at times, to counterproductive regulation. Consequently, business leaders must always assert ethical leadership so as to protect the foundations of sustainable prosperity."

A Code of Conduct typically is issued by a board of directors; however, it outlines specific behaviours that are required or prohibited as a condition of ongoing employment. A code of conduct might forbid sexual harassment, racial intimidation or viewing inappropriate or unauthorized content on company computers. These are rigorous standards that usually are tightly enforced by company leaders. Ethics consultant Cornelius von Baeyer notes that, "There is considerable information that codes, along with other measures, have helped pull some companies out of the morass of scandal, and have helped many companies build a healthier work climate and reputation."

Both codes are similar insofar as they attempt to encourage specific forms of behaviour by employees. Ethics guidelines attempt to provide guidance about values and choices to influence decision-making, whereas conduct regulations assert that some specific actions are appropriate or inappropriate. In both cases, the company's desire is to obtain a narrow range of acceptable behaviours from employees.

The codes attempt to regulate behaviour in very different ways. Ethical standards generally are wide-ranging and non-specific, designed to provide a set of values or decision-making approaches that enable employees to make independent judgments about the most appropriate course of action. Conduct standards generally require little judgment; you obey or incur a penalty, and the code provides a fairly clear set of expectations about which actions are required, acceptable or prohibited.

For the vocational rehabilitation professional their professional Code of Ethics and Code of Conduct are for the purpose of protecting clients from harm.

8.17 Personal versus professional morals/ethics

Ethics is a word that can be used loosely, so it's important to understand the meaning of this question by first discussing what is meant by personal ethics or professional ethics. Usually personal ethics refers to one's conscience and the term professional ethics means adherence to a professional code.

On occasions these two roles can come into conflict. For example, some doctors have refused to prescribe the "morning-after" pill, because they believe it will terminate a human life. In this case the doctor has decided that his personal ethics will guide him or her. Alternatively, a police officer may enforce a law that they personally believe is unjust. In this case the police officer has decided to put aside personal concerns and allow professional obligations to guide his or her behaviour. Likewise a judge may follow the law and impose the death penalty even though he or she may be personally opposed to it. There are instances where a vocational rehabilitation professional may be asked to services to an individual who has a history of spousal abuse. In this instance the Consultant would decide to put aside his or her personal revulsion to this type of behaviour and to be guided by professional standard of practice.

The resolution of ethical dilemma caused by a difference between personal and profession ethics can be viewed in a couple of ways. One manner of resolution would be by drawing a line between an individual's role as a professional and their role as an individual. The person can decide to follow a professional code of ethics when they are acting as a professional even though they may personally disagree. However, if the person's professional obligation put the individual in such a state of conflict that they felt could not uphold their personal ethic, then they have the option of resigning. Using this method means that the individual has both a personal and professional codes of ethics which are separate but interdependent. In particular situations the individual's personal code of conduct takes precedence and in other the individual's professional code of conduct is supreme.

Another manner of resolution is seeing "ethics" as encompassing both the individual and professional codes of conducts. Ethics, which is the practice of becoming excellent at being human according to Socrates, is always conducted with respect to something. At first glance, we might think that personal (which is to say private, or pertaining to one's life outside of work) and professional (which is to say public, or pertaining to one's work life) are two separate categories, but perhaps this distinction is false. Rather, they are two aspects of the same realm: namely, part of being human and functioning in the world. Thus, personal ethics can be seen as more general, and is simply "practicing becoming an excellent human being" with respect to people and situations in everyday life (our family, our friends, our community). Professional ethics can be seen as more specific, and is "practicing becoming an excellent human being" with respect people and situations in work life (co-workers, clients, other professionals, the organization).

The basic underlying ethical values and commitments remain the same, but how they are enacted may differ. For example, honesty is a virtue which is vital in both personal and professional settings. However, the amount and type of information which one discloses to their spouse is much different than the amount and type of information which one discloses to their boss, their client, or other professionals. Further, the way in which the individual handles these situations differs. For example, accurate financial disclosure is a type of honesty. Financial disclosure within a person's household might mean that budgeting software is up to date and used regularly, but financial disclosure within a company may mean the individual needs to comply with accounting principles and laws. A person can use whatever accounting system they like in the household, as long as the bills get paid. One cannot, however, make up their own accounting system for use in a company, because there are specific traditions and laws to be followed in order to demonstrate that the person is truly being honest.

There is often extensive discussion within the profession regarding the adherence to the Code of Ethics; with little mention of a personal ethical framework. However, there are situations that a vocational rehabilitation professional's personal "belief" system may come into conflict with his or her professional code of ethics. Without examination of one's personal ethics this could create, at the very least, an uncomfortable decision making process.

Example: A vocational rehabilitation professional is undertaking return-to-work planning with a worker with a disability. As part of the planning they do a home visit to conduct an initial vocational plan. When they enter the client's home there is an overwhelming smell of marijuana. As the client lives by themselves it is clear that they were the one's partaking in the activity. How the vocational rehabilitation professional reacts to this situation may be dependent on their personal code of ethics. For one VRC their view is that smoking marijuana is an illegal act they believe should be reported, at least to the insurer and perhaps to the local authorities. For another VRC they may believe that smoking marijuana is a personal preference and "none of their business", they may do nothing

If these two VRC's are questioned about their decisions regarding the client smoking marijuana they both could point to the profession's Code of Ethics for support. For the one who finds this activity as illegal they could point to those sections of the Code which detail the relationship they have to third party fee-payers. For the one who finds the activity a personal decision, they could point to those sections of the Code which detail the autonomy of the client.

Clearly there is an interaction between one's personal code of ethics and professional code of ethics. Our personal code of ethics can be impacted by our background, education, family, religious affiliation, community or a myriad of other factors. It may be rigid and adhered to over time and settings. Or it may be fluid and change depending on "how we feel" at the moment. Every person has a personal code of ethics even if it is not thought about or consciously delineated. It impacts how we see and interact with the world.

A professional Code of Ethics is adopted by organizations to assist members in understanding the difference between 'right' and 'wrong' and in applying that understanding to their

decisions. Professional Codes of Ethics are typically based on a foundation of agreed upon “principles”. Out of these principles there is a determination on their impact on the profession. For example the principle of “veracity” (telling the truth) may be seen as important. From this the profession develops codes of conduct that define what veracity means in dealing with clients, third parties, the public, etc. As novel situations arise or with the development of new technology more and more codes need to be added to take these into account.

Regardless if one is making decisions based on his or her personal or professional code there are instances when individuals will disagree what constitutes ethical conduct. Such situations require the ability to think clearly and creatively about the rationale for belief and values; the ability to identify priority values and if possible to reframe problems so that solutions are in concert with the values of all concerned.

8.18 Ethical Inquiries

There are three types of ethical inquiries: normative ethics, meta-ethics and descriptive ethics. The first type, **normative ethics**, is the study of “ethical” action. It investigates a set of questions which arise when considering how one “ought to act”. It attempts to derive its standards of right and wrong from subjectively interpreted social behaviours.

Examples of behaviours which are judged to be right or wrong within this type of ethical inquiry would be: lying, honesty, stealing, etc. In summary, normative ethics attempts to discover the standards of right and wrong within the end-product of things like honesty and not within the origins of the natural laws that dictate what is right and wrong.

There are four normative theories:

- Utilitarianism with the principle of utility as the basic moral principle
- Kantianism with the categorical imperative as the fundamental moral principle
- Ethical intuitionism with the plurality of moral principles and
- Virtue ethics with virtues as its focus

Professional Codes of Ethics are an example of normative ethics. The Vocational Rehabilitation Association of Canada’s Code of Ethics is a specific ethical standard for vocational rehabilitation professionals. Section 1 states in part that the vocational rehabilitation professional agrees to “Ethical Standards and Professional Conduct is a specific ethical standard for Disability Management Professionals. Section 1 states in part that the Disability Management Professional agrees to “respect the dignity, autonomy, self-determination, and rights of all persons with whom they interact in a professional capacity”. This is an example of normative ethics as it lays out specifics of what is right.

Meta-ethics is not an enquiry of what “ought to be done”; rather it is concerned with understanding the language of morality through an analysis of the meaning of ethical related

concepts and theories. This type of examination looks at the meaning of such things as virtuous character, goodness and happiness.

Meta-ethics is concerned with determining the nature of judgments of moral right or wrong, good and bad. It is not concerned with finding out which actions or things are right and wrong, or which states are good and bad, but with understanding the nature and meaning of concepts of right and wrong, good and bad. Meta-ethics does not ask whether lying is always wrong. Rather, it tries to ascertain whether there really is a difference between right and wrong, or tries to clarify what it means to say that an action is right or wrong. A meta-ethical inquiry may ask: What, if anything, makes a judgment that lying is always wrong, true (or false)?

The final area of ethical inquiry is **descriptive ethics**. This is often seen as scientific inquiry rather than an ethical enquiry. Individuals working in the area of descriptive ethics aim to uncover people's belief about such things as values, which actions are right and wrong. An example of this could be someone doing an investigation on vocational rehabilitation professional's attitudes regarding being transparent and honest in their discussions with those they are providing service.

8.19 Ethical Perspectives

Ethical thoughts and reasoning fall along a continuum from ethical relativism to ethical objectivism. Ethical relativism is a belief that it is acceptable for ethics and morality to differ among people and societies. There are two main types of ethical relativism: ethical subjectivism and cultural subjectivism. Individuals who follow an ethical subjectivism perspective believe that there are no moral absolutes and that individuals create their own morality. People's beliefs about actions being right or wrong depends on how people feel about actions rather than on reason or systematic ethical analysis. On the other hand, cultural relativism is an ethical theory that moral evaluation is rooted in a particular culture, and hence, what is right or wrong in one culture may not be so in another.

At the other end of the spectrum is ethical objectivism. This is the belief that universal or moral objective principles exist. Examples of this type of ethical approach would include natural law theory, deontology and utilitarianism. Individuals who follow this line of reasoning believe that moral truths exist independently from opinion. "Moral facts" are like "physical" facts in that what the facts are does not depend on what anyone thinks they are.

8.20 Brief Historical Overview of the History of Ethics

The scope of this course is not broad or long enough to deal adequately with the rich history of ethics from around the world. Rather, the focus will be on the Greco-Roman tradition that, for the most part, impacts most directly the thinking and actions of individuals within our culture.

Socrates (469 – 399 BCE)

Many historians and philosophers look to Socrates as the start of modern philosophy and ethics. It is not because he was the first, but his thoughts and influence created an immense change in the manner individuals would think and see the world.

In the 5th Century BC, the City-State of Athens was seen to be the centre of the world's intellectual life. This century was viewed as the "Golden Age of Pericles" and it came to epitomize the height of Athenian culture and democracy. The Parthenon was being built, the plays of Sophocles and Euripides were being written and the citizens of Athens enjoyed political freedom.

As Robert Cavalier pointed out:

At the time of Socrates, Greek culture already had a long history. Through a series of migrations/invasions, early Greek civilization had achieved its first high point during the Mycenaean Period (c. 1,150-1,000 BCE). The epic Battle of Troy (c. 1,200 BCE) was later to be retold by Homer (c. 750 BCE) in the Iliad and the Odyssey. These stories (mythoi) were emblematic of the Greek self-understanding as it withstood a series of invasions from Persia during the opening of the Fifth Century. And it was this century that was to witness the Golden Age of Pericles as well as the decline and downfall of Athens. It was also this setting that provided the cultural context for the writings of Plato and Aristotle in the Fourth Century BCE.¹⁷⁷

Unfortunately, we have no original writings of Socrates. Rather, our understanding is derived from the testimonies of others – most notably Plato, Xenophon and Aristophanes.

Prior to Socrates, philosophy and ethics was in the realm of "religion". Socrates, was the first major philosopher to examine the area of "values" separate from religion.

In the Apology, he describes the events that shaped his approach to philosophy. Socrates' friend journeyed to the shrine of Apollo at Delphi and asked the Oracle whether there was anyone wiser than Socrates. Apollo, speaking through the Oracle, said there was no one wiser than Socrates. Socrates had a problem with this answer and set out to prove that the priestess was wrong. To do this he began to question Athenians who had a reputation for wisdom (politicians, poets and artists). What he found was that none of those who were considered "wise" possessed "wisdom". In the end Socrates concluded that Apollo was correct, in that he was much wiser than others. He reasoned that he was wise because he knew how ignorant he was, whereas those who he interviewed did not.

His "ignorance" was the starting point of Socrates' philosophy. In understanding his philosophy it is important to realize that by feigning ignorance, he was able to seduce others into making moral claims, and able to show them how little they actually knew about the topic being discussed.

Plato described Socrates' method of argument as "elenchus" or examination. Socrates does not lecture, nor does he provide answers to the questions he raises; instead, he asks questions of others that lead them to the truth. In most of these discussions, the dialogue ends inconclusively, with the individual being at a complete loss to know what he truly believes.

The heart of Socrates ideas were always ethical. He believed that if one knows what the good is, one will always do what is good.

Prior to him, ethics was grounded in the world of religion. An example of this was from the story of Euthyphro. He as a pious man, who took his father to trial because of his father's involvement in the death of a slave. When he was questioned by Socrates about this course of action, Euthyphro claimed that his actions were right because, among other reasons, "the gods would agree".

A summary of Socrates arguments against such a position, could be:

- If something is right because god says so, then "good" is dependent on the will of god.
- If something is right because it is right, then good is independent of the will of god.

The first interpretation would mean that "ethics" is obedience to the will of god. The second interpretation would mean that "ethics" is different than theology and could be studied as a separate form of thought. He also believed that by doing "good" it would lead the person to happiness.

Ultimately, this second definition of good (and as such, evil) is separate from religion and stands alone as a potential area of consideration and thought. This type of argument was disruptive to Athenian society and worked against Socrates. As a result of this "heresy" he was eventually put to death.

Plato (427 – 347 BCE)

Plato was also an Athenian and a friend of Socrates. Much of what we now know about the philosophy and ethical consideration of Socrates are conveyed through the writings of Plato. But Plato is a significant and historically significant figure on his own.

One of the bedrock notions of our society is that an individual should be ethical. But few philosophers take up the question: "Why should a person be ethical?" One of the philosophers that attempts to answer this question is Plato. In his seminal work *The Republic*, he undertakes description of a variety of topics including: the ideal society, the nature of reality, justice, knowledge and ethics.

In *The Republic*, a character named Glaucon believes that people are not really good and that the only reason any person does what is ethical is that they get something out of it. To illustrate this he tells a story about a man named Gyges. Through a series of events Gyges finds a ring

that gives him the ability to become invisible. When he realized the power he had he volunteered to be a messenger for the king. Rather than doing what was considered ethical, Gyges committed adultery with the king's wife, attacked the king with her help, killed him, and took over the kingdom. Glaucon, relays the moral of the story as: being given the opportunity everyone would act the same way Gyges acts.

At this point Plato raises an interesting question. If a person knew that they could get away with anything they wanted to do, no matter how unethical, how ethical would they be?

Plato argued that being ethical is valuable in and of itself. He believed that virtue is its own reward and that virtue is the very health of the soul.

In order to understand Plato's line of thought there are two important concepts that must be considered. First, he believed that the soul could be healthy or unhealthy in a similar manner that the body can be healthy or unhealthy. The second idea is that the actions and behaviours of the individual have a direct impact on the health of the soul.

In understanding the "health of the soul", Plato viewed it in a very similar way to the health of the body. A healthy body allows an individual to feel a wide range of emotion from contentedness to excitement. When the body is ill, all the individual can think about is how bad they feel. A healthy body is often not even considered. The person has a full range of abilities and they can do what they want to do. Their mind is clear and they can consider a wide range of possibilities. In short they can make better decisions.

By having a healthy body, the individual has the freedom and ability to take control of their lives. Illness clouds the mind, hurts the body and limits what the person can do. Being healthy is intrinsically enjoyable and allows us to get those things out of life we want. As such, Plato would argue that we live happier lives.

As a healthy body is better than an unhealthy one, Plato viewed that a healthy soul is better than one that is unhealthy. With a healthy soul the person's view of the world is not distorted by fears, insecurities, irrational anxieties, or overpowering desires. Their judgment is not blinded by greed or self-interest. They have the ability to objectively determine what is right or wrong. A healthy soul is free to make decisions without the cloud of illness.

Plato believed that the individual's behaviours has a direct impact on the health of the soul. If the person makes virtuous choices, they are able to move towards having a healthy soul. If they make unethical decisions, the person's soul move towards being unhealthy. A healthy soul leads to the person's happiness. As Socrates expresses it to Polus, one of the characters in the Gorgias, "I call a good and honourable man or woman happy, and one who is unjust and evil wretched. ... You believe it is possible for a happy man to be wrong and be unjust ... and I say this is impossible."

Aristotle (384 – 322 BCE)

Perhaps the most famous ancient philosopher is Aristotle. His impact is felt in the way individuals think, all the way to our present time. Aristotle was a student of Plato for almost twenty years, but didn't always agree with his teacher.

Aristotle's seminal writing on ethics was *The Nicomachean Ethics*. Unlike his predecessors, Aristotle believed there are no absolute moral standards. Any ethical theory must be based on the realities of daily life and grounded in reality.

Aristotle criticized Plato's belief in a separate realm of Forms. He argued, instead, that rational beings can discover the 'essences' of things and that a being's essence is its potential fulfillment (as the essence of an acorn is to become an oak tree). The essence of 'human being' is rationality and, therefore, a life of contemplation (a.k.a. Philosophy) is the best kind of life for true human flourishing. But in order to have this kind of life, a degree of leisure must be possible -- and to guarantee this, to assure that we are not always hunting or fighting, a good State (polis) must be in existence. Hence, for Aristotle, the creation of a good politician and a good political order are of the highest practical importance. It is in this context that he writes his works on 'ethics' and attempts to describe the nature of good character and the way in which humans who possess 'practical wisdom' determine right and wrong courses of action.

According to Aristotle, things of any variety have a characteristic function that they are properly used to perform (e.g. knives have the purpose of cutting, chairs are for sitting, etc.). The good for human beings, then, must essentially involve the entire proper function of human life as a whole, and this must be an activity of the soul that expresses genuine virtue or excellence. He viewed that the highest good of all human activity is directed towards finding happiness. He believed that this can be found as a continuous contemplation of eternal and universal truth.

And of this nature happiness is mostly thought to be, for this we choose always for its own sake, and never with a view to anything further: whereas honour, pleasure, intellect, in fact every excellence we choose for their own sakes, it is true, but we choose them also with a view to happiness, conceiving that through their instrumentality we shall be happy: but no man chooses happiness with a view to them, nor in fact with a view to any other thing whatsoever.

Aristotle felt that happiness can be obtained through living a virtuous life and the development of reason. However, there is a condition that the person must have sufficient external goods to ensure health, leisure and the opportunity to undertake virtuous action.

Ethical acts are not by chance but are active choices by the individual. Virtuous acts require conscious choice and moral purpose or motivation. We all have personal moral responsibilities for our actions.

However, Aristotle was not a moral absolutist. He did not believe that ethics were an abstract ideal. Moral virtue is a relative mean between extremes of excess and deficiency, and in general

the moral life is one of moderation in all things except virtue. No human appetite or desire is bad if it is controlled by reason according to a moral principle. Moral virtue is acquired by a combination of knowledge, habituation, and self-discipline.

Aristotle believed that moral actions always occur within a social environment. A virtuous life can only be lived if there is a moral and stable political system. For him ethics and politics are closely related, for politics is the science of creating a society in which men can live the good life and develop their full potential.

Later Greek Ethics: Epicureanism and Stoicism

Later Greek ethical thought is conducted within the same Platonic/Aristotelian framework. It is generally agreed that happiness (eudaimonia) is the ultimate human good, and living a good life will involve cultivating and exercising virtues. Epicurus (342 270 BCE) agrees that happiness is the central driving force. However, he identifies “happiness” as more or less continuously experiencing pleasure and also freedom from distress and pain. He does not see this as experiencing pleasure in the short term (i.e. pursuing any and every pleasure presented). Rather, he sees that pleasure needs to be optimized in the “long run”. The individual needs to put things into place to attain the maximum amount of pleasure as a long term policy, and not to seek gratification.

It is impossible to live a pleasant life without living wisely and well and justly. And it is impossible to live wisely and well and justly without living a pleasant life.

In Epicurus’ mind, the life of pleasure will be the same as the life of virtue. He sees that individuals should pursue a virtuous life as that will directly bring pleasure. His basic doctrine is that a life of virtue is the life which generates the most amount of pleasure, and it is for this reason that we ought to be virtuous.

The beginnings of Stoic philosophy starts with Zeno of Citium (334 – 262 BCE) and further expanded by Cleanthes and Chrysippus. The philosophy asserts that virtue (such as wisdom) is happiness and judgment should be based on behaviour, rather than words. That we don’t control and cannot rely on external events, only ourselves and our responses.

Stoicism taught that "the world is independent of our will" and consequently that a life detached from the natural events of life will be calmer and less troubled than a life bound up with false desires for worldly things.

A basic tenet of Stoic thinking is that the universe is governed by the laws of reason and is structured in the best possible manner. As such, a full life is one that is lived in accordance with reason. Moral goodness and happiness are attained by mirroring the perfect rationality of the work in oneself and by finding out and living one’s own assigned role in the larger order of things.

Early Christian Ethics

As was pointed out by Cavalier, ethics at the start of the Christian era was a “convergence of three great cultures: Greek, Roman and Jewish.” During the early days of the Christian era there was little emphasis on formalized ethics. Rather the emphasis was on character and emphasized virtues such as: caring, love, justice and compassion. It was more an ethics of action rather than thought.

The reception of this faith, however, was already set into motion by the Orphic and Platonic separation of the soul from the body and the Stoic conception of a universal Logos. And whether one interprets this whole story from the perspective of the historical Jesus or the Christ of Faith, the evolution of the early Church up to the flourishing of the Medieval University Schools stands as an important moment in the history of ethics.

The Middle Ages

After the Roman Empire was conquered and divided (c. 476 CE), the golden age of philosophy and intellectual pursuit ended in Western Europe. The following years were the Middle or Dark Ages, which lasted until approximately 1500 CE. With the fall of the Roman Empire and the failed political stability that it provided, Christianity became the dominant religion and the Catholic Church took on the role of educating the people. Christianity is a monotheistic, revelatory religion, whereas Greek philosophy was based on worship of multiple gods and the use of reason. As Greek philosophy was deemed to be heretical, its study was discouraged during the Church-dominated Middle Ages. However, Augustine and Aquinas, two of the major Church Fathers, were both influenced by the ancient Greeks.

St. Augustine (354 – 430 CE) is often seen as the Plato of the Middle Ages. Although Augustine was a Christian and Plato was a non-Christian, Augustine’s belief in a heavenly place of unchanging moral truths is similar to Plato’s belief in ideal Forms. He believed that the truths of God are imprinted on the hearts of the individual.

Indeed, when Gentiles, who do not have the Law, do by nature what the Law requires, they are a law to themselves, even though they do not have the Law, since they show that the work of the Law is written on their hearts, their consciences also bearing witness, and their thoughts either accusing or defending them. Romans 2: 14 – 15

After the collapse of the Roman Empire, Augustine composed one of his most famous writings, *The City of God*. He used the collapse to explain a philosophy that is sometimes compared to Plato’s conception of the world of Forms and Appearances. People who live according to the Spirit, live in the City of God (this could be compared to Plato’s world of perfection), while people who live according to the “flesh” live in the City of Man (this could be compared to Plato’s world of imperfection). To move away from evil, one must have the grace of God.

Humans were viewed as finite beings that must have divine intervention to bridge the gap required to have a relationship with the infinite being of God. To be ethical is not only a good thing to do, but is commanded by God.

The Crusades assisted Europe in coming out of the Dark Ages. When the Christian armies entered Islamic lands such as North Africa, Spain and Portugal, they were reintroduced to the texts of the Greeks, especially Aristotle. As St. Augustine reflected the thoughts of Plato; another Church Father, St. Thomas Aquinas (1224 – 1274) seems to be influenced by Aristotle's teachings.

Similar to Aristotle, Aquinas believed that individuals have a purpose and that developing excellence of character (virtues) leads to human happiness and good moral reasoning. Aquinas saw the character of God as the exemplification of perfect goodness, and as the goal of human life. Happiness is seen by him as a union with God. For him, then, the goal of human life is fully achieved in the beatific vision, identified as a supernatural union with God in the afterlife.

Aquinas expanded Aristotle's conception of the end goal of perfect happiness and grounded the requirements for happiness in the knowledge and love of God and Christian virtues. He replaced Aristotle's emphasis on the virtue of pride with an emphasis on the virtue of humility.

Modern Philosophy and the Age of Enlightenment

Modern philosophy began when the influence of the Catholic Church waned during the Middle Ages. At the same time this was occurring there was an opposite increase in the influence of the scientific methodology. The start of the science revolution can be dated to 1543 when Copernicus put forward his ideas regarding a heliocentric universe. However, science did not take over as the intellectual driving force until the 17th century, when both Kepler and Galileo moved scientific debate to the forefront of society.

As the idea of empirical science grew, there was a new way of thinking that began to see the universe and people as similar to machines. There was a belief by both philosophers and scientists that everything could be reduced to their component parts. These reductionists hoped that after most or all knowledge was discovered, the universe and human behaviour could be predicted and controlled. They saw that "fixing a problem" in society was similar to "fixing a machine". This type of thinking can be viewed as a "mechanistic" approach. (This is in contrast to a humanistic approach, which acknowledges that human behaviour runs along a complex continuum and that some situations cannot be predicted or fixed.)

Thomas Hobbes took advantage of this new freedom of thought. He provoked widespread reaction when he argued in his work, *Leviathan* (1651), that there is no ultimate or objective "good". Good and evil are naturally relative to people's appetites so that they come to regard what they are inclined to pursue as good and what they are inclined to avoid as bad.

Hobbes felt that individuals are at the core “selfish” and only are looking out for their own welfare. Human nature seeks primarily the satisfaction of their own desires. He characterized the state of human nature as an utterly lawless state, in which the notion of right and wrong has no place. Each individual has the right to do whatever he/she deems as necessary to preserve themselves. Such a state Hobbes called “war”, as every individual is against every individual. Since it is to everyone’s benefit that this condition of war be ended, as a result, a social contract is drawn up in which each person agrees to restrict his/her freedom for peace as long as everyone else is willing to do the same. In general terms a social contract is enforced between all individuals which basically says: “I will limit my freedom in order to protect myself from your freedom”.

The only way to achieve this peaceful society, Hobbes explained, was for all members of a society to unconditionally transfer all of their ability and will to defend themselves to a sovereign power under a form of social contract. With this social contract established, the sovereign power would accept the responsibility for mediating all disputes concerning the society, both internal and external. Should any member of the society violate an agreement with another member of that society, that individual would be guilty of violating their unconditional agreement to support the social contract, which would then render them unjust and subject to punishment.

During the 18th century the philosopher David Hume (1711 – 1776) proposed another idea about moral reasoning. He argued that there is a distinction between facts and values when moral reasoning is practiced. This fact/value distinction also has been called the is/ought gap. Hume argued that an individual cannot take a “fact” of what is and then determine an ethical judgment of what ought to be. In essence Hume argued that reason does not motivate action (reason looks solely at fact) and as such morality must be fundamentally a matter of feeling rather than reason. For example, he looks at “sympathy” which makes the wellbeing of one person a concern for others. Hume argues that it is because of their natural sympathy that human beings come to regard certain states as virtues, more particularly, those states that are useful to their possessors (e.g. courage) and that are useful to others (e.g. justice).

As will be seen in the next section, Hume sowed the seeds of utilitarianism. This thought will be picked up by Jeremy Bentham (1748 – 1832) and John Stuart Mills (1806 – 1873). In summary this type of philosophy holds that actions are right in proportion as they tend to promote happiness; wrong as they tend to produce the reverse of happiness. Morality is about increasing the amount of happiness in the world.

Immanuel Kant can be seen as a milestone in the history of ethics. In contrast to the views of utilitarianism, Immanuel Kant (1724 – 1804) proposed the idea of the deontological ethical theory. He argued that “good will” is the only unconditional good, that is, the only thing that is good in all circumstances. The good will is good not because of what it brings about (compared to utilitarianism), but in virtue of its own principle of willing.

In Kant's formulation of the deontological ethical theory he was lead to the "Categorical Imperative". The basic principle of morality is an imperative because it commands certain forms of action. It is a categorical imperative because it commands unconditionally, quite independently of the particular ends and the desires of the individual. This means that the person should only act in such a way that the action could become a universalized principle.

An example for a vocational rehabilitation professional who operates with deontological understanding could be the following:

You are working with a disabled worker who has a documented limitation of "no lifting above shoulder level". You are on your way home and you see this worker in his front yard with a large mallet breaking up his front driveway. You watch for some time and notice that he raises the mallet above his head with no difficulty and then swings forcefully down, breaking the concrete with no problem. You consider whether you should or shouldn't report this incident to the funding insurance company. If you think it is best not to report the incident, the question you would ask yourself could be: "If everyone who was aware of a disabled worker performing tasks beyond their capabilities and did not report it, what would be the result?" Conversely, if you think it is best to report the incident, the question you would ask yourself could be: "If everyone who was aware of a disabled worker performing tasks beyond their capabilities and reported it, what would be the result?"

Post-Modern Philosophy Era

After the scientific dominance of the Enlightenment era, people began to question whether a single-minded allegiance to science was creating problems for human societies. Postmodernism is often considered to have begun around 1950, after the end of World War II. However, some trace its beginnings back to the German philosopher Friedrich Nietzsche (1844 – 1900) in the late 1800s.

Nietzsche's criticism of convention moral codes revolves around his notion of slave morality. His belief is that the Judeo-Christian moral code has a focus on duty and self-sacrifice, which he believes has its genesis in the resentment of the weak and oppressed. Slaves morality is a subversion of master morality (the natural states of the strong), in which noble and life affirming values have been transformed into vices and the contrary, slavish and life-negating values, transformed into values. Slave morality is the outcome of weak individuals coming to regard the naturally strong as evil and transforming their own resentment into current conceptions of morality, which have greatly debilitated human life.

Recent Directions in Ethics

In the first half of the twentieth century there was a preoccupation with nature and the meaning of ethical judgments. It was focused on "what ethics is" (meta-ethics) rather than

looking at how the individual “ought to act” (normative ethics). It was termed “Analytic Philosophy”.

One of the most influential leaders in this area was G. E. Moore (1873 – 1958). He argued against naturalistic ethical theories that attempt to identify goodness with natural properties such as being pleasurable or being desired. He believed that any attempt to define a moral property such as “goodness” in terms of natural properties must fail. He believed that goodness was a simple non-natural property that was indefinable and known through “intuition”.

In the middle of the twentieth century another direction was taken in ethical considerations. Lawrence Kohlberg (1927 – 1987), psychologist, believed that an individual’s ethical decision making changes and matures similar to other biological and cognitive changes. Building on the work of Piaget and others, Kohlberg argues that as an individual ages, their methodology of making an ethical decision also changes.

Kohlberg defined six moral development stages, each more adequate at responding to moral dilemmas than its predecessor. The six stages of moral development are grouped into three levels: pre-conventional morality, conventional morality and post conventional morality. Pre-conventional morality is especially common in children, although some adults can also display this type of reasoning. Morality at this level makes decisions based on direct consequences (e.g. if I disobey my parents I will get spanked). Conventional morality is common in teens and adults. To reason in a conventional way is to judge the morality of actions by comparing them to society's views and expectations (e.g. Everyone is doing it!). Finally, it is marked by a growing realization that individuals are separate entities from society, and that the individual’s own perspective may take precedence over society’s view; individuals may disobey rules inconsistent with their own principles.

Most recently, interest in the concept of virtue and ancient ethical theory more generally has increased largely as a result of work by Philippa Foot, Alistair MacIntyre, Bernard Williams, and Elizabeth Anscombe. Anscombe’s article “Modern Moral Philosophy,” for instance, argues that duty-based conceptions of morality are incoherent for they are based on the idea of a “law but without a lawgiver.” Her point is that a system of morality conceived along the lines of the Ten Commandments, as a system of rules for action, depends on someone having actually made these rules. However, in the modern climate, which is unwilling to accept that morality depends on God in this way, a rule-based conception of morality is stripped of its metaphysical foundation. Anscombe recommends a return to the virtue ethical theories of the ancients, particularly Aristotle, which grounds morality in the interests and well-being of human moral agents and can do so without appeal to any questionable metaphysics.

8.21 Learning from History

Often, it is only in hindsight that individuals are able to analyze a historical era in which there is a converging of norms and beliefs that are held in high esteem or valued by large groups within

a society. The influences of historical eras build upon each other and are often hard to separate. For example some Christians still base much of their ethical reasoning on the philosophy generated in the Middle Ages. At the same time, it is evident that individualistic ways to think that were popular during the Enlightenment era remain popular today in Western societies because autonomy is so highly valued. The varied historical influences that have affected moral reasoning, consequently, have formed a pattern of rich and interesting values, perspectives and practices that are evident in the globally connected world.

All of these theories of ethics can prove confusing for the vocational rehabilitation professional. The question can be asked: "What difference do these theories make on the day to day decisions that must be made in assisting a disabled worker back to work?" In the world today we are in the throes of a giant ethical leap that is essentially embracing everything that is said and done. Scientific technological advances, economic realities, pluralistic worldviews and global communication make it difficult for the vocational rehabilitation professional to ignore the important ethical issues in the world community, their everyday lives and their work. As controversial and sensitive ethical issues continue to challenge the vocational rehabilitation professional, many professionals have begun to develop an appreciation for traditional philosophies of ethics and the diverse viewpoints of others.

Ethical directives are not always clearly evident and people sometimes disagree about what is right and wrong. These factors led some to believe that ethics can be based merely on personal opinions. However, if vocational rehabilitation professionals are to enter into the global dialogue about ethics, they must do more than practice ethics based simply on their personal opinions, their intuitions or the unexamined beliefs that are proposed by others. It is important for the vocational rehabilitation professional to have a basic understanding of the concepts, principles, approaches and theories that have been used in studying ethics throughout history so they can identify and analyze ethical issues and dilemmas that are relevant in the 21st century.

The study of ethics is a very broad knowledge that needs to be broken down and focus on each part of ethics. In the western civilization, the school of studying ethics can be divided and separated into 3 major parts of which is the study of the past work by old or ancient philosophers. The first philosopher is Aristotle, where student study that justice, charitable trust and kindness are the right ways that should be act and implement in our lives that could give advantage to the person that practice it and the society which that person lives in. The second element which was introduced by Kant focuses on the concept of the duty of morality that should be obligatory. It explains that all humans are somehow connected with each other and share the same knowledge which is being a rational human being. By this, it is an obligation for humans to obey it by having a great level of respect and values towards others.

Finally, the third branch of western civilization's study of ethics is through utilitarianism where a person should maximize the utility of life, in this case happiness. People should tend to be

more grateful and maximize the happiness that is around them and at the same time reduce the pain that is pulling them from being happy.

All the study that is being done by the western civilization could be narrowed as the 'Normative ethics'. It is a part of study made by philosophers that investigates questions regarding what to act on different situations. Choosing between right or wrong could be the hardest question in someone's life. The one they choose reflects back on the ethical level of the person itself and any decision they make will show different consequences.

Besides the normative ethics which is basically the choosing on what to act on different situations, meta-ethics which relates to understanding and what do we mean when talking about choosing between what is right and what is wrong. We understand that being ethical and choosing which we think is the right path is the best way in making decision that is reflecting a great levels of moral and value. However, all this definition between the true or false is implemented and done by our judgment. Our judgment can sometimes affect by feelings despite positive or negative. The actions we choose can define how our perception towards being an ethical person with great moral values.

8.22 Ethics of Conduct

Ethical theories and principles are the foundations of ethical analysis because they are the viewpoints from which guidance can be obtained along the pathway to a decision. Each theory emphasizes different points, such as predicting the outcome and following one's duties to others in order to reach an ethically correct decision. However, in order for an ethical theory to be useful, the theory must be directed towards a common set of goals. Ethical principles are the common goals that each theory tries to achieve in order to be successful.

An examination of the numerous ethical theories is beyond the scope of this Study Guide. Ethical schools of thought tend to focus either on the consequences of an individual's actions (consequentialism) or the character of the individual performing the actions.

Consequentialism

- **Deontology (Right Action):**

The deontological theory states that people should adhere to their obligations and duties when analyzing an ethical dilemma. This means that a person will follow his or her obligations to another individual or society because upholding one's duty is what is considered ethically correct. For instance, a deontologist will always keep his promises to a friend and will follow the law. A person who follows this theory will produce very consistent decisions since they will be based on the individual's set duties.

Philosophy's most representative deontological thinker is Immanuel Kant (1724-1804). Kant believed that he had discovered the fundamental moral law that would determine the ethical character of an action without regard to its consequences. Kant called his moral law the categorical imperative--a command that holds no matter what the circumstances. He believed further that the validity of this ethical principle stemmed from reason itself and from our nature as free, rational moral agents with inherent value.

For an action to be good, Kant believes that it must not simply conform to a moral law, but be done for the sake of a moral law. Indeed, Kant claims that the only thing inherently good is a good will, that is, one that follows reason's guidance and acts from a sense of duty. A good will chooses what it does simply and purely because it is the right thing to do, not because it is inclined to do some deed nor because it has positive consequences. Moreover, Kant claims that reason dictates that the principle according to which one is willing, what Kant terms an action's "maxim," should be able to be a universal law.

Kant's initial formulation of the categorical imperative reflects the belief that since ethics is essentially a rational enterprise, ethical principles should have the same character as such rational activities as logic and mathematics. For example, they should be internally consistent and universally valid. Kant argues that if one can will the maxim of one's action as a universal law, the principle on which one's deed is based meets these requirements and thereby conforms to a sense of duty. Maxims which fail this test are, by contrast, self-defeating and contradictory. Kant illustrates this with the example of a false promise. He writes,

[A] man finds himself forced by need to borrow money. He well knows that he will not be able to repay it, but he also sees that nothing will be loaned him if he does not firmly promise to repay it at a certain time. He desires to make such a promise, but he has enough conscience to ask himself whether it is not improper and opposed to duty to relieve his distress in such a way. Now, assuming he does decide to do so, the maxim of his action would be as follows: When I believe myself to be in need of money, I will borrow money and promise to repay it, although I know I shall never do so. Now this principle of self-love or of his own benefit may very well be compatible with his whole future welfare, but the question is whether it is right. He changes the pretension of self-love into a universal law and then puts the question: How would it be if my maxim became a universal law? He immediately sees that it could never hold as a universal law of nature and be consistent with itself; rather it must necessarily contradict itself. For the universality of a law which says that anyone who believes himself to be in need could promise what he pleased with the intention of not fulfilling it would make the promise itself and the end to be accomplished by it impossible; no one would believe what was promised to him but would only laugh at any such assertion as vain pretense.

The false promise, then, is morally wrong because the maxim on which it is based is internally inconsistent. Universalizing it destroys the very concept of a promise which it aims to use. Such a principle of volition is illogical. The behaviour of anyone who follows such a principle is morally flawed because it is literally irrational.

Although deontology contains many positive attributes, it also contains its fair number of flaws. One weakness of this theory is that there is no rationale or logical basis for deciding an individual's duties. For instance, businessman may decide that it is his duty to always be on time to meetings. Although this appears to be a noble duty we do not know why the person chose to make this his duty. Perhaps the reason that he has to be at the meeting on time is that he always has to sit in the same chair. A similar scenario unearths two other faults of deontology including the fact that sometimes a person's duties conflict and that deontology is not concerned with the welfare of others. For instance, if the deontologist who must be on time to meetings is running late, how is he supposed to drive? Is the deontologist supposed to speed, breaking his duty to society to uphold the law, or is the deontologist supposed to arrive at his meeting late, breaking his duty to be on time? This scenario of conflicting obligations does not lead us to a clear ethically correct resolution nor does it protect the welfare of others from the deontologist's decision. Since deontology is not based on the context of each situation, it does not provide any guidance when one enters a complex situation in which there are conflicting obligations.

For the vocational rehabilitation professional who is following the deontological theory they would use rational thought to determine ethical courses of action. For example the individual may believe that honesty (i.e. fidelity) is categorical imperative. This means that in every instance the individual is honest without regard to the consequences. For example:

The President of a vocational rehabilitation company is contacted by a third party funder to provide placement assistance to a large number of clients. The VRC knows that by getting this contract it will provide financial stability for the company and in turn assure stable income for the staff for years to come. However, the President realizes that the organization does not have the skills or capacity to provide this service. The President wants to say that they can assist in the placement of the clients, but also realizes that this would not be a true statement and to say "yes" would be a breach of his duty to be honest.

Let's assume the President decides to say yes to this offer. The maxim of his action would be as follows: *"When I am offered a chance to financially stabilize my company and provide for myself and my staff over the long term I will agree to take on a contract although I know that I cannot fulfill it."* Now this principle of taking a benefit may well be compatible with the company's future welfare, but the question is whether it is right. He changes this premise into a universal law and the puts the question: *"How would it be if my maxim became a universal law?"* He immediately sees that it would never hold

as a universal law of nature and consistent with itself; rather it must necessarily contradict itself. For the universality of the law which says that anyone who believes himself to be in need of financial gain could promise what he pleased without any intention of being able to accomplish the required service it would make the promise itself and the end to be accomplished by it impossible; no one would believe what was promised.

In addition, the maxim would also hold that “I can promise whatever I wish in order to have financial gain, regardless of its consequence to others.” By accepting the contract and not being able to fulfill the obligations the third party funder would have a financial loss (e.g. they paid something for nothing) and perhaps more important the clients would never receive a job placement, placing at risk the disabled individuals and their families. If this was a universal law for all vocational rehabilitation companies, third party funders would not ask for services as there would be no assurance that the requested services could/would be provided.

- **Utilitarianism (Greatest Good):**

The utilitarian ethical theory is founded on the ability to predict the consequences of an action. To a utilitarian, the choice that yields the greatest benefit to the most people is the choice that is ethically correct. One benefit of this ethical theory is that the utilitarian can compare similar predicted solutions and use a point system to determine which choice is more beneficial for more people. This point system provides a logical and rationale argument for each decision and allows a person to use it on a case-by-case context.

There are two types of utilitarianism, act utilitarianism and rule utilitarianism. Act utilitarianism adheres exactly to the definition of utilitarianism as described in the above section. In act utilitarianism, a person performs the acts that benefit the most people, regardless of personal feelings or the societal constraints such as laws. Rule utilitarianism, however, takes into account the law and is concerned with fairness. A rule utilitarian seeks to benefit the most people but through the fairest and most just means available. Therefore, added benefits of rule utilitarianism are that it values justice and includes beneficence at the same time.

As with all ethical theories, however, both act and rule utilitarianism contain numerous flaws. Inherent in both are the flaws associated with predicting the future. Although people can use their life experiences to attempt to predict outcomes, no human being can be certain that his predictions will be true. This uncertainty can lead to unexpected results making the utilitarian look unethical as time passes because his choice did not benefit the most people as he predicted. For example, if a person lights a fire in a fireplace in order to warm his friends, and then the fire burns down the house because the soot in the chimney caught on fire, then the utilitarian now seems to have chosen

an unethical decision. The unexpected house fire is judged as unethical because it did not benefit his friends.

Another assumption that a utilitarian must make is that he has the ability to compare the various types of consequences against each other on a similar scale. However, comparing material gains such as money against intangible gains such as happiness is impossible since their qualities differ to such a large extent.

A third failing found in utilitarianism is that it does not allow for the existence of supererogation or heroes. In other words, people are obligated to constantly behave so that the most people benefit regardless of the danger associated with an act. For instance, a utilitarian who sacrifices her life to save a train full of people is actually fulfilling an obligation to society rather than performing a selfless and laudable act.

As explained above, act utilitarianism is solely concerned with achieving the maximum good. According to this theory an individual's rights may be infringed upon in order to benefit a greater population. In other words, act utilitarianism is not always concerned with justice, beneficence or autonomy for an individual if oppressing the individual leads to the solution that benefits a majority of people. Another source of instability within act utilitarianism is apparent when a utilitarian faces one set of variable conditions and then suddenly experiences a change in those variables that causes her to change her original decision. This means that an act utilitarian could be nice to you one moment and then dislike you the next moment because the variables have changed, and you are no longer beneficial to the most people.

Rule utilitarianism also contains a source of instability that inhibits its usefulness. In rule utilitarianism, there is the possibility of conflicting rules. Let us revisit the example of a person running late for his meeting. While a rule utilitarian who just happens to be the Prime Minister may believe that it is ethically correct to arrive at important meetings on time because the members of the Federal government will benefit from this decision, he may encounter conflicting ideas about what is ethically correct if he is running late. As a rule utilitarian, he believes that he should follow the law because this benefits an entire society, but at the same time, he believes that it is ethically correct to be on time for his meeting because it is a Federal government meeting that also benefits the society. There appears to be no ethically correct answer for this scenario.

For the vocational rehabilitation professional following the ontological theory of ethics they would consider the “greatest good for the greatest number” in their decision making process. As the deontological theory had “action” (i.e. what the person does) as the starting point for ethical decision making, the utilitarian theory looks at the consequences of the action (i.e. was the greatest good done to the greatest number). Using the same example as above:

The President of a vocational rehabilitation company is contacted by a third party funder to provide placement assistance to a large number of clients. The VRC knows that by getting this contract it will provide financial stability for the company and in turn assure stable income for the staff for years to come. However, the President realizes that the organization does not have the skills or capacity to provide this service.

The President of the company considers that by accepting this contract it will make him and the staff of his company happy (e.g. provide financial stability) and the third party funder happy (e.g. being able to get services provided to clients).

However, he also realizes that as the company will not be able to provide the required job placement services all the clients which are referred will be affected. In addition, since these clients will not be placed in jobs there will be a direct financial impact on their families. By taking the contract and not being able to fulfill the obligations the President's happiness would be short lived as the company's reputation would be negatively impacted and further referrals would be curtailed. Also, the third party's happiness would be short lived as they have made a financial expenditure with no return on investment.

If the President of the vocational rehabilitation company followed a utilitarian theory of ethics it would be apparent that it would not be advisable to take the contract as the "pain" it would cause would far outweigh any "happiness" that would be derived. The greatest good to the greatest number of people would be for him to turn down the contract.

8.23 Ethics of Character

- **Virtue Ethics:**

Both deontological and utilitarian ethical theories are called *deontic* or action-based theories of morality because they focus entirely upon the *actions* which a person performs. Those theories focus on the question, "Which action should I choose?" Virtue ethics, however, take a very different perspective.

Virtue-based ethical theories place less emphasis on which rules people should follow and instead focus on helping people develop good character traits, such as kindness and generosity. These character traits will, in turn, allow a person to make the correct decisions later on in life. Virtue theorists also emphasize the need for people to learn how to break bad habits of character, like greed or anger. These are called vices and stand in the way of becoming a good person.

Recently virtue ethics has not been a very common topic for study, but it dates back to the ancient Greek thinkers and is thus the oldest type of ethical theory in Western philosophy. Plato discussed four key virtues: wisdom, courage, temperance and justice.

The first systematic description of virtue ethics was written down by Aristotle in his famous work *Nichomachean Ethics*. According to Aristotle, when people acquire good habits of character, they are better able to regulate their emotions and their reason. This, in turn, helps us reach morally correct decisions when we are faced with difficult choices.

One reason why virtue ethics can be popular and why they make an important contribution to our understanding of morality is that they emphasize the central role played by motives in moral questions. To act from virtue is to act from some particular motivation; thus to say that certain virtues are necessary for correct moral decisions is to say that correct moral decisions require correct motives.

Neither utilitarian nor deontological moral theories require motives to play a role in our evaluation of moral decisions — but encouraging correct motivations is very often a key component of the moral education of young people. We are taught that we should desire certain outcomes and that we should want to accomplish certain goals by our actions.

Another reason why virtue theories are so attractive is that the other moral theories share in common the difficulty in dealing with complicated moral calculations over what actions to take or which moral duties to emphasize. Virtue theories promise that once we are successful in creating the sort of person we want to be, arriving at the correct moral decisions will come naturally.

Key questions which virtue ethical systems ask include:

- What sort of person do I want to be?
- What virtues are characteristic of the person I want to be?
- What actions will cultivate the virtues I want to possess?
- What actions will be characteristic of the sort of person I want to be?

For the vocational rehabilitation professional following the virtue theory of ethics they would consider “what is the most excellent manner I can act as a human being” in their decision making process. As the deontological theory had “action” (i.e. what the person does) as the starting point for ethical decision making and the utilitarian theory looks at the consequences of the action (i.e. was the greatest good done to the greatest number), the virtue theory looks at motivation of the action. Using the same example as above:

The President of a vocational rehabilitation company is contacted by a third party funder to provide placement assistance to a large number of clients. The VRC knows that by getting this contract it will provide financial stability for the company and in turn assure stable income for the staff for years to come. However, the President realizes that the organization does not have the skills or capacity to provide this service.

In making the ethical decision the President would ask himself: "In making this decision what kind of person do I want to be?" He would need to decide between "greed" (taking something without giving anything in return) and "honest" (telling the third party funder that the company cannot handle this type of contract). The decision to be honest would display a greater virtue than being greedy.

One of the main weaknesses of this theory is that it requires the individual to examine his or her motivation in choosing a particular direction. Modern psychology informs us that character traits are largely a function of our genetics and environment. As such, making an "ethical" decision would be reflective of our particular upbringing and exposure to ethical behaviour. Being ethical then would mean that it is dependent on things outside of our direct control.

D. Values

8.24 Autonomy

Autonomy is the principle that addresses the concept of independence. The essence of this principle is allowing an individual the freedom of choice and action. It addresses the responsibility of the vocational rehabilitation professional to encourage clients, when appropriate, to make their own decisions and to act on their own values. There are two important considerations in encouraging clients to be autonomous. First, helping the client to understand how their decisions and their values may or may not be received within the context of the society in which they live, and how they may impinge on the rights of others. The second consideration is related to the client's ability to make sound and rational decisions. Persons incapable of making competent choices, such as children, and some individuals with mental handicaps, should not be allowed to act on decisions that could harm themselves or others.

8.25 Nonmaleficence

Maleficence is the term for doing wrongfully what could not be done rightfully. On the other hand, nonmaleficence is the concept of not causing harm to others. Often explained as "above all do no harm", this principle is considered by some to be the most critical of all the principles, even though theoretically they are all of equal weight¹⁷⁸. This principle reflects both the idea of not inflicting intentional harm, and not engaging in actions that risk harming others¹⁷⁹.

8.26 Beneficence

Beneficence reflects the vocational rehabilitation professional's responsibility to contribute to the welfare of the client. Simply stated it means to do good, to be proactive and also to prevent harm when possible¹⁸⁰.

8.27 Justice

Justice does not mean treating all individuals the same. Kitchener points out that the formal meaning of justice is "treating equals equally and unequals unequally but in proportion to their relevant differences" (p.49). If an individual is to be treated differently, the vocational rehabilitation professional needs to be able to offer a rationale that explains the necessity and appropriateness of treating this individual differently.

8.28 Fidelity

Fidelity involves the notions of loyalty, faithfulness, and honoring commitments. Clients must be able to trust the vocational rehabilitation professional and have faith in the relationship if growth is to occur. Therefore, the vocational rehabilitation professional must take care neither to threaten the relationship nor to leave obligations unfulfilled.

8.29 Veracity

Veracity is dealing truthfully with individuals with whom vocational rehabilitation professionals come into professional contact. Clients must be able to have faith that what they are being told by the VRP is true.

E. Ethical Decision Making

There are dozens of ethical decision making processes that have been written about and described in the literature over the years. Some of the major works are: Parsons (2001), Van Hoose and Paradise (1979), Kitchener (1984), Stadler (1986), Haas and Malouf (1989), Forester-Miller and Rubenstein (1992), and Sileo and Kopala (1993). In addition there has been purposeful alignment of these steps with the vocational rehabilitation Association of Canada's Code of Ethics Guidelines. The following steps are a synthesis of these sources when confronting an ethical dilemma:

8.30 Define the parameters of the problem

Gather as much information as you can that will illuminate the situation. In doing so, it is important to be as specific and objective as possible. Writing ideas on paper may help you gain clarity. Outline the facts, separating out innuendos, assumptions, hypotheses, or suspicions. There are several questions you can ask yourself: Is it an ethical, legal, professional, or clinical problem? Is it a combination of more than one of these? If a legal question exists, seek legal advice.

Other questions that it may be useful to ask yourself are: Is the issue related to me and what I am or am not doing? Is it related to a client and/or the client's significant others and what they are or are not doing? Is it related to the institution or agency and their policies and procedures?

If the problem can be resolved by implementing a policy of an institution or agency, you can look to the agency's guidelines. It is good to remember that dilemmas you face are often complex, so a useful guideline is to examine the problem from several perspectives and avoid searching for a simplistic solution.

One of the major threats in this area is jumping to conclusions before the parameters of the situation are clearly understood. Care needs to be taken that one attempts, as much as possible, to be objective about the information that is being gathered. This could mean talking directly to the individual(s) involved (e.g. colleague, client, etc.) prior to moving forward to further steps in the ethical decision making process.

8.31 Identify the ethical/legal issues

There are several avenues to follow in order to ensure that you have examined the problem in all its various dimensions. Consider the moral principles of autonomy, nonmaleficence, beneficence, justice, and fidelity. Decide which principles apply to the specific situation, and determine which principle takes priority for you in this case. In theory, each principle is of equal value, which means that it is your challenge to determine the priorities when two or more of them are in conflict.

Also you need to identify if any legal issues are involved. For example, client confidentiality is one of the central tenets of providing service. What a client tells you needs to be kept in confidence and only shared with others in a very limited and defined manner. However, in cases of a client being a threat to themselves or others or if there is evidence of abuse of children; the vocational rehabilitation professional is under an obligation to report these concerns to the proper authority.

8.32 Consider personal biases, stresses or self-interest

There are a number of biases an individual needs to take into consideration when making an ethical decision:

- **Confirmation bias:** This is probably the most common and the most subliminal, as many naturally exhibit this bias without even knowing it. Often times called selective search for evidence, confirmation bias occurs when decision makers seek out evidence that confirms their previously held beliefs, while discounting or diminishing the impact of evidence in support of differing conclusions.
- **Anchoring:** This is the over-reliance on a single piece of *a priori* information or experience that affects one's ability to adjust to new potentially relevant information.
- **Halo effect:** This is the distortion of a person's overt positive or negative characteristics that are amplified and applied to other situations or scenarios. Basically, it is the perception that if someone demonstrates well in a certain area, then they will automatically perform well at something else regardless of how interconnected the tasks are.

- **Overconfidence bias:** This is another potentially disruptive personal bias and occurs when a person subjectively overestimates the reliability of their judgments versus an objectively accurate outcome.
- **Groupthink:** This is a bias within group decision making that leads the group toward harmony rather than a realistic evaluation of alternatives.

8.33 Consult Code of Ethics

After you have clarified the problem, refer to the Code of Ethics to see if the issue is addressed. If there is an applicable standard or several standards and they are specific and clear, following the course of action indicated should lead to a resolution of the problem. To be able to apply the ethical standards, it is essential that you have read them carefully and that you understand their implications.

8.34 Generate possible courses of action

Develop alternative courses of action remembering that you do not have to do this alone. (Where feasible, include interdisciplinary team members, clients, and others who may be affected by the decisions to share in the process. If the situation is difficult, consult with your professional association or other trusted professionals to maintain your objectivity and increase your options for action).

8.35 Consider the potential consequence of all options and determine a course of action

Considering the information you have gathered and the priorities you have set, evaluate each option and assess the potential consequences for all the parties involved. Ponder the implications of each course of action for the client, for others who will be affected, and for yourself as a vocational rehabilitation professional. Eliminate the options that clearly do not give the desired results or cause even more problematic consequences. Review the remaining options to determine which option or combination of options best fits the situation and addresses the priorities you have identified.

8.36 Evaluate the selected course of action

Review the selected course of action to see if it presents any new ethical considerations. Stadler (1986) suggests applying three simple tests to the selected course of action to ensure that it is appropriate. In applying the test of justice, assess your own sense of fairness by determining whether you would treat others the same in this situation. For the test of publicity, ask yourself whether you would want your behaviour reported in the press. The test of universality asks you to assess whether you could recommend the same course of action to another counselor in the same situation.

If the course of action you have selected seems to present new ethical issues, then you'll need to go back to the beginning and reevaluate each step of the process. Perhaps you have chosen the wrong option or you might have identified the problem incorrectly.

If you can answer in the affirmative to each of the questions suggested by Stadler (thus passing the tests of justice, publicity, and universality) and you are satisfied that you have selected an appropriate course of action, then you are ready to move on to implementation.

8.37 Implement the course of action

Taking the appropriate action in an ethical dilemma is often difficult. The final step involves strengthening your ego to allow you to carry out your plan. After implementing your course of action, it is good practice to follow up on the situation to assess whether your actions had the anticipated effect and consequences.

8.38 Act

Act with an individual or collective commitment, to assume responsibility for the consequences of the action. (A collective commitment, as may occur within an interdisciplinary team, requires that someone be assigned the responsibility for follow-up).

8.39 Establish a plan to evaluate the results

This includes responsibility for corrections of negative consequences, if any.

8.40 Evaluate the organizational systems

It is important to identify and remedy the circumstances, which may facilitate and reward unethical practices,

It is important to realize that different professionals may implement different courses of action in the same situation. There is rarely one right answer to a complex ethical dilemma. However, if you follow a systematic model, you can be assured that you will be able to give a professional explanation for the course of action you chose. Van Hoose and Paradise (1979) suggest that a counselor "is probably acting in an ethically responsible way concerning a client if (1) he or she has maintained personal and professional honesty, coupled with (2) the best interests of the client, (3) without malice or personal gain, and (4) can justify his or her actions as the best judgment of what should be done based upon the current state of the profession" (p.58). Following this model will help to ensure that all four of these conditions have been met.

F. Applying Ethical Practice

Many complaints against vocational rehabilitation professionals could be avoided by good communication with clients, staff and colleagues. Good communication involves, first, listening to others. Understanding the person's wishes, expectations and values before doing anything is important. In this section we will examine some of the key issues involved in providing services to clients.

8.41 Informed consent

One of the central principles of the any Code of Ethics is the value of "autonomy". As was noted earlier autonomy is the principle that addresses the concept of independence. The essence of this principle is allowing an individual the freedom of choice and action. It addresses the responsibility of the vocational rehabilitation professional to encourage clients, when appropriate, to make their own decisions and to act on their own values.

One of the methods that Codes of Ethics use to promote autonomy of the client is to assure that "informed consent" is an important part of the vocational rehabilitation professionals practice.

All clients are entitled to provide informed consent, refusal or expression of choice regarding:

- Service delivery
- Release of information
- Concurrent services
- Composition of the service delivery team
- Involvement in research projects.

General Principles

To be valid, a client's consent must include the following:

- ***Relate to the VR Service.*** The vocational rehabilitation professional cannot receive consent for one procedure (e.g., vocational assessment) and then use it to do a different service (e.g., job placement). The client's consent must be for what is actually going to be done.
- ***Be Specific.*** The VR cannot ask for a vague consent. For example, one cannot ask for the client to consent to any service the VR believes is appropriate. One must explain the actual assessment or counselling procedure that is being proposed. This means that the VR often has to obtain the client's consent many times as changes in service become advisable. This also means that a VR cannot obtain a "blanket consent" when the client first comes in, to cover every service.

- **Be Informed.** It is necessary that the client understands what they are agreeing to. The VR must explain to the client everything the client needs to know before asking the client to give consent. For example, if someone asks for your consent to drive your car without telling you that they intend to use it to race over rocky fields, your consent was not informed. To be informed consent, it must include the following:
 - *Nature of the Service.* The client must understand exactly what the VR is proposing to do. For example, does the VR intend to just ask questions or will there be a formalized vocational assessment (e.g. paper/pencil test).
 - *Who will be doing the Procedure?* Will the VR be undertaking the service personally or will an assistant or colleague be doing it? If it is an assistant or colleague, is he or she registered with the College, another College, or unregistered?
 - *Reasons for the Service.* The VR must explain why he or she is proposing a particular service. What are the expected benefits? How does the procedure fit in with the overall vocational rehabilitation plan? How likely is it that the hoped for benefits will happen?
 - *Particular Client Concerns.* If the individual client has a special interest in some aspect of the VR services, the client needs to be told.
- **Voluntary.** The VR cannot force a client into consenting to a service. This is particularly important when dealing with younger or older clients who may be overly influenced by family members or friends. This is also important where the assessment or other VR service will have financial consequences for the client (e.g., the client will lose his or her job or will lose financial benefits if the client refuses to consent). The VR should discuss with the client that consent is his or her choice and that the client should not let anyone pressure them into doing something the client does not want to do.
- **No Misrepresentation or Fraud.** The VR must not make claims about the assessment or other VR service that are not true. Clients must be given accurate factual information and honest opinions.

Therefore, consent to any VR service must involve effective communication between the vocational rehabilitation professional and the client. The VR must make sure that the client understands what he or she is agreeing to. While it may sound like a lot of work, most of the time informed consent can be obtained quickly and easily. It is only when dealing with complex or particularly risky matters that a lot of time is required.

The vocational rehabilitation professional is required to:

- Ensure that they have the knowledge and skills necessary to complete the consent process.
- Explain to the client, and formally document, the suggested action plan prior to requesting consent.

- Ensure for an accessible consent process. This might require the use of easy words, pictures and detailed explanations in an appropriate manner. This will reinforce the independence and dignity of the client.
- Keep the client informed and review consent with the client throughout the action plan.
- Record how the client gives consent. This could be: orally, in writing, through a representative, through other means.
- Ensure consent is formally documented in all circumstances where the client or significant others could be at risk.
- Ensure that carers and/or other family members are taken into consideration and included if necessary when discussing and obtaining consent.
- Ensure the client has the mental capacity to give consent. The assumption is that they have unless a formal assessment of the client has indicated otherwise.
- Obtain written consent before audio-recording, photographing or videoing a client for information purposes, research, training or publication. Full explanation for the activities must be given.
- Maintain all written consent forms in the client's records.
- Ensure consent is obtained and documented before a student participates with a client either with the professional or independently.
- Encourage their employer, if there is one, to update and maintain policies and procedures related to consent and release of information.

Obtaining Consent:

There are three different ways in which a vocational rehabilitation professional can receive consent. Each has its advantages and disadvantages.

- *Written Consent.* A client can give consent by signing a written document agreeing to the services. A written consent provides some evidence that the client did give consent. One disadvantage of written consent is that people confuse a signature with consent. A client who signs a form without actually understanding the services has not given a true consent. Also, the use of written consent documents can discourage the asking of questions. In addition, the VR might not then check with the client to make sure the client understands the information and is truly consenting.

A written document is often the most effective manner to obtain consent. This is typically for the documentation of "higher level" services. For example if a VR is undertaking a vocational assessment, a written consent should detail what will be done, the consequences, benefits and any other information that may be relevant.

- *Verbal Consent.* A client can give consent by a verbal statement. A verbal consent is the best way for the VR and the client to discuss the information and ensure that the client really understands it. Making a brief note in the client record of the discussion can provide useful evidence later on if there is a complaint.

Verbal consent is often given for ongoing tasks. Using the above example the VR would probably not have in writing consent for such things as: the specific room the assessment will be given, the time of the assessment, etc.

- *Implied Consent.* A client can give consent by their actions. In completing a vocational assessment the VR may ask if the client understands the instructions and a client's nod would be an indication of implied consent.

In cases where gaining consent is difficult, the vocational rehabilitation professional should apply appropriate legal approaches.

(a) Adults with impaired capacity.

A client may not be incapacitated simply by the nature of their mental disorder/learning disability. The vocational rehabilitation professional must keep this in mind when seeking consent since, in common law, the vocational rehabilitation professional has a duty to act in the best interests of the client. The professional's responsibility is to preserve the life, health and general well-being of the client.

The vocational rehabilitation professional is required to:

- Provide the client with the opportunity to make decisions and to give consent.
- Record when consent is given freely.
- Determine and record the client's legal status.
- Act in the client's best interests in cases where the client does not have the requisite capacity to make their own decisions.

(b) Language or communication barriers

The vocational rehabilitation professional is required to:

- Work with an interpreter when there are language barriers.
- Identify and record the need for and future use of an interpreter in the client's file.
- Introduce communication aids to reduce communication barriers and record the adjustments in the client's files.
- Adopt and follow procedures for engaging interpreters and/or communications aids.

8.42 Boundaries

Vocational rehabilitation professional must be careful to act as a professional health care provider, and not as a friend, to clients. Becoming too personal or too familiar with a client is confusing to clients and will make them feel uncomfortable. Clients will be uncertain as to whether the professional advice or services are motivated by something else other than the best interests of the client. It is also easier for a VR to provide professional services when there

is a “professional distance” between them and the client (e.g., telling the client the truth about the client’s vocational assessment scores).

Maintaining professional boundaries is about being reasonable in the circumstances. For example, one should be careful about accepting gifts from clients, but there are some circumstances in which it may be appropriate to do so (e.g., a small New Year’s gift from a client). In other areas, however, crossing professional boundaries is never appropriate. For example, it is always professional misconduct to engage in any form of sexual behaviour with a client.

The following are some of the areas where vocational rehabilitation professionals need to be very cautious to maintain professional boundaries.

- ***Self-Disclosure***

When a vocational rehabilitation professional shares personal details about his or her private life, it can confuse clients. They might assume that the VR wants to have more than a professional relationship. Self-disclosure suggests that the professional relationship is serving a personal need for the VR rather than serving the client’s best interests. Self-disclosure can result in the VR becoming dependent on the client to serve the VR’s own emotional needs, which is damaging to the relationship.

- ***Giving or Receiving of Gifts***

Giving and receiving gifts is potentially dangerous to the professional relationship. A small token of appreciation by the client purchased while on a holiday, around New Year’s, or given at the end of vocational rehabilitation services may be acceptable. In addition, one must be sensitive to the client’s culture where refusing a gift is considered to be a serious insult. However, anything beyond small gifts can indicate that the client is developing a personal relationship with the vocational rehabilitation professional.

The client may even expect something in return. Gift giving by a VR will often confuse a client. Even small gifts of emotional value, such as a “friendship” card, can confuse the client even though the financial value is small. While many clients would find a Christmas / holiday season card from a VR to be a kind gesture and good business sense, some clients might feel obliged to send one in return. So even here thought should be given to the type of clients in one’s service (e.g., some new Canadians might be unfamiliar with the tradition).

- ***Ignoring Established Customs***

Established customs usually exist for a reason. Ignoring a custom confuses the nature of the professional relationship. For example, vocational rehabilitation sessions are usually held during regular business hours at an office rather than at a restaurant. Ignoring this

custom, the client might begin thinking that the meeting is a social visit. Or, the client might feel that he or she has to pay for the meal. Treating clients as special, or different from other clients, can be easily misinterpreted.

- ***Personal Opinions***

Everyone has personal opinions. Vocational rehabilitation professionals are no exception. However, VRPs should not use their position to promote their personal opinions (e.g., religion, politics or even a vegan lifestyle) on clients. Similarly, strongly held personal reactions (e.g., that a client is unpleasant and obnoxious) should not be shared. Disclosing personal reactions does not help the professional relationship.

- ***Becoming Friends***

Being a personal friend with a client is a form of dual relationship. Clients should not be placed in the position where they feel they must become a friend of the VR in order to receive ongoing service. VRs bear the main responsibility to not allow a personal friendship to develop. It is difficult for all but the most assertive of clients to communicate to the VR that they do not want to be friends.

8.43 Multiple relations/Dual relations

A multiple/dual relationship is where the client has an additional connection to the vocational rehabilitation professional other than just as a client (e.g., where the client is a relative of the VR). Any multiple relationship has the potential for the other relationship to interfere with the professional one (e.g., being both the individual's VR and employer). It is best to avoid these relationships whenever possible. Where the other relationship predates the professional one (e.g., a relative, a pre-existing friend), referring the client to another VR is the preferred option. Where a referral is not possible (e.g., in a small town, where there is only one VR), special safeguards are essential (e.g., discussing the dual relationship with the client and agreeing with the client to be formal during visits and never talk about the issues outside of the office).

8.44 Client confidentiality

Client confidentiality is the principle that a vocational rehabilitation professional should not reveal information about their clients to a third party without the consent of the client or a clear legal reason. This concept is commonly provided for in law in most countries

8.45 Privileged information

Some professions (e.g. lawyers, priests, etc.) are covered under "privileged information", that is they are allowed to keep secret information which came to them from a client. Vocational rehabilitation professionals do not have this privilege. This means, that if proper legal

procedures are followed the VRP must disclose information to proper authorities what has been shared with them by the client.

8.46 Critiquing professional reports

There are occasions when a vocational rehabilitation professional is asked to critique another VRP's reports and/or assessments. These can be troublesome as often there is a professional/personal relationship between the vocational rehabilitation professionals. In these instances the limitations to provide services would be similar to a dual-relationship with clients. If there is a relationship between the two vocational rehabilitation professionals, this needs to be declared. Needless to say, the critiquing VRP must be totally objective in their review of any report.

8.47 Mandatory reporting

In different provinces there are different protection acts that guide the general population about when they are responsible for reporting crimes (this mainly applies to cases of abuse) and if it is mandatory or voluntary to report the crime. If they are found guilty of not reporting a crime they may be guilty of committing an offense under the act specific to their province, but not under the Criminal Code of Canada.

In general terms the vocational rehabilitation professional needs to report instances where abuse of a child is taking/or will be taking place. Also, those instances where there could be immediate serious danger to the client or someone else and these should be reported.

8.48 Submission of addendum report

Even though a vocational rehabilitation professional takes great care in the preparation of their reports, errors can be made. It is advisable that when an error has been made in a report that an addendum be added clarifying the situation, rather than a resubmission of the entire report. By doing an addendum, this helps to avoid a situation where the VRP is accused of making unwarranted changes to a report to satisfy a stakeholder's request.

8.49 Conflict of interest

A situation in which a vocational rehabilitation professional has a private or personal interest sufficient to appear to influence the outcome of their professional duties. Conflict of interest is not restricted to financial benefit of the VRP.

Review:

1. The three components of burnout are:
 - a. Exhaustion, cynicism and inefficacy
 - b. Depression, cynicism and anger
 - c. Depression, anger and inefficacy
 - d. Anger, hopelessness and boredom
2. It has been found that individuals who have a weaker conviction regarding free will are:
 - a. Less inclined to cheat than those with stronger convictions
 - b. More inclined to cheat than those with stronger convictions
 - c. Cheating behaviour is not impacted by a convention about free will
 - d. More likely to have a strong self-image
3. Having a large caseload and limited time can:
 - a. Increase vocational rehabilitation professional's effectiveness
 - b. Provide the client with greater service
 - c. Lead to unintentional unethical behaviours
 - d. Has no impact on service or ethics
4. For an organization what typically outlines specific behaviours that are required or prohibited as a condition of ongoing employment?
 - a. Code of ethics
 - b. Code of conduct
 - c. Code of behaviour
 - d. Code of performance
5. What type of ethics studies ethical actions and investigates a set of questions regarding how one "ought to act"?
 - a. Meta-ethics
 - b. Descriptive ethics
 - c. Proscriptive ethics
 - d. Normative ethics
6. The "categorical imperative" is associated with which ethical philosopher:
 - a. Immanuel Kant
 - b. Fredrick Nietzsche
 - c. James Fowler
 - d. John Kohlberg
7. Which ancient philosopher believed that as one could have a healthy body, an ethical person can have a healthy soul?
 - a. Aristotle
 - b. Socrates
 - c. Plato
 - d. Epicurus
8. Which modern ethicists believed that as an individual ages, the individual's methodology of making an ethical decision also changes. He postulated six moral development stages?
 - a. Immanuel Kant

- b. Lawrence Kohlberg
 - c. Fredrick Nietzsche
 - d. David Hume
9. Which school of ethical thought should adhere to their obligations and duties when analyzing an ethical dilemma?
- a. Utilitarianism
 - b. Virtue
 - c. Hedonism
 - d. Deontology
10. A vocational rehabilitation professional makes their decisions based on the principle: “what action would yield the greatest benefit to the most people”. Which school of ethical thought are they following?
- a. Utilitarianism
 - b. Virtue
 - c. Hedonism
 - d. Deontology
11. Which value addresses the concept of independence:
- a. Beneficence
 - b. Autonomy
 - c. Non-maleficence
 - d. Justice
12. Which value involves the notions of loyalty, faithfulness and honouring commitments?
- a. Justice
 - b. Beneficence
 - c. Non-maleficence
 - d. Fidelity
13. When faced with a dilemma, the first step in ethical decision making is:
- a. Consult with ethical mentor
 - b. Define the parameters of the problem
 - c. Consult the code of ethics
 - d. Identify the legal issues
14. What term is used for the distortion of a person’s overt positive or negative characteristics?
- a. Halo effect
 - b. Confirmation bias
 - c. Anchoring
 - d. Overconfidence bias
15. When a vocational rehabilitation professional has additional connections to a client other than the VR process this is termed?
- a. Client confidently
 - b. Boundaries
 - c. Multiple relationships
 - d. Informed consent

Answers:

- 1 Exhaustion, cynicism and efficacy – 8.2
- 2 More inclined to cheat than those with stronger convictions – 8.9
- 3 Lead to unintentional unethical behaviours – 8.12
- 4 Code of conduct – 8.16
- 5 Normative ethics – 8.18
- 6 Immanuel Kant – 8.18
- 7 Plato – 8.20
- 8 Lawrence Kohlberg – 8.20
- 9 Deontology – 8.22
- 10 Utilitarianism – 8.22
- 11 Autonomy – 8.24
- 12 Fidelity – 8.28
- 13 Define the parameters of the problem – 8.30
- 14 Halo effect – 8.32
- 15 Boundaries – 8.42

Domain Nine - Communication and Record Keeping

This Domain examines: keeping accurate records, what should/should not be documented, communication with other professionals, file and document security, speaking to a group, use of computer programs (such as word processor, PowerPoint, excel), adult learning, release of information, etc.

A. Communication

9.1 Promoting active participation

Vocational rehabilitation professionals must work to promote active participation by all stakeholders in the vocational rehabilitation process through:

- Consistent and regular communication with all stakeholders regarding the benefits of vocational rehabilitation. Communication tools such as brochures, newsletters, formal presentations, etc., can assist in the promotion of active participation.
- Involving the client in identifying their concerns or barriers to enter or return-to-work and in identifying their own goals
- Meeting regularly with the client and other key stakeholders
- Developing a process for all stakeholders to provide feedback on job entry or return-to-work practices or suggestions for improvements

In promoting the Program the vocational rehabilitation professional needs to determine his/her audience. These are the individuals and groups that will enhance the possibility of long term success.

In demonstrating leadership to the vocational rehabilitation process the vocational rehabilitation professional needs to have a vision of what the program should become. This would involve the Program development processes and systems that match “best practices”. Part of the vocational rehabilitation professional’s vision should be the level of participation of stakeholders.

After a determination of the level of proposed participation, the vocational rehabilitation professional would communicate the expectations. This could be done through one-to-one meetings, staff meetings, management meetings, etc.

“A dream is just a dream. A goal is a dream with a plan and a deadline.” (Harvey Mackay). The vocational rehabilitation professional is often the “head cheerleader” for the Program. In their role they use both their leadership and relationship skills to promote the value of the Program. Leadership skills are demonstrated through setting a vision and then providing a plan to meet

that vision. Relationship skills are demonstrated through the interaction the vocational rehabilitation professional has with other stakeholders inside and outside the organization.

In promoting the Program the vocational rehabilitation professional needs to be able to look at those things which enhance the goals of the program and those things which create roadblocks. Barriers to the program could include such things as: too large of case load, not enough financial resources, insurance contract does not support early and safe return-to-work, etc.

By being able to identify the program's strengths and weaknesses the vocational rehabilitation professional is able to better prepare for the future.

Every program will have some barriers to moving forward. It could be such things as resources, time, cooperation, education, etc. After identifying these barriers the vocational rehabilitation professional needs to identify appropriate tools/resources to lessen their effects.

After the determination of the mechanisms for developing support among key stakeholders, the vocational rehabilitation professional needs to prepare and implement the strategy. In order for this to be effective a timeline should be developed which details:

- What material/tools will be used
- Who will be the target audience
- When will it be used
- Where will it be delivered
- How will it be delivered

The vocational rehabilitation professional should put into place mechanisms to monitor the effectiveness of the promotional strategy. Examples of this could include:

- Pre-post-test of workplace knowledge of the vocational rehabilitation process.
- Focus groups
- Satisfaction questionnaires
- Etc.

The vocational rehabilitation professional should use the results of these evaluations to better target his/her audience or make the message more accessible

9.2 Group leadership

There is a tendency for all groups, whether newly formed or experiencing a change in leadership, to go through predictable stages of growth and regression. An awareness of group development stages is important in helping to increase positive results.

- **Stage 1 – Forming/Orientation**

During the forming stage, members discover what behaviours are acceptable to the group. For newly established groups, this stage is the transition from individual to member status. For groups with new leadership, purpose, or members, this stage is a period of testing behaviour and dependence on the group's leader for guidance in a new, unstructured environment.

As the group forms and matures, natural leaders will emerge. The members in these roles will change several times during this phase of group development.

This stage is also characterized by the following:

- Attempts to identify tasks in terms of relevancy and decide how the group will accomplish the tasks
- Decisions on the type of information needed and how it will be used
- Hesitant participation
- Initial feelings about the group
- Complaints about the organizational environment
- Suspicion, fear and anxiety about the new situation
- Little work is accomplished

In this stage, the leader needs to encourage members to get acquainted with each other. Close supervision and direction is needed.

- **Stage 2 – Storming/Dissatisfaction**

During the storming stage, members can become hostile or overzealous as a way of expressing their individuality and resisting group formation. Members recognize the extent of the task needed and may respond with animosity or apathy.

Other characteristics of this stage include:

- Infighting, defensiveness and competition
- Disunity, increased tension and jealousy
- Polarization of group members
- Sharp fluctuations in relationships and reversals of feelings
- Concern over excessive work
- Establishing a pecking order
- Little work is accomplished

The leader can help the group move through this stage by encouraging and supporting members and emphasizing areas of agreement.

- **Stage 3 – Norming/Resolution**

During the norming stage, members accept the group norms, their own roles, and personality traits of fellow members.

Some group behaviours:

- Cohesion around shared goals
- Resolution of conflict
- More acceptance of diversity in the group
- Reconciliation; show of affection
- Re-evaluation

Members have seen the coming together (forming), the semi-separation (storming), and now they have reconciled themselves to working together (norming) despite their differences with a new definition of purpose.

Other characteristics of this stage include:

- An attempt to achieve maximum harmony by avoiding conflict
- A new ability to express emotions constructively
- A sense of cohesiveness with a common spirit and goals
- Establishing and maintaining group boundaries
- Developing effective decision making techniques
- A moderate amount of work is accomplished
- A sense of connection characterized by confiding in each other, expressing opinions and discussing team dynamics

As the group assumes increased responsibility, the leader continues to encourage and support participation by all.

- **Stage 4 – Performing/Production**

Now that the group has established its own norms, it becomes capable of diagnosing and solving problems and making decisions.

Characteristics:

- Interdependency
- Have a sense of ownership
- A great deal of work is accomplished

The group is starting to utilize its newly found “norms of trust,” and can begin focusing on the service to be done; there should be enough drive, creativity, and cohesiveness to take on most tasks.

The leader provides minimal input to the group.

- **Stage 5 – Adjourning**

Characteristics:

“Now What?”

Possible group feelings or reactions:

- Negativity
- Dissatisfaction
- Hostility
- Purging
- Crisis

The group is realizing the end of service is near; it has been a time of sharing and growing with each other and now members are going to separate. For many, the group has been a safety net and truly has become their community.

In leading a group the vocational rehabilitation professional needs to be aware of the group’s needs and level of functioning. Each stage requires different leadership skills:

In “Stage 1” observe the group in action as much as possible. Observe how some people lead and some follow. Notice how members interact, the social skills they use, their mannerisms—all tell a story.

- Be patient—it’s a virtue
- Be prepared—a good leader always is
- Be knowledgeable—you are the expert, so know your material
- Be a team player—the example you set as a staff will influence the members
- Be a leader—by being a good follower if that is what is needed
- Be a counsellor—members may need a shoulder to lean on
- Be a facilitator—help members think things through
- Be a supervisor—like it or not, it’s part of the job
- Have members establish group ground rules, the processes for enforcing violations, and the consequences
- Be a teacher—be energetic; make the material alive and not boring
- Develop a common vision and mission

In “Stage 2”, the storming phase is just what it implies— the vocational rehabilitation professional should know members and their personalities by now, how they get along with each other, and how each tend to react to situations. Presence in the field is highly recommended to maintain order and ensure situations do not get out of hand.

See Stage 1 for all of the things to be, and add mediator—use your good skills to handle disagreements

- Arrange for group meetings with venting sessions—allow members' voices to be heard
- Set and maintain a positive tone for the group
- Make sure ground rules are understood and observed
- Allow members to contribute changes to the program
- Spend time one-to-one with members
- Develop a common vision and mission

In “Stage 3” Members are trying out how they can best work together; more solid leaders merge and must be nurtured and encouraged. Make sure that these leaders have the skills to lead, and also that they have the respect and approval of the other members.

- Be happy—you made it through storming
- Be a cheerleader—encourage your group and recognize them for the good work they are doing

In “Stage 4” as the group enters the phase of creative and constructive service, be aware and attentive toward keeping them on track and productive. Let the group assume more responsibility, but remain available for problems that might arise. Members will emerge more and more as leaders and as a team.

- Involve the members more in the community
- Assist members in implementing their decisions
- Involve the group in community events
- Stay attentive to their needs

Help members evaluate the group and realize that the group is not an end in itself—that most of the work takes place outside the group.

Although the last stage (Stage 5) will seldom occur for the vocational rehabilitation professional it is included in this section as a general assistance. In *Stage 5* some members may exhibit negative behaviour—be aware that some people hate to say goodbye, and members are also wondering about the future. Offer ample opportunities for interactive discussions and times for reflections. The vocational rehabilitation professional may lead the sessions, but allow free rein for the group to express themselves as needed.

In each of the stages the group members have a specific role to play in order to make the activities successful. The vocational rehabilitation professional needs to understand the role played by each of the group members. This will allow him/her to take advantage of particular member's strengths and to curtail the negative influence of other members.

In setting a meeting it is important to develop an agenda as early in the process as possible. The agenda outline what will be accomplished in the meeting, who should be there and other pertinent details.

Minutes of the meeting should be kept and distributed to those in attendance. The minutes will reflect the actions agreed upon during the meeting, who will undertake the actions and the timeline.

The vocational rehabilitation professional should follow up on the agreed upon action to assure they are completed within the agreed upon timeline.

As was detailed above, groups progress through a number of stages. The length of time a group spend in any one stage is dependent on a variety of factors including the composition of the group, leadership, number of meetings, etc. Some groups can “get stuck” in a particular stage and not move on to be productive.

One of the roles of the vocational rehabilitation professional is to identify the composition of the group and provide constructive leadership. By identifying (tactfully) the barriers to moving forward, a plan can be put into place to have the group become more productive.

There are occasions when the group dynamics interfere with progress. For example the union and management representatives may have “outside issues” that are brought to the Disability Management Committee. As the group leader, the vocational rehabilitation professional needs to be able to identify these negative group dynamics and deal with them effectively.

B. Presenting to Groups

9.3 Understanding the audience

The first step in preparing a presentation is to learn more about the audience to whom you'll be speaking. It's a good idea to obtain some information on the backgrounds, values, and interests of your audience so that you understand what the audience members might expect from your presentation.

9.4 Understand the material

Next, if possible select a topic that is of interest to the audience and to you. It will be much easier to deliver a presentation that the audience finds relevant, and more enjoyable to research a topic that is of interest to you.

9.5 Define the objective of the presentation

Once you have selected a topic, write the objective of the presentation in a single concise statement. The objective needs to specify exactly what you want your audience to learn from

your presentation. Base the objective and the level of the content on the amount of time you have for the presentation and the background knowledge of the audience. Use this statement to help keep you focused as you research and develop the presentation.

9.6 Drafting the body of the speech

After defining the objective of your presentation, determine how much information you can present in the amount of time allowed. Also, use your knowledge about the audience to prepare a presentation with the right level of detail. You don't want to plan a presentation that is too basic or too advanced.

The **body** of the presentation is where you present your ideas. To present your ideas convincingly, you will need to illustrate and support them. Strategies to help you do this include the following:

- Present data and facts
- Read quotes from experts
- Relate personal experiences
- Provide vivid descriptions

And remember, as you plan the body of your presentation it's important to provide variety. Listeners may quickly become bored by lots of facts or they may tire of hearing story after story.

9.7 Drafting the introduction and conclusion

Once you've prepared the body of the presentation, decide how you will begin and end the talk. Make sure the introduction captures the attention of your audience and the conclusion summarizes and reiterates your important points. In other words, "Tell them what you're going to tell them. Tell them. Then, tell them what you told them."

During the **opening** of your presentation, it's important to attract the audience's attention and build their interest. If you don't, listeners will turn their attention elsewhere and you'll have a difficult time getting it back. Strategies that you can use include the following:

- Make the introduction relevant to the listeners' goals, values, and needs
- Ask questions to stimulate thinking
- Share a personal experience
- Begin with a joke or humorous story
- Project a cartoon or colorful visual
- Make a stimulating or inspirational statement
- Give a unique demonstration

During the opening you want to clearly present your topic and the purpose of your presentation. Clearly articulating the topic and purpose will help the listeners focus on and easily follow your main ideas.

During the **conclusion** of your presentation, reinforce the main ideas you communicated. Remember that listeners won't remember your entire presentation, only the main ideas. By reinforcing and reviewing the main ideas, you help the audience remember them.

9.8 Practicing and delivering the presentation

Most people spend hours preparing a presentation but very little time practicing it. When you practice your presentation, you can reduce the number of times you utter words and phrases like, "um," "well," and "you know." These habits can easily diminish a speaker's credibility. You can also fine-tune your content to be sure you make your most important points in the time allotted.

In addition to planning the content of your presentation, you need to give advanced thought to how you want to deliver it. Do you want to commit your presentation to memory, use cards to guide you, or read from a script? Or, you might want to use a combination of methods. To help you decide, read the advantages and disadvantages of the four delivery methods described below.

C. Documentation

9.9 File documentation

The vocational rehabilitation Association of Canada's (VRAC) Code of Ethics details the following in regard to file documentation:

Vocational rehabilitation professionals will establish and maintain documentation that accurately, sufficiently, and timely reflects the services provided, and that identifies who provided the service. If case notes need to be altered it is done in a manner that preserves the original note and is accompanied by the date of change, information that identifies the person who made the change, and the reason for the change. Vocational rehabilitation professionals will maintain appropriate client file documentation. Subject to the reason for referral, documentation will include:

- *Reason for referral*
- *Professional disclosure/informed consent*
- *Signed consents to release information*
- *Initial vocational assessment*
- *Correspondence*
- *Regulatory orders, if available*

- *Written evaluation*
- *Vocational assessment/testing results*
- *Written agreement such as training-on-the job*
- *Medical/psychological reports*
- *Other interventions*
- *Written closure report*

Vocational rehabilitation professionals understand that all written reports and file documentation constitute legal records and, as such, are subject to discovery. Therefore, all case documentation should be factual and objective. In addition, vocational rehabilitation professionals understand that reporting requirements differ between referral sources and jurisdictions. VR providers should remain in compliance with each referral source's reporting requirements.

Regardless of reporting frequency, the following information should be maintained in the file at all times:

- Written evaluation.
- Written plan.
- Written closure report.
- Medical/psychological reports, including current written work restrictions.
- Correspondence between interested parties.
- Regulatory orders affecting or related to the client.
- Updated authorization for information requests/releases.

Client records are confidential and should not be disclosed without client authorization or legal requirement. In addition, adequate storage and confidentiality mechanisms to protect file information should exist.

Records should be maintained for the number of years after closure that is consistent with jurisdictional requirements or agency policy. If records are eventually destroyed, it should be done in a manner assuring preservation of confidentiality.

9.10 Meeting documentation

There are many occasions when a vocational rehabilitation professional will participate in meetings with others. These meetings could include such individuals as: the client, employer, insurer, funder, union leadership, etc. It is imperative that records of these meetings are accurate and reflect what was said in as an objective manner as possible.

If the VRP electronically records a meeting, this should be revealed prior to any discussion and agreed to by all participants (i.e. no secret recordings).

D. Report Writing

9.11 Content

There are numerous types of reports that a vocational rehabilitation professional may be required to write during the course of their employment. Reports typically following the course of the vocational rehabilitation process.

In writing any report the first consideration for the vocational rehabilitation professional is to have a clear understanding of their audience.

A formal report could be written at any point in the process however, the most common would be:

- Intake report
- Initial vocational rehabilitation plan
- Follow up reports
- Employability Assessment

Intake Report: Many organizations undertake an intake interview at the beginning of the vocational rehabilitation process. One of the main purposes of this interview and the resulting report is to understand the client's subjective view of their present situation. It is assumed at this point in time the VRP will have received some "objective" background information on the client. This objective information could include such documents as: work history, education history, professionally delineated restrictions/limitations, etc.

The following sections should be typically in this type of report:

- Introduction - this section details the individual's "tombstone" date, including: marital/family status, type of claim, home situation, date of birth, claim number etc. This section is designed to provide a brief overview of the client's identification. Some items such as "claim number" also assists in the referring agent identify the appropriate client.
- Third Party Information – this section would detail any information that a VRP may have in regards to a client. This could include such documentation as: medical reports, physio/occupational therapy reports, specialists' reports, vocational testing, education reports, etc. The type and degree of reports may vary from individual to individual.

Often these third party reports are many pages in length and contain information not applicable to the vocational rehabilitation process. This section would need only to contain a summary of the findings which are directly related to moving the individual along the employability continuum.

- **Results of Interview** – this section is a detailing of information obtained from the client during the intake interview. There is often a difference between the “objective” views of the third party professional and the “subjective” view of the client. It is important to understand if there are any differences the client perceives in their functioning level and the medical findings.

It is also important to make note of the client’s view of the future. Do they seem themselves entering the workforce in the near future? Do they believe that they can do their old job? What are their interests regarding future employment? Do they believe they need further training/education? In general what thoughts do they have regarding the future?

- **Recommendations** – the final section of the Intake Report is an outline of the steps that will be needed to move the client towards a vocational rehabilitation plan. This may include such recommendations as: additional vocational rehabilitation counselling, vocational testing, career exploration, etc.

Initial vocational rehabilitation Plan (IVRP): Alternate names for this could include: individual vocational rehabilitation plan, intake report, written vocational rehabilitation plan, etc. Regardless of what it is called the essence of this report is the same; that is, what was the client like when entering the vocational rehabilitation process.

In constructing an IVRP, the vocational rehabilitation professional is trying to “paint a verbal picture” of the present state of the client and delineate plans for the future. Prior to constructing this report the VRP should have:

- Obtained appropriate third party professional information. This could include: medical reports, occupational therapy reports, rehabilitation reports, physiotherapy reports, psychological assessments, vocational assessments, etc.
- Conducted an intake interview with client. The goal of this interview is to obtain subjective information regarding the individual’s view of their past and present situation.
- Undertaken needed vocational rehabilitation sessions to determine potential future direction(s).

The typical IVRP has the following sections:

- **Introductory data** – name, claim number etc.
- **Back ground information** – similar to the initial report.
- **Vocational rehabilitation services provided** – this could include the results of vocational rehabilitation counselling, test results, documented medical restrictions/limitations, transferable skills analysis. The intent of this section is to describe clearly the client’s present strengths and limitations.
- **Vocational direction** – based on the results of the vocational rehabilitation services this section delineates the chosen client’s chosen vocational direction. There needs to be a clear demonstration how this matches such things as:

client's aptitudes/interests, within worker's restrictions, wage rate, education requirements, etc.

- Vocational rehabilitation Plan – this section outlines the steps needed to move the client from their present situation to the chosen vocational goal. This could include such activities as: job club, resume preparation, job placement, formalized schooling/training, etc. This information should be as complete as possible with a thorough defense of the direction chosen. It should include all associated costs related to the plan.

Follow up Reports: In many instances the vocational rehabilitation plan will go over a number of months; for example when the client is in an education program. This report should reflect:

- Past recommendations
- Vocational rehabilitation services provided
- Results of the services in relation to the previous recommendations
- Recommendations for the near future.

The purpose of this report is to detail the client's progress towards their vocational goal. It assures the plan is being monitored any changes are made as appropriate.

Employability Assessment: Often this is the final report on the client and is written at the end of the vocational rehabilitation services. This report details where the client is in relation to returning to his/her former earning capacity. After the delivery of VR services the client's long term earning capacity may be:

- Lower than then expected or earned prior to disability
- At the same level as pre-disability
- On occasion the client's expected earning capacity could be higher than pre-disability

This report would typically contain:

- Pre-disability profile – e.g. earning capacity, physical/cognitive abilities, work potential, etc.
- Vocational rehabilitation assessment – e.g. vocational testing, third party documentation of limitations/restrictions, transferable skills analysis, etc.
- Vocational rehabilitation services provided – e.g. job search, placement, job club, education, training, etc.
- Current earning capacity and job availability – this section looks at the client's present status and his/her earning capacity based on restrictions/limitations and vocational services. In many instances this may require a labour market analysis.

9.12 Confidentiality

In general terms client files are to be held strictly confidential with a few important exceptions:

- File contents should always be available for the client (i.e. person-served) review and inspection.

- Reports which are paid for by a third party are available to the fee-payer. Depending on the funding arrangement they probably will not have access to the rest of the client's file.
- File contents are available to the legal system with the proper legal process (e.g. subpoena, or on stand in court).

As file content cannot always be held in strict confidentiality, the vocational rehabilitation professional must take great care in what is added. This is particularly true for information that the client shares which does not have a direct impact on the vocational rehabilitation process. For example, the client may share information about their personal life which has no direct bearing on the process.

9.13 Report writing for court

A report that is requested by the court is somewhat different than reports for other third parties in that the "client" is the court and not the "person-served". The expectation is that the report will be completely unbiased and based on fact. The one exception is that the vocational rehabilitation professional, if deemed by the court as an expert, can provide "opinion". However, even in providing an opinion to the court, it must be based on objective fact and not on speculation.

E. Security

9.14 File security

Client confidentiality can only be preserved if file information is secured at all times.

- **Document security**

Most offices, even in today's age of technology, have some form of client paper files. It is important to keep these files confidential at all times. Files, when not in use, should be in a locked file cabinet, which can only be accessed by those who have authority to see them.

The information in any specific client file, should only contain information about that client. If this is impossible (for example a long listening of multiple client), all other clients should be redacted in a client's file.

- **Electronic security**

Many vocational rehabilitation professionals are moving away from paper files to electronic files, which creates new concerns about confidentiality.

- **Passwords:** All client files should be protected by a “strong” password (e.g. not 1234). These passwords should be updated on a regular basis. Ideally, all client files should be held on a separate drive from other business information, and can only be accessed by authorized individuals.
- **Transporting electronic devices:** Transporting of electronic files (e.g. carrying a laptop) can present unique difficulties. If transporting electronic files, the device should always be in possession of the vocational rehabilitation professional (e.g. not left in car). Great care must be taken not to lose these devices, even if the client files are password protected. An area that is of concern is transporting electronic devices across International Borders in that the guards have a legal right to fully inspect any device being transported. In these instances, it would probably be better to leave all files in “the cloud” and download them as needed.
- **Sending/receiving electronic documents**
Of particular concern in preserving client confidentiality is sending or receiving files/documents through the Internet. If possible, all documents should be sent through more secure forms of delivery such as registered mail. However, in those instances where the Internet is used, the files should be encrypted and only be able to be read by those authorized to receive the file/document.

9.15 Release of information

Client information should only be released under specific circumstances:

- Information given directly to client
- Information required by the legal system once the proper legal process has been used
- Reports provided to a third party who is authorized to receive the information (e.g. paid for the report)
- Information provided to a third party (e.g. medical practitioner) with the written permission of the client

9.16 Destruction of files

At this time there is no definitive directives regarding the time frame to maintain client files. However, most organization maintain client files up to five years and business files up to seven years. Whatever, the case, it is advisable to use a professional file destruction company to destroy client files.

Great care must be taken when getting rid of old computers that all client files are completely removed and destroyed.

F. Use of Computer Technology

The vocational rehabilitation professional needs have a good understanding of the most used computer software.

9.17 Word Processors

As most reports are now written on the computer, the vocational rehabilitation professional should be knowledgeable about most used word processors including: Microsoft Word, Word Perfect and Google Docs.

9.18 Internet Search Engines

Internet search engines are a valuable tool for the vocational rehabilitation professional in doing such tasks as job search, transferable skills analysis, etc. The VRP should be aware of the most used internet search engines including: Google, Fire Fox and Mozilla.

9.19 Spreadsheets

Spreadsheets are a convenient way for the vocational rehabilitation professional to store and organize data (e.g. clients, days off work, etc.). The VRP should be aware of the most used spreadsheet software including: Microsoft Excel and Open Office.

9.20 Presentation software

Often, presentations are much more interesting if there is visual content and not just the individual speaking. The vocational rehabilitation professional should be aware of the most used presentation software, including: PowerPoint and Prezi.

Review

1. In the “forming” stage of group development:
 - a. Little work is done
 - b. Most work is done
 - c. Work is not important
 - d. Some work is done
2. Which stage of group development demonstrates the initial stages of cohesion around shared goals:
 - a. Forming
 - b. Storming
 - c. Norming
 - d. Performing
3. Groups progress through a number of stages:
 - a. On a consistent and regular basis
 - b. At the same rate
 - c. In an undetermined manner
 - d. Dependent on a variety of factors
4. The first step in presenting to an audience:
 - a. Determine what you want to say
 - b. Understand the audience
 - c. Do a draft of the speech
 - d. Prepare the final draft
5. The VRAC Code of Ethics:
 - a. Has specific recommendations regarding documentation
 - b. Does not address documentation
 - c. Does not see documentation as an ethical issue
 - d. Directs individuals to the code of conduct
6. An Employability Assessment is typically done:
 - a. At the beginning of the vocational rehabilitation process
 - b. At the end of the vocational rehabilitation process
 - c. When the client is starting the rehabilitation process
 - d. When the client finishes the rehabilitation process
7. Generally client file content:
 - a. Should never be revealed to anyone
 - b. Should only be seen by the VRP
 - c. Should only be seen by the VRP and funder
 - d. Should be available to the client

8. For court purposes, if the vocational rehabilitation professional has been deemed an “expert witness” they may:
 - a. Provide an opinion based on accepted facts
 - b. Provide an opinion based on hearsay
 - c. Provide only facts
 - d. Provide opinion based on speculation

Answers

1. Little work is done – 9.2
2. Norming – 5.2
3. Dependent on a variety of factors – 9.2
4. Understand the audience – 9.3
5. Has specific recommendations regarding documentation – 9.9
6. At the end of the vocational rehabilitation process – 9.11
7. Should be available to the client – 9.12
8. Provide an opinion based on accepted facts – 9.13

Appendix A

Possible Accommodations

a) Amyotrophic Lateral Sclerosis (ALS) Possible Accommodations

- **Muscle weakness in hands, arms, legs or the muscles of speech, swallowing, or breathing:** An individual with ALS may benefit from a flexible work schedule, liberal use of leave time, being allowed to work from home, elimination of physical exertion and workplace stress, scheduled rest breaks away from the workstation, and ergonomic workstation design, including ergonomic seating and forearm supports.
- **Twitching (fasciculation) and cramping of muscles, especially those in the hands and feet:** Ergonomic equipment, foot rests, and heated clothing and heaters are useful for controlling stationary postures and cold work areas. For computer access, speech recognition, alternative input devices, one-handed keyboards, alternative keyboards, expanded keyboards, and miniature keyboards can help.
- **Impairment of the use of the arms and legs:** A wheelchair or scooter may accommodate individuals who have difficulty moving around a workplace. Adjustable workstations also help individuals convert standing areas to sitting workstations. For building access, accessible parking, ramps, stair and chair lifts, and elevators are helpful. Implementing appropriate emergency evacuation procedures may also be a benefit.
- **"Thick speech" and difficulty in projecting the voice in more advanced stages:** An individual with ALS who has difficulty with speech may be accommodated by typing information into the computer and using speech output (screen reading software), using voice amplification, or a communication aid.
- **Dealing with workplace stress:** An individual with ALS may benefit from reduction or elimination of stress in the current position, transfer to a less stressful position, flexible schedule to recover from any effects caused by workplace stress, and work at home to avoid workplace stress.

b) Attention Deficit Hyperactivity Disorder: *Possible Accommodations*

There are several adjustments that could accommodate the needs of adults with ADHD. These need not be expensive or time-consuming to organise.

- Generally, managers should implement systems that include regular meetings, reviews, and structured feedback for the individual.
- Verbal information should be supplemented in written format with clear, concise instructions.

- More specifically, to optimise attention and reduce distraction, employees could be provided with a private office, located in quieter rooms or positioned to reduce likelihood of distraction.
- They could also be offered flex-time to work at quieter times of the day, or provided with headphones to reduce external noise.
- Impulsivity could be accommodated by a buddy system, as teaming up with a colleague will help the individual to remain focused.
- Hyperactivity can be dealt with by allowing productive movements at work, encouraging staff to remain active, and ensuring structured breaks are included in long meetings.
- Adults with ADHD suffer with organisation, time management and memory problems, and employers can tackle these problems by providing alarms or beepers, the use of structured notes and agendas, and providing regular supervision or mentoring, delegating more tedious tasks such as paperwork, and/or introducing incentives and rewards for task-completion. Best practice is one that identifies the problem and then successfully implements reasonable adjustments

c) **Bradyphrenia: *Possible Accommodations***

As this can be a symptom of Parkinson's disease, many of the issues involved will be identical.

1. **Cognitive slowing (also called bradyphrenia)**- Many people with Parkinson's Disease struggle with a slowing down of their thinking. This can sometimes appear as a problem monitoring one's own stream of thoughts, a very high order cognitive skill that is vulnerable to neurological insult. In addition to causing loss of one's train of thought (such as in long meetings) it can lead to missed information, misunderstanding, and difficulty efficiently putting together what has just been said.
2. **Change in organizational skills**- Parkinson's disease can cause one's ability to organize tasks to decline. It can mean a person has trouble figuring out how to start a project or deciding what comes next on tasks they are already involved in. One of the first signs of cognitive change with - Parkinson's disease is when the 8-hour work day stretches to a 12-hour work day, with work often going home because there simply wasn't time to finish it. This one is definitely going to appear in a job performance review.
3. **Stubbornness or inflexible behaviour**. To be an effective problems solver, one must let unproductive thoughts or strategies go, then move on to try something else. Folks with Parkinson's disease can get stuck and have difficulty moving on, sometimes to the point of appearing rigid. The latter is a word that one does not want to hear when a supervisor is discussing behavioural data in a review.

4. **Changes in verbal fluency and word finding.** Parkinson's disease can cause delays in coming up with words for objects or concepts, often resulting in frustrating pauses while the person searches for what she means to say. In addition to slowing down discussions, this common problem can cause folks with Parkinson's disease to decrease interactions with people in an effort to avoid embarrassment. Job reviews might describe a person as lacking confidence.

d) **Burns: *Possible Accommodations***

Typical workplace accommodations for an individual experiencing significant burn injury could include:

- A modified work schedule (4 hours per day in the beginning, with a gradual increase to fulltime).
- Working in a clean and dry environment.
- Limits on how much they can lift.
- Limited exposure to extreme temperatures (avoiding extreme heat or prolonged periods of cold).
- Altering work schedules to accommodate outpatient physical therapy and other medical appointments.
- Special software and hardware so a person with limited or no hand function can work on a computer.
- Adaptive equipment to help them perform your job tasks.

It is also helpful to educate the employer and co-workers about burn injuries so they are more understanding to the individual's needs and have realistic expectations of their performance.

e) **Complex Regional Pain Disorder: *Possible Accommodations***

Possible accommodations for an individual who is experiencing Chronic Regional Pain Syndrome could include:

Activities of Daily Living:

- Allow use of a personal attendant at work
- Allow use of a service animal at work
- Make sure the facility is accessible
- Move workstation closer to the restroom
- Allow longer breaks
- Refer to appropriate community services
- Provide access to a refrigerator

Depression and Anxiety:

- Develop strategies to deal with work problems before they arise
- Provide sensitivity training to coworkers

- Allow telephone calls during work hours to doctors and others for support
- Provide information on counseling and employee assistance programs
- Allow time off for medical treatment

Fatigue/Weakness:

- Reduce or eliminate physical exertion and workplace stress
- Schedule periodic rest breaks away from the workstation
- Allow a flexible work schedule and flexible use of leave time
- Allow a self-paced workload
- Provide parking close to the worksite and an accessible entrance
- Install automatic door openers
- Provide an accessible route of travel to other work areas used by the employee
- Move workstation close to other work areas, office equipment, and break rooms

Muscle Pain and Stiffness:

- Implement ergonomic workstation design, i.e., ergonomic chair and adjustable workstation to alternate between sitting and standing
- Reduce repetitive tasks or interrupt the tasks with other duties
- Provide carts and lifting aids
- Modify worksite temperature and/or dress code
- Use fan/air-conditioner or heater at the workstation
- Allow work from home during extremely hot or cold weather

f) **Diabetes Mellitus: *Possible Accommodations***

Hypo/Hyperglycemia:

- Allow for storage of medications, such as insulin and/or food
- Provide an area to test blood sugar levels
- Provide an area to administer medications (insulin)
- Provide appropriate containers for needles/syringe disposal
- Provide a rest area for reorientation after hypo/hyperglycemic episode
- Allow frequent breaks for food as needed
- Provide appropriate food for office sponsored events and reward programs
- Consider modifications to policies involving food storage and consumption

Neuropathy (Nerve damage):

- Modify job tasks requiring fine finger dexterity
- Provide protective clothing and equipment
- Eliminate or reduce the need to use sharp objects
- Provide anti-fatigue mats or padded carpeting
- Allow flexibility to sit or stand
- Provide parking accommodations

Fatigue or Weakness:

- Allow frequent rest breaks
- Reduce or eliminate strenuous activities
- Provide anti-fatigue mats or padded carpeting
- Provide a rest area with cot
- Allow flexibility to sit or stand
- Allow job sharing
- Shorten work day and extend work week

Vision Impairment:

- If the individual benefits from magnification, consider external magnification devices or computer screen magnification software
- If the individual does not benefit from magnification, consider Braille, tactile graphics, or assistive technology (e.g., screen reading software)
- If the individual is experiencing blurriness or haziness use of high contrast settings and themes may be helpful
- Provide a digital voice recorder
- Provide a qualified reader
- Allow flexible schedule to use public transportation to and from work
- Allow use of service animal for assistance with vision and/or mobility
- If the individual experiences photosensitivity, consider alternative lighting such as lamps or fluorescent light filters

Kidney Disease:

- Provide easy access to restroom facilities
- Allow a flexible schedule or time off for treatment (dialysis)
- Some individuals may be able to telework from the dialysis site

Cognitive Limitations:

- Provide written job instructions and prioritize assignments
- Increase job structure
- Use of day planner or electronic organizer
- Provide reminders
- Provide flexible work hours
- Minimize distractions

Psychological Limitations:

- Reduce stress
- Allow time off for counseling or therapy

Other Considerations:

- Provide area to brush teeth to prevent periodontal gum disease
- Evaluate safety hazards
- Avoid temperature extremes to help deal with poor circulation
- Educate coworkers on emergency situation procedures and identification of symptoms of hypoglycemia or hyperglycemia

g) Hearing issues/Deafness: *Possible Accommodations*

There are numerous accommodations that could be provided for an individual who has hearing difficulties. These include (but not limited to):

Difficulty Communicating Face-to-Face

- Write notes with pen and paper, tablet PC, dry erase or chalk board, etc.
- Use a computer and keyboard to type messages back and forth
- Use a computer and speech-recognition software to communicate one-on-one
- Send e-mail or text messages as an alternative to face-to-face communication
- Hire a qualified sign language or oral interpreter, or video remote interpreter (VRI) on an as-needed basis (e.g., during a job interview, orientation, benefits seminar, training, or disciplinary meeting)
- Use a personal assistive listening device (ALD) or portable assistive listening system (ALS) if the individual can benefit from amplification
- Use portable communication access technology designed for individuals who are deaf or hard of hearing
- Use an augmentative and alternative communication device (AAC), with or without speech
- Encourage employees to learn and use basic sign language
- Install mirrors to communicate the presence of other workers or customers (e.g., in areas where an employee's back may be turned) and ask the employee how he or she prefers to be approached so that he or she is not startled
- Position a small sign at the employee's workstation (e.g., check-lane register, help desk) that indicates the person has a hearing loss and that communication should be direct, in writing
- Provide disability awareness training when integrating employees who are deaf into the work environment

Difficulty Communicating in Groups, Meetings, or Training

- Meet in a small group and sit at a round table to facilitate lip-reading
- Meet in a quiet room to avoid distractions and exposure to extraneous noise (e.g., office equipment, hallway chatter, machinery, etc.) and if necessary install noise abatement panels to reduce noise
- Adjust lighting and seating to create an optimal listening experience
- Educate staff regarding meeting etiquette (e.g., one person talk at a time, do not

- cover mouth with hands or papers, maintain eye contact)
- Provide written materials in advance, such as the meeting agenda, training outline, or course materials, or offer minutes afterwards
- Allow extra time for training
- Use an FM, infrared, or induction loop *assistive listening system (ALS)
- Hire a qualified sign language or oral *interpreter, or *video remote interpreter (VRI) on an as-needed basis (e.g., during a job interview, orientation, benefits seminar, training, or disciplinary meeting)
- Contract for on-site or remote real-time captioning services, known as communication access real-time translation
- Provide computer-assisted note taking where a skilled note taker/typist uses a laptop to compose notes during the meeting
- Record and transcribe meetings
- Caption training DVDs/videos and web-based training modules that include sound
- Use relay conference captioning (RCC) during group conference calls
- Use high quality conferencing equipment during group conference calls
- Use a conferencing phone with a headset for more direct sound
- Provide disability awareness training when integrating employees who are deaf into the meeting or training environment

Difficulty Communicating by Telephone

- Use telephone amplification/clarity technology
- Use a hearing aid compatible headset or amplified noise canceling headset. Hearing aid compatible headsets are designed for use with t-coil equipped hearing aids.
- Use a cochlear implant patch cord
- Use a captioned telephone
- Use a TTY
- Use a voice carry over phone (VCO)
- Use video relay service (VRS)
- Use a voicemail transcription service to send an e-mail or a text message of voicemail messages. For employees who are deaf who receive direct calls, voicemail messages could be left so the employee could call the caller back using the relay system.
- Include the Telecommunications Relay Service (TRS) number (711) with the employee's business number on his or her business card, as well as a note about using the relay service
- For employees who are severe to profoundly deaf, and who do not use speech, methods for receiving and handling incoming telephone calls include:
 - Use the relay service with a TTY (analog line required) or VCO phone,
 - Use the relay service with PC as a TTY (software),
 - Use the relay service with videophone equipment (video relay (VRS) calls), or
 - Use an interpreter to interpret calls
- Use e-mail or instant messaging (IM) instead of voice phone

- Use mobile two-way text messaging instead of voice phone
- Use Bluetooth technology and mobile phone amplification and clarity devices with cellphone
- Use relay conference captioning (RCC) during group conference calls
- Use high quality conferencing equipment during group conference calls
- Use a conferencing phone with a headset for more direct sound

Difficulty Communicating in the Field

- Use a high-end professional two-radio system with noise-canceling technology
- Use a two-way radio with text-messaging capability
- Use a cellular phone with text messaging, a two-way mobile device, or a cellular phone that has both text messaging and two-way radio capability
- If "in the field" communication takes place within sight, workers may be able to use hand signals and signs to communicate instead of two-way radios
- Use a portable TTY and relay service

Safely Operating or Working Around Vehicles

- Establish set paths of travel for industrial vehicles and pedestrians using industrial tape, paint, or ropes
- Establish and enforce rules requiring all moving equipment, forklifts, and vehicles to stop and flash lights/beep horn at intersections
- Install flashing strobe lights on moving vehicles
- Install a *directional worker alert system that provides a visual warning of oncoming vehicles
- Install industrial mirrors in strategic locations (e.g., blind corners) at the work environment
- The individual who is deaf or hard of hearing may be willing to wear a hat or vest of a unique color to serve as a warning to others to be cautious
 - Note: An employer should not require such a vest or hat if other employees do not wear such vests or hats.
- Use a *vibrating personal pager to alert the person who is deaf. Pagers can be useful when it is possible to have another employee send a warning signal to the person who is deaf.
- Install a *vehicle rear vision system in the forklift or other vehicle, to improve the operator's ability to visually assess the environment

Difficulty Responding to Sounds in the Environment

- Use a visual or vibrating *alerting device.
 - Note: Alerting devices are used to alert people to a broad range of sounds, including (but not limited to) abnormal machine sounds, timers, a telephone ringing, doorbell, baby crying, and emergency signals.
- Modify equipment by adding a light to the sound source.
 - Note: Speak with the manufacturer of the equipment for suggestions before making modifications and consult with an electrician, or appropriate professional.
- Install lighted fire strobes and other visual or vibrating alerting devices to supplement audible alarms.
- Provide a vibrating text pager that may be triggered by the emergency alerting system or establish a web-based text alert system.
- Allow the employee to bring his or her *hearing dog into the workplace.

Difficulty Wearing Hearing Protection

- Turn-off hearing aids and use ear muffs.
- Turn-off hearing aids and use *active hearing protection, ear muffs that block sound but use electronic circuitry to transmit low-level sounds through the earmuffs.
- Remove hearing aids and use ear plugs or muffs.

- Turn-off/remove hearing aids and use communication headset that provides noise attenuation and radio communication.
- Use hearing aid turned-off, with no protector, only if the ear piece of the hearing aid is not vented and fits snugly in the ear.
- Use custom-made hi-fidelity ear plugs; see an audiologist.

h) **Herniated disc** *Possible Accommodations*

Fatigue/Weakness:

- Reduce or eliminate physical exertion and workplace stress
- Schedule periodic rest breaks away from the workstation
- Allow a flexible work schedule and flexible use of leave time
- Allow work from home
- Implement ergonomic workstation design
- Provide a scooter or other mobility aid if walking cannot be reduced

Gross Motor Impairment:

- General
 - Modify the worksite to make it accessible
 - Provide parking close to the worksite
 - Provide an accessible entrance
 - Install automatic door openers
 - Provide an accessible restroom and break room
 - Provide an accessible route of travel to other work areas used by the employee
 - Modify the workstation to make it accessible
 - Make sure materials and equipment are within reach range
 - Move workstation close to other work areas and break rooms
- Industrial
 - Provide overhead structure for lifting devices
 - Modify the work area to make it adjustable
 - Place frequently used tools and supplies at or near waist height
 - Provide low task chairs for work that cannot be brought to waist height
 - Provide stand/lean stools and anti-fatigue mats for standing work
 - Make wheelchairs, scooters, industrial tricycles, or golf carts available if walking long distances is required
 - Provide compact lifting devices to push and pull supplies and tools from storage
- Office Settings
 - Provide a height adjustable desk and ergonomic chair
 - Move workstation close to common use office equipment
 - Provide low task chair and rolling safety ladder to access high and low file drawers and supplies
 - Provide a cart to move files, mail, and supplies
 - Provide a lazy Susan carousel or desktop organizers to access frequently used materials

- Service Settings
 - Provide anti-fatigue mats and stand/lean stools for functions requiring long periods of standing
 - Provide a height adjustable desk and ergonomic chair
 - Move workstation close to commonly used office equipment
 - Provide compact lifting devices to push and pull stock and supplies from shelves
 - Provide carts to move supplies and stock
- Medical Settings
 - Provide a spring-bottomed linen cart
 - Make patient lifting and transfer devices available
 - Make wheelchairs, scooters, industrial tricycles, or golf carts available if walking long distances is required
 - Train employees on proper lifting techniques and on proper use of patient lifting and transfer devices
 - Provide powered beds for transporting patients
 - Provide adjustable exam tables
 - Provide a height adjustable desk and ergonomic task chairs

i) **HIV/AIDS: *Possible Accommodations***

Fatigue/Weakness:

- Accessible facility (Ramps, parking etc.)
- Reduce/eliminate lifting, walking, etc.
- Flexibility to sit or stand (Adjustable workstation)
- Rest area with cot
- Later start time
- Frequent rest breaks
- Shorten work day and extend work week
- Job sharing
- Telework

Chronic Diarrhea:

- Worksite or workstation near restroom (Inconspicuous)
- Flexible work schedule to allow for restroom breaks
- Flexible leave policy
- Telework

Decreased Cognitive Abilities: (Problems with concentration, memory, etc.)

- Increase levels of job structure
- Provide written job instructions
- Prioritize job assignments
- Flexible work hours
- Rest periods to reorient
- Memory notebook or scheduler (Can be electronic or paper)
- Minimize distractions
- Self-paced workload

- Reduce job stress
- Educate coworkers about psychological implications if needed (Keep the individual with HIV/AIDS and his/her disability confidential)
- Evaluate safety hazards

Vision Impairment: Reading information from computer screen (For those who benefit from magnification and other modifications)

- External screen magnifier
- Screen magnification software
- Larger sized monitor
- Anti-Glare or anti-radiation computer screen guard
- High resolution monitor
- Special computer glasses to reduce glare
- Change font size or contrast in existing software application
- Frequent breaks to rest eyes when fatigue is a factor
- Additional training

Vision Impairment: Reading information from computer screen (For those who do not benefit from magnification)

- Screen reading software
- Refreshable Braille display
- Dual channel headset if using a computer with speech output and the telephone at the same time
- Providing a Qualified Reader
- Additional training

Vision Impairment: Reading information from printed materials (For those who benefit from magnification and other modifications)

- Hand/Stand magnifier
- Improved lighting or task lighting
- Reduce glare on paper copy (Close blinds on windows, change lighting in area, etc.)
- Closed circuit television system (Desktop & Portable models are available)
- Enlarge information on photo copier
- Optical wear (Eye glasses, Low Vision Enhancement Systems, Flip-down magnifiers, etc.)
- Frequent breaks to rest eyes when fatigue is a factor
- Additional training

Vision Impairment: Reading information from printed materials (For those who do not benefit from magnification)

- Optical character recognition system (Also known as a scanner with speech output - PC based & portable models are available)
- Providing a Qualified Reader
- Additional training

Sensitivity to Light:

- Lower wattage overhead lights
- Task lighting
- Broad spectrum lighting
- Install flicker free lighting

- Optical wear (Protective eye glasses)
- Move work station to another area
- Place blinds on windows

Respiratory Difficulties: (Problems breathing)

- Good ventilation
- Clean work environment free from dust, smoke, odor and fumes (Air purifier, appropriate ventilation, working windows, etc.)
- Avoid temperature extremes
- Educate coworkers to wash hands frequently and to stay at home if sick
- Telework

Neurological Complications: (Problems with numbness in fingers, legs, feet or difficulties with seizures, headaches, noise, dizziness, mood swings and concentration)

- Eliminate need to use sharp objects
- Provide protective clothing/equipment
- Modify job tasks requiring fine finger dexterity
- Reduce noise (Use partitions, white noise, environmental sound machines, headsets and/or move employee to a more quiet environment)

Skin Infections: (May include open sores, bruises, lesions and rashes)

- Avoid infectious agents and chemicals
- Avoid invasive procedures (activities that could be harmful to people with skin conditions)
- Flexible leave policy

Psychological Implications: (Difficulties adjusting to having a disability, stress, etc.)

- Identify stressors and reduce stress
- Educate coworkers, but keep person and his/her condition confidential
- Peer counseling
- Allow telephone calls to emotional supports
- Open door policy to supervisor
- Negotiating time for accommodations
- Time off for counseling or therapy
- Provide praise and positive reinforcement

Weight Loss:

- Ergonomic chair with extra padding
- Arm supports
- Alternate working positions to prevent sores from forming (i.e., sitting & standing)
- Have access to refrigerator (To store food supplements or medications)

j) Multiple Sclerosis: *Possible Accommodations*

Cognitive Impairment:

- Provide written job instructions when possible
- Prioritize job assignments

- Allow flexible work hours
- Allow periodic rest breaks to reorient
- Provide memory aids, such as schedulers or organizers
- Minimize distractions
- Allow a self-paced workload
- Reduce job stress
- Provide more structure

Fatigue/Weakness:

- Reduce or eliminate physical exertion and workplace stress
- Schedule periodic rest breaks away from the workstation
- Allow a flexible work schedule and flexible use of leave time
- Allow work from home
- Implement ergonomic workstation design
- Provide a scooter or other mobility aid if walking cannot be reduced

Fine Motor Impairment:

- Implement ergonomic workstation design
- Provide alternative computer access
- Provide alternative telephone access
- Provide arm supports
- Provide writing and grip aids
- Provide a page turner and a book holder
- Provide a note taker

Gross Motor Impairment:

- Modify the worksite to make it accessible
- Provide parking close to the worksite
- Provide an accessible entrance
- Install automatic door openers
- Provide an accessible restroom and break room
- Provide an accessible route of travel to other work areas used by the employee
- Modify the workstation to make it accessible
- Adjust desk height if wheelchair or scooter is used
- Make sure materials and equipment are within reach range
- Move workstation close to other work areas, office equipment, and break rooms

Heat Sensitivity:

- Reduce worksite temperature
- Use cool vest or other cooling clothing
- Use fan/air-conditioner at the workstation
- Allow flexible scheduling and flexible use of leave time
- Allow work from home during hot weather

Speech Impairment:

- Provide speech amplification, speech enhancement, or other communication device
- Use written communication, such as email or fax
- Transfer to a position that does not require a lot of communication
- Allow periodic rest breaks

Vision Impairment:

- Magnify written material using hand/stand/optical magnifiers
- Provide large print material or screen reading software
- Control glare by adding a glare screen to the computer
- Install proper office lighting
- Allow frequent rest breaks

k) Repetitive strain disorder *Possible Accommodations***Fatigue/Weakness:**

- Reduce or eliminate physical exertion and workplace stress
- Schedule periodic rest breaks away from the workstation
- Allow a flexible work schedule and flexible use of leave time
- Allow work from home

Fine Motor Impairment:

- Implement ergonomic workstation design
- Provide alternative computer and telephone access
- Provide arm supports
- Provide writing and grip aids
- Provide a page turner and a book holder
- Provide a note taker
- Provide ergonomic tools and other adaptations

Gross Motor Impairment:

- Modify the worksite to make it accessible
- Provide parking close to the worksite
- Provide an accessible entrance
- Install automatic door openers
- Modify the workstation to make it accessible
- Make sure materials and equipment are within reach range
- Move workstation close to other work areas, office equipment, and break rooms
- Provide carts and lifting devices

Temperature Sensitivity:

- Modify worksite temperature
- Modify dress code
- Use fan/air-conditioner or heater at the workstation

- Allow flexible scheduling and flexible use of leave time
- Allow work from home during extremely hot or cold weather
- Maintain the ventilation system
- Redirect air conditioning and heating vents
- Provide an office with separate temperature control

I) Spinal cord injuries *Possible Accommodations*

Standard Desk too low for Wheelchair Access

- Remove center drawer
- Raise desk with wooden blocks
- Purchase higher or adjustable height desk

Pedestal desk center opening too narrow for wheelchair access

- Purchase a table
- Purchase an L-shaped desk with open clearance for wheelchair

Holding a telephone receiver difficult due to limited hand or arm function

- Provide a speakerphone
- Purchase a telephone headset

Using a standard keyboard/mouse with impaired hand or arm function

- Provide a keyboard drawer at appropriate height
- Provide a trackball
- Purchase hardware or software that provides for alternative access such as voice activation

Managing papers difficult with limited hand function

- Book holders
- Catalogue racks
- Copy holders
- Tabletop vertical files
- Lazy Susan tabletop holders
- Automatic page turners

Physical access into the facility

- Access to reserved parking for disabled
- Accessible route from parking into facility
- Maintenance of accessible features: firm and stable path of travel, snow removal, elevator or lift maintenance
- Lever hardware on doors
- Power doors for heavy doors

Physical access within facility

- Widen narrow doorways to 32", or add offset hinges which can add 1-1.5 inches of clearance
- Maintain at least 36" clear path of travel through furniture, files, and other objects
- Keep most frequently used materials and information on lower shelves/tables and do not use top drawers of file cabinets if person is unable to reach them

Bathroom access issues

- Lowered mirrors and paper towel dispensers
- Knee clearance for sinks and wrapped pipes
- Combine two stalls into one larger one
- Add elevated toilet or toilet seat
- Add grab bars

Morning routine for personal care may necessitate changes in work schedules

- Flexible schedule
- Telecommute part time
- Part-time employment

m) Strokes (CVA) Possible Accommodations**Cognitive Impairment:****Maintaining Concentration:**

- Reduce distractions in the work area
- Provide space enclosures or a private office
- Allow for use of white noise or environmental sound machines
- Allow the employee to play soothing music using a cassette player and headset
- Increase natural lighting or provide full spectrum lighting
- Reduce clutter in the employee's work environment
- Plan for uninterrupted work time
- Divide large assignments into smaller tasks and steps
- Restructure job to include only essential functions

Staying Organized and Meeting Deadlines:

- Make daily TO-DO lists and check items off as they are completed
- Use several calendars to mark meetings and deadlines
- Remind employee of important deadlines via memos or e-mail or weekly supervision
- Use a watch or pager with timer capability and electronic organizers
- Divide large assignments into smaller tasks and steps
- Assign a mentor to assist employee determining goals and provide daily guidance

- Schedule weekly meetings with supervisor, manager or mentor to determine if goals are being met

Handling Memory Deficits:

- Allow the employee to tape record meetings
- Provide type written minutes of each meeting
- Use notebooks, calendars, or sticky notes to record information for easy retrieval
- Provide written as well as verbal instructions
- Allow additional training time
- Provide written checklists
- Provide environmental cues to assist in memory for locations of items, such as labels, color coding, or bulletin boards
- Post instructions over all frequently used equipment

Handling Problem Solving Deficits:

- Provide picture diagrams of problem solving techniques, i.e., flow charts
- Restructure the job to include only essential functions
- Assign a supervisor, manager or mentor to be available when the employee has questions

Working Effectively with Supervisors:

- Provide positive praise and reinforcement
- Provide written job instructions
- Write clear expectations of responsibilities and the consequences of not meeting them
- Allow for open communication to managers and supervisors
- Establish written long term and short term goals
- Develop strategies to deal with problems before they arise
- Provide written work agreements
- Develop a procedure to evaluate the effectiveness of the accommodation

Handling Stress and Emotions:

- Provide praise and positive reinforcement
- Refer to counseling and employee assistance programs
- Allow telephone calls during work hours to doctors and others for needed support
- Provide sensitivity training to coworkers
- Allow the employee to take a break to use stress management techniques to deal with frustration

Handling Change:

- Recognize that a change in the office environment or of supervisors may be difficult
- Maintain open channels of communication between the employee and the new and old supervisor to ensure an effective transition

- Provide weekly or monthly meetings with the employee to discuss workplace issues and productions levels

Maintaining Stamina during the Workday:

- Allow flexible scheduling / Allow part-time work schedules
- Allow longer or more frequent work breaks
- Provide additional time to learn new responsibilities
- Provide self-paced workload
- Provide backup coverage for when the employee needs to take breaks
- Allow for time off for counseling
- Allow for use of supportive employment and job coaches
- Allow employee to work from home during part of the day
- Provide for job sharing opportunities

Physical Limitations

- Typing tutorials teach methods for typing more effectively and rapidly with one hand on a standard keyboard; One-handed keyboards use right and left controls for typing with a reduced number of keys to depress; Software conversion allows one-handed typing by electronically re-assigning keys onto half of the standard keyboard; and Speech recognition software enters data to the computer via voice command
- A variety of writing aids are available for people with reduced grip and unsteady hands
- Several products are designed to allow standing for longer periods including lumbar support stands, standing frames, and set/stand stools. Some devices provide standing support and mobility. Work table and desk users can alternate between sitting and standing by use of adjustable height sit/stand work stations
- Canes, crutches, rolling walkers with seats, manual wheelchairs, power wheelchairs and electric scooters provide assistance for better balance, increased mobility, safer navigation, and conservation of personal energy
- Ergonomic office chairs, task stools, and lift-assist seats/cushions provide comfortable options for seated work
- Rolling safety ladders are easily maneuvered into place, by wheels or casters, provide handrails for safety, and have a more gradual climbing slope than conventional ladders
- Lightweight, portable material lifts are offered in a wide range of types including hand trucks with electric lift options, electric lift-tables, scissors lifts, tailgate lifts/platforms and articulating cranes
- Grip-cuffs, soft-orthotic gripping aids, and special gloves can effectively hold tools, cutlery and other small items

- Elevated work platforms, step-stands, kick-stools, and long handled reachers/tools allow easier access for reaching either high or low work areas
- Power assistive-steering systems can be retrofitted to existing vehicles, as well as, the use of specially designed steering knobs to aid in gripping/turning the steering wheel, driver side and passenger side personal lifts, and seating help with entering/exiting vehicles, as well as wheelchair ramps and lifts.

Speech and Language Impairments

Communicating with the Person with the Speech or Language Impairment:

- Be patient, do not complete words or phrases for the individual
- Concentrate on the content of the conversation not the delivery
- Communicate as naturally as possible

Communicating One-on-One or in Groups:

- Provide pen and paper, chalk or dry-erase boards
- Allow the use of a computer with word processing software, word prediction software, and/or speech output software
- Provide a portable speech amplifier
- Provide, or allow the use of augmentative and alternative communication (AAC) devices (AAC devices provide communication access through typed or pre-programmed words and sentences, or through pictorial symbols.)
- Provide a TTY (TTYs are traditionally used for text telephone communication for individuals who have no speech or speech that is difficult to understand, but can also be useful to communicate one-on-one through a TTY trainer device that connects TTYs together without a telephone line.)
- Allow the use of e-mail or instant messaging

Communicating on the Telephone:

- Provide telephone equipment that offers outgoing speech amplification
- Allow the use of AAC devices, or speech amplifiers with the telephone
- Provide a TTY
- Allow the use of Speech-to-Speech (SRS) relay services

n) Traumatic (Acquired) Brain Injury Possible Accommodations

Physical Limitations:

- Install ramps, handrails, and provide handicap parking spaces
- Install lever style door handles
- Clear pathways of travel of any unnecessary equipment and furniture

Visual Problems:

- Provide written information in large print
- Change fluorescent lights to high intensity, white lights
- Increase natural lighting
- Provide a glare guard for computer monitors
- Consult a vision specialist particularly with someone who has lost part of or all of their vision

Maintaining Stamina during the Workday:

- Permit flexible scheduling, allow longer or more frequent work breaks
- Provide additional time to learn new responsibilities
- Provide self-paced workload
- Provide backup coverage for when the employee needs to take breaks
- Allow for time off for counseling
- Allow for use of supportive employment and job coaches
- Allow employee to work from home during part of the day
- Provide for job sharing opportunities
- Allow part-time work schedules

Maintaining Concentration:

- Reduce distractions in the work area
- Provide space enclosures or a private office
- Allow for use of white noise or environmental sound machines
- Allow the employee to play soothing music using a cassette player and headset
- Increase natural lighting or provide full spectrum lighting
- Reduce clutter in the employee's work environment
- Plan for uninterrupted work time
- Divide large assignments into smaller tasks and steps
- Restructure job to include only essential functions

Difficulty Staying Organized and Meeting Deadlines:

- Make daily TO-DO lists and check items off as they are completed
- Use several calendars to mark meetings and deadlines
- Remind employee of important deadlines via memos or e-mail or weekly supervision
- Use a watch or pager with timer capability
- Use electronic organizers
- Divide large assignments into smaller tasks and steps
- Assign a mentor to assist employee in determining goals and provide daily guidance
- Schedule weekly meetings with supervisor, manager, or mentor to determine if goals are being met

Memory Deficits:

- Allow the employee to tape record meetings
- Provide type written minutes of each meeting
- Use notebooks, calendars, or sticky notes to record information for easy retrieval
- Provide written as well as verbal instructions
- Allow additional training time
- Provide written checklists and use color-coding to help identify items
- Post instructions close to frequently used equipment

Problem Solving Deficits:

- Provide picture diagrams of problem solving techniques, e.g., flow charts
- Restructure the job to include only essential functions
- Assign a supervisor, manager, or mentor when the employee has questions

Working Effectively with Supervisors:

- Provide positive praise and reinforcement
- Provide written job instructions
- Write clear expectations of responsibilities and the consequences of not meeting them
- Allow for open communication with managers and supervisors
- Establish written long term and short term goals
- Develop strategies to deal with problems before they arise
- Provide written work agreements
- Develop a procedure to evaluate the effectiveness of the accommodation

Difficulty Handling Stress and Emotions:

- Provide praise and positive reinforcement
- Refer to counseling and employee assistance programs
- Allow telephone calls during work hours to doctors and others for needed support
- Provide sensitivity training to coworkers
- Allow the employee to take a break as a part of a stress management plan

Attendance Issues:

- Provide flexible leave for health problems
- Provide a self-paced work load and flexible hours
- Allow employee to work from home
- Provide part-time work schedule

Issues of Change:

- Recognize that a change in the office environment or of supervisors may be difficult for a person with a brain injury

- Maintain open channels of communication between the employee and the new and old supervisor in order to ensure an effective transition
- Provide weekly or monthly meetings with the employee to discuss workplace issues and production levels

o) Cancer Possible Accommodations

Fatigue/Weakness:

- Reduce or eliminate physical exertion and workplace stress
- Schedule periodic rest breaks away from the workstation
- Allow a flexible work schedule and flexible use of leave time
- Allow work from home
- Implement ergonomic workstation design
- Provide a scooter or other mobility aid if walking cannot be reduced
- Provide parking close to the worksite
- Install automatic door openers
- Make sure materials and equipment are within reach range
- Move workstation close to other work areas, office equipment, and break rooms
- Reduce noise with sound absorbent baffles/partitions, environmental sound machines, and headsets
- Provide alternate work space to reduce visual and auditory distractions

Medical Treatment Allowances:

- Provide flexible schedules and leave time
- Allow a self-paced workload with flexible hours
- Allow employee to work from home
- Provide part-time work schedules

Respiratory Difficulties:

- Provide adjustable ventilation
- Keep work environment free from dust, smoke, odor, and fumes
- Implement a "fragrance-free" workplace policy and a "smoke free" building policy
- Avoid temperature extremes
- Use fan/air-conditioner or heater at the workstation
- Redirect air conditioning and heating vents

Skin Irritations:

- Avoid infectious agents and chemicals
- Avoid invasive procedures (activities that could exacerbate a person's skin condition)
- Provide alternate and protective clothing

Stress:

- Develop strategies to deal with work problems before they arise
- Provide sensitivity training to coworkers
- Allow telephone calls during work hours to doctors and others for support
- Provide information on counseling and employee assistance programs
- Allow flexible work environment:
 - Flexible scheduling
 - Modified break schedule
 - Leave for counseling
 - Work from home/Flexi-place

Temperature Sensitivity:

- Modify worksite temperature
- Modify dress code
- Use fan/air-conditioner or heater at the workstation
- Allow flexible scheduling and flexible use of leave time
- Allow work from home during extremely hot or cold weather
- Maintain the ventilation system
- Redirect air conditioning and heating vents
- Provide an office with separate temperature control

p) Cardiovascular disease Possible Accommodations**Fatigue/Weakness:**

- Reduce or eliminate physical exertion
- Schedule periodic rest breaks away from the workstation
- Allow a flexible work schedule and flexible use of leave time
- Allow work from home
- Implement ergonomic workstation design
- Provide a scooter or other mobility aid if walking cannot be reduced
- Provide parking close to the worksite
- Install automatic door openers
- Move workstation close to other work areas, office equipment, and break rooms
- Provide mechanical assists and lifting aids

Respiratory Difficulties:

- Provide adjustable ventilation
- Keep work environment free from dust, smoke, odor, and fumes
- Implement a "fragrance-free" workplace policy and a "smoke free" building policy
- Avoid temperature extremes
- Use fan/air-conditioner or heater at the workstation
- Redirect air conditioning and heating vents
- Provide adequate exhaust systems to remove fumes from office machines

- Allow individual to wear a respirator mask
- Allow work from home

Seizure Activity and Blackouts:

- Eliminate the need to use sharp objects
- Eliminate blinking and flickering lights
- Replace fluorescent lighting with full spectrum or natural lighting
- Use computer monitor glare guards, adjust monitor intensity and color, and decrease the cursor speed of the mouse
- Provide protective clothing/equipment
- Modify job tasks requiring fine finger dexterity
- Allow flexible work hours
- Allow periodic rest breaks
- Allow work from home

Stress:

- Develop strategies to deal with work problems before they arise
- Provide sensitivity training to coworkers
- Allow telephone calls during work hours to doctors and others for support
- Provide information on counseling and employee assistance programs
- Reduce workplace stress

Temperature Sensitivity:

- Modify worksite temperature
- Modify dress code
- Use fan/air-conditioner or heater at the workstation
- Allow flexible scheduling and flexible use of leave time
- Allow work from home during extremely hot or cold weather
- Maintain the ventilation system
- Redirect air conditioning and heating vents
- Provide an office with separate temperature control

q) Asthma Possible Accommodations

Fatigue/Weakness:

- Accessible facility (Ramps, parking etc.)
- Reduce/eliminate lifting, walking, etc.
- Flexibility to sit or stand (Adjustable workstation)
- Rest area with cot
- Later start time
- Frequent rest breaks
- Shorten work day and extend work week
- Job sharing

Avoiding Environmental Triggers:

Some respiratory impairments are aggravated by environmental triggers. It may be helpful to:

- Maintain a clean and healthy work environment
- Provide air purification
- Condition, heat, dehumidify, or add moisture to the air as appropriate
- Provide additional rest breaks for the individual to get fresh air or take medication
- Create a smoke and fragrance-free work environment
- Consider an alternative work arrangement such as work from home
- Allow for alternative work arrangements when construction is taking place
- Use alternative pest management practices
- Implement a flexible leave policy
- Allow for alternative means of communication such as telephone, e-mail, instant messaging, fax, or memos

r) Fetal alcohol syndrome Possible Accommodations**Accommodation for Limitations in Intellectual Abilities Reading:**

- Provide pictures, symbols, or diagrams instead of words
- Read written information to employee
- Provide written information on audiotape
- Use voice output on computer
- Use line guide to identify or highlight one line of text at a time

Writing:

- Provide templates or forms to prompt information requested
- Allow verbal response instead of written response
- Allow typed response instead of written response
- Use speech recognition software on computer
- Use spell-check on computer
- Use a scribe to write the employee's response
- Provide ample space on forms requiring written response

Math:

- Allow use of calculator
 - Large-display calculator
 - Talking calculator
- Use counter or ticker
- Make pre-counted or pre-measured poster or jig
- Provide talking tape measure
- Use liquid level indicators
- Mark the measuring cup with a "fill to here" line

Organization:

- Minimize clutter
- Color-code items or resources
- Provide A-B-C chart
- Provide 1-2-3 chart
- Divide large tasks into multiple smaller tasks
- Avoid substantial reorganization of workspace
- Label items or resources
 - Use symbols instead of words
 - Use print labels instead of hand-written labels

Task Completion:

- Provide verbal prompts (reminders)
- Provide written or symbolic reminders
- Use alarm watch or beeper
- Use jig for assembly to increase productivity
- Arrange materials in order of use
- Use task list with numbers or symbols
- Avoid isolated workstations
- Provide space for job coach
- Provide additional training or retraining as needed

Memory:

- Use voice activated recorder to record verbal instructions
- Provide written information
- Provide checklists
- Prompt employee with verbal cues (reminders)
- Post written or pictorial instructions on frequently-used machines

Accommodation for Limitations in Motor Abilities**Computer Use:**

- Use key guard
- Use alternative input devices
 - speech recognition
 - speech output
 - trackball
 - joystick
 - touchscreen

Telephone Use:

- Use large-button phone
- Use phone with universal symbols (fire, police, doctor, emergency contact)
- Use phone with speed-dial, clearly labeled

- Use receiver holder
- Use headset

Handling Objects:

- Use ergonomic tools, handle build-ups, or other tool adaptations
- Use orthopedic writing aids
- Use grip aids
- Use jig or brace

Accommodations for Limitations in Social Abilities

Emotional Support:

- Give positive feedback
- Use visual performance charts
- Provide tangible rewards
- Use co-workers as mentors
- Use Employee Assistance Program (EAP)
- Provide job coach

Interacting with Co-Workers:

- Provide sensitivity training (disability awareness) to all employees
- Use role-play scenarios to demonstrate appropriate behaviour in workplace
- Use training videos to demonstrate appropriate behaviour in workplace
- Model appropriate social skills
 - Where to eat at work
 - When to eat at work
 - When to hug other co-workers
 - How to pay for coffee
 - What to do if you are mad
 - Who to ask for help
 - When to leave your workstation

Working Effectively with Supervisors:

- Communicate one-to-one with employee
- Deal with problems as they arise
- Keep job coach informed
- Train supervisors on communication etiquette
- Discuss disciplinary procedures
- Monitor effectiveness of accommodations currently provided

s) Eating Disorders Possible Accommodations

Attendance:

- Allow flexible scheduling
- Provide modified break schedule
- Allow leave for counseling
- Allow work from home/Flexi-place

Maintaining Concentration:

- Reduce distractions in the work area
- Provide space enclosures, sound absorption panels, or a private office
- Allow for use of white noise or environmental sound machines
- Allow the employee to play soothing music using an ear-bud and computer or music player
- Plan for uninterrupted work time
- Purchase organizers to reduce clutter
- Restructure job to include only essential functions
- Provide memory aids such as schedulers, organizers, or email applications

Managing Emotions:

- Encourage the use of stress management techniques to deal with frustration
- Increase natural lighting or provide full spectrum lighting
- Allow the presence of a support animal
- Allow telephone calls during work hours to doctors and others for needed support
- Allow flexible breaks
- Refer to employee assistance program (EAP)

Fatigue:

- Allow flexible work environment
- Allow flexible scheduling
- Provide modified break schedule
- Allow leave for counseling
- Allow work from home/Flexi-place
- Provide a goal-oriented workload
- Reduce or eliminate physical exertion and workplace stress
- Implement ergonomic workstation design

Stress:

- Refer to counseling and EAP
- Allow telephone calls during work hours to doctors and others for needed support
- Allow the presence of a support animal
- Allow flexible work environment:
- Allow flexible scheduling
- Provide modified break schedule

- Allow leave for counseling
- Allow work from home/Flexi-place

Malnutrition:

- Allow work from home/Flexi-place
- Allow food at the work station
- Provide more frequent breaks for food consumption

t) **Crohn disease: Possible Accommodations**

- **Using the restroom as needed:** An individual with a GI disorder may benefit from a flexible schedule to incorporate restroom breaks, a workstation closer to the restroom to reduce break time and deal with urgency, a change in job assignment to a job that allows flexible breaks, and work from home during flare-ups.
- **Working while undergoing treatment:** An individual with a GI disorder may benefit from flexible use of leave time to seek treatment, flexible scheduling to make up time missed for treatment, and part-time work or work from home while recovering from a flare-up.
- **Meeting the physical demands of the job:** An individual with a GI disorder may benefit from job restructuring to remove marginal job functions that are physically demanding, equipment or other accommodations that reduce the physical demands of the job, and transfer to a vacant position that is less physically demanding.
- **Dealing with workplace stress:** An individual with a GI disorder may benefit from reduction or elimination of stress in the current position, transfer to a less stressful position, flexible schedule to recover from any effects caused by workplace stress, and work at home to avoid workplace stress.

u) **Tourette syndrome: Possible Accommodations**

Difficulty Handling Emotions and Workplace Stress:

- Encourage the use of stress management techniques to deal with frustration
- Provide a quiet place for the individual to go when tics are severe
- Have an agreed upon cue for the individual to leave the room
- Allow the presence of a support animal
- Allow telephone calls during work hours to doctors and others for needed support
- Allow flexible breaks
- Refer to employee assistance program (EAP)

Difficulty Concentrating:

To reduce auditory distractions:

- Purchase a noise canceling headset
- Hang sound absorption panels
- Provide a white noise machine
- Relocate employee's office space away from audible distractions
- Redesign employee's office space to minimize audible distractions

To reduce visual distractions:

- Install space enclosures (cubicle walls)
- Reduce clutter in the employee's work environment
- Relocate employee's office space away from visual distractions
- Redesign employee's office space to minimize visual distractions

Difficulty Organizing:

- Develop color-code system for files, projects, or activities
- Use daily checklist to help with organization
- Use weekly chart to identify daily work activities
- Monitor progress and assess frequently
- Use a job coach to teach/reinforce organization skills
- Assign a mentor to help employee
- Allow supervisor to prioritize tasks
- Assign new project only when previous project is complete, when possible
- Break long-term projects into small, sequential steps
- Provide incentives for beginning and completing a task
- Provide a "cheat sheet" of high-priority activities, projects, people, etc.
- Allow the individual to get up and move around
- Number and sequence the steps of a task

Working Effectively:

Supervisors can also implement management techniques that support an inclusive workplace culture while simultaneously providing accommodations. Successful techniques include the following:

- Provide positive praise and reinforcement
- Provide day-to-day guidance and feedback
- Provide written job instructions via email
- Develop clear expectations of responsibilities and the consequences of not meeting performance standards
- Schedule consistent meetings with employee to set goals and review progress
- Allow for open communication
- Establish written long term and short-term goals

- Develop strategies to deal with conflict
- Develop a procedure to evaluate the effectiveness of the accommodation
- Educate all employees on their right to accommodations
- Provide sensitivity training to coworkers and supervisors
- Do not mandate that employees attend work related social functions
- Encourage all employees to move non-work related conversations out of work areas

v) **Raynaud's disease: Possible Accommodations**

Sensitivity to Cold Temperatures:

- Modifying worksite temperatures
- Modifying dress code
- Using heaters at workstations
- Allowing flexible scheduling and flexible use of leave time during inclement weather
- Allowing work from home during extremely cold weather
- Maintaining the ventilation system
- Redirecting air conditioning and heating vents
- Making available heated gloves or cold resistant material and extra clothing
- Providing work areas with separate temperature controls

Fine Motor Impairment:

Office Settings

- Implementing ergonomic workstation design
- Providing writing aids, page turner, book holder, etc.
- Providing alternative computer and telephone access
- Providing arm supports and grip aids
- Offering filing modifications
- Providing a note taker

Industrial Settings

- Providing ergonomic tools and other adaptations such as:
 - power tools instead of hand tools
 - tools that can be used in either hand
 - tools without single finger activation
 - tools that have pistol shaped handles for power grips
- Reducing palm stress by providing tool wraps to pad long handles
- Providing newer tools with access to tool balancers/positioners

Service Settings

- Providing ergonomic knives and food service equipment
- Using money counters and bill handlers
- Using ergonomic and spring-loaded scissors
- Providing cake decorating syringes that use plungers
- Using ergonomic mop buckets and mops
- Providing adjustable carts (e.g., motorized, multi-purpose) and compact lifting devices

Medical Settings

- Using large handles and other adaptations for microscopy work: PC scopes, pipettes, and test tube holders
- Using ergonomic dental and surgical instruments

Stress Intolerance:

- Referring to counseling and EAP
- Identifying and removing environmental triggers such as particular smells or noises
- Allowing telephone calls during work hours to doctors and others for needed support
- Allowing the presence of a support animal
- Allowing flexible work environment:
- Providing flexible scheduling
- Modifying break schedule
- Giving leave for counseling
- Allowing work from home/Flexi-place

Concentration Issues:

- Providing written job instructions when possible
- Prioritizing job assignments
- Providing clear expectations of timelines
- Allowing flexible work hours and allow a self-pace workload
- Allowing periodic rest periods to reorient
- Providing memory aids, such as schedulers or organizers
- Minimizing distractions
- Reducing job stress
- Allowing access to music and/or white noise

Fatigue/Weakness:

- Reducing or eliminating physical exertion and workplace stress
- Scheduling periodic rest breaks away from the workstation
- Allowing a flexible work schedule and flexible use of leave time

- Allowing work from home
- Implementing ergonomic workstation design

w) **Epilepsy: Possible Accommodations**

Accommodation Ideas for Cognitive Impairments Associated with Epilepsy

Memory:

People with epilepsy may experience memory deficits, which can affect their ability to complete tasks, remember job duties, or recall daily actions or activities. This could be caused by a side-effect of medications or from recent seizure activity.

- Provide written or pictorial instructions or prompt with verbal cues
- Offer training refreshers
- Use a chart to describe steps to complicated tasks
- Maintain, safely and securely, paper lists of crucial information such as passwords
- Use voice recordings of verbal instructions
- Provide the employee directory with pictures
- Use nametags and door/cubicle name markers
- Provide a building directory or employee directory by name, floor, unit, etc.
- Label items on the employee's desk (in-box, this week's videos, etc.)
- Use auto-dial phone features to connect quickly to used numbers

Time Management:

People with epilepsy may have difficulty managing time, which can affect their ability to complete tasks within a specified timeframe. It may also be difficult to prepare for, or to begin, some work activities.

- Divide large assignments into several small tasks
- Set a timer to make an alarm
- Provide a checklist of assignments
- Supply an electronic or handheld organizer and train on how to use effectively
- Use a wall calendar to emphasize due dates

Stress management:

People with epilepsy may have seizures when stress is not properly managed. Situations that create stress can vary from person to person, but could likely involve heavy workload, unrealistic timeframes, shortened deadlines, or conflict among coworkers.

- Provide praise and positive reinforcement
- Refer to employee assistance programs
- Allow the employee to make telephone calls to doctors (and others) for support
- Provide sensitivity training
- Modify work schedule

Accommodation Ideas for Motor Impairments Associated with Seizures

Driving:

People with epilepsy may have driving restrictions. For specific information about a state's regulations involving driving with epilepsy, pair the employee with a co-worker who can drive to meetings or events

- Allow telework or work from home
- Transfer the employee to a position that does not require driving
- Adjust schedule so the employee can access public transportation
- Help facilitate a carpool with co-workers for transportation to/from work

Balancing/Climbing:

People with epilepsy may have difficulty balancing or climbing.

- Cushion a fall by using rubber matting on floor and by adding padded edging to corners and edges
- Install machine guarding
- Use rolling safety ladders with handrails and locking casters
- Provide head protection
- Provide eye protection
- Use fall protection

Fatigue:

People with epilepsy may experience fatigue due to a side-effect of medications or to recent seizure activity.

- Use anti-fatigue matting on the floor
- Provide flexible start or ending times
- Adjust workweek
- Provide private or secure rest area during breaks

Ensuring Safety in the Workplace:

Take some universal precautions to ensure safety in the workplace.

- Designate a person to respond to emergencies
- Keep aisles clear of clutter
- Provide a quick, unobstructed exit
- Post clearly marked directions for exits, fire doors, etc.
- Know when to (or not to) call 9-1-1
- Consult employee's plan of action to determine how to respond/react when employee has a seizure on the job (see "Plan of Action" section for additional information)

Accommodation Ideas for Sensory Impairments Associated with Seizures

Photosensitivity:

People with epilepsy may have seizures or headaches due to light sensitivity, which can be exacerbated by light sources such as computer screens or fluorescent lights.

- Use a flicker-free monitor (LCD display, flat screen)
- Use a monitor glare guard
- Use a cubicle shield
- Allow frequent breaks from tasks involving computer
- Provide alternative light sources:
 - Replace fluorescent lights with full spectrum lighting
 - Use natural lighting source (window) instead of electric light
- Provide fluorescent light tube covers

Seeing/Hearing/Communicating:

During or after seizures, an employee may temporarily have limited ability to see, hear, or speak.

- Allow the employee time to recuperate from seizure
- Identify hand signals or other universal signals that the employee might use to communicate with another person
- Use PECS (picture exchange communication system) to communicate
- Use paging systems to communicate with coworkers
- Provide 2-way radios with texting options
- Use alert systems to send message

Other Accommodations

Attendance/Absenteeism:

Seizure activity can affect a person's attendance at work.

- Allow employee to remain on the job after a seizure when possible
- Provide flexible schedule
- Modify an attendance policy
- Provide leave while the employee is adjusting to medications
- Work a straight shift instead of rotating shifts

Personal Care:

During or after a seizure, people with epilepsy may exhibit behaviours such as crying, drooling, spitting, or urinating. As a result, the person may need time following a seizure to engage in activities of daily living such as grooming and changing clothes.

- Allow the employee to keep a change of clothes at the workplace
- Provide a private space to regain composure and perform self-care tasks
- Provide sensitivity training/disability awareness to coworkers

x) **Guillain-Barre syndrome: Possible Accommodations**

- **Managing fatigue or muscle weakness:**

An individual with GBS may benefit from a flexible work schedule, liberal use of leave time, being allowed to work from home, a reduction or elimination of physical exertion and workplace stress, scheduled rest breaks away from the workstation, and ergonomic workstation design. Ergonomic equipment, adjustable workstations (office and industrial), and supine workstations may also be useful.

- **Impairment of the use of the legs and feet:**

A wheelchair or scooter may accommodate individuals who have difficulty moving around a workplace. For building access, accessible parking, ramps, stair and chair lifts, and elevators are helpful. Implementing appropriate emergency evacuation procedures may also be a benefit. Stand-lean stools and anti-fatigue matting may assist with relieving fatigue for individuals who have to stand for long periods.

- **Impairment of the hands and fingers:**

For computer access, speech recognition, alternative input devices, one-handed keyboards, alternative keyboards, expanded keyboards, alternative mice, and miniature keyboards can help. Writing aids; alternative telephone access; filing modifications such as modified filing trays, Lazy-Susan carousels, and automated filing systems; reachers; page turners; and book holders may also be helpful. For access to tools, ergonomic tools, tool balancers, and anti-vibration wraps and gloves will often help increase gripping ability. For assistance with lifting, compact lifting devices, lift tables and vacuum lifts are often used. For driving, steering grips or hand controls may be useful.

y) **Alzheimer's: Possible Accommodations**

Memory:

- Provide a voice activated recorder to record verbal instructions
- Provide written information
- Provide checklists
- Prompt employee with verbal cues (reminders)
- Post written or pictorial instructions on frequently-used machines or for routine procedures
- Provide templates or forms to prompt for needed information
- Remove marginal job functions to allow more focus on essential functions
- Use color-coding to indicate important information
- Extend training time when significant workplace changes occur

Organization:

- Minimize clutter
- Color-code items or resources
- Divide large tasks into multiple smaller tasks
- Avoid re-organization of workspace
- Label items or resources
- Use symbols instead of words

Time Management/Completing Tasks:

- Provide verbal prompts (reminders)
- Provide written or symbolic reminders
- Arrange materials in order of use
- Use task list with numbers or symbols
- Provide additional training or retraining as needed
- Provide a timer and a recommended amount of time to complete tasks
- Provide a watch with multiple settings
- Rid desk or work area of clutter and items/materials not used

Difficulty Performing Job Duties:

- Retain as many job tasks as possible that the employee is familiar with and proficient in
- Remove marginal job functions to allow more focus on essential functions
- Incorporate simpler tasks from other employees' job descriptions
- Consider a reduction in the work hours
- Alter when and/or how a job function is performed
- Recognize that a reassignment to a position that better matches the skills and capabilities of the employee may be necessary

z) Spondylosis: Possible Accommodations

Activities of Daily Living:

- Allow use of a personal attendant at work
- Allow use of a service animal at work
- Make sure the facility is accessible
- Move workstation closer to the restroom
- Allow longer breaks
- Refer to appropriate community services
- Allow access to a refrigerator

Fatigue/Weakness:

- Reduce or eliminate physical exertion and workplace stress
- Schedule periodic rest breaks away from the workstation
- Allow a flexible work schedule, flexible use of leave time, and work from home
- Implement ergonomic workstation design
- Provide a scooter or other mobility aid if walking cannot be reduced

Fine Motor Impairment:

- Implement ergonomic workstation design
- Provide alternative computer access
- Provide alternative telephone access
- Provide arm supports
- Provide writing and grip aids
- Provide a page turner and a book holder
- Provide a note taker

Gross Motor Impairment:

- Modify the worksite to make it accessible
- Provide parking close to the worksite
- Provide an accessible entrance
- Install automatic door openers
- Provide an accessible restroom and break room
- Provide an accessible route of travel to other work areas used by the employee
- Modify the workstation to make it accessible
- Adjust desk height if wheelchair or scooter is used
- Make sure materials and equipment are within reach range
- Move workstation close to other work areas, office equipment, and break rooms

Photosensitivity:

- Minimize outdoor activities between the peak hours of 10:00 am and 4:00 pm
- Avoid reflective surfaces such as sand, snow, and concrete
- Provide clothing to block UV rays
- Provide “waterproof” sun-protective agents such as sun blocks or sunscreens
- Install low wattage overhead lights
- Provide task lighting
- Replace fluorescent lighting with full spectrum or natural lighting
- Eliminate blinking and flickering lights
- Install adjustable window blinds and light filters

Skin Irritations:

- Avoid infectious agents and chemicals
- Avoid invasive procedures
- Provide protective clothing

Sleep Disorder:

- Allow flexible work hours
- Allow frequent breaks
- Allow work from home

Stress:

- Develop strategies to deal with work problems before they arise
- Provide sensitivity training to coworkers
- Allow telephone calls during work hours to doctors and others for support
- Provide information on counseling and employee assistance programs
- Allow flexible work environment:
 - Flexible scheduling
 - Modified break schedule
 - Leave for counseling
 - Work from home/Flexi-place

Temperature Sensitivity:

- Modify worksite temperature
- Modify dress code
- Use fan/air-conditioner or heater at the workstation
- Allow flexible scheduling and flexible use of leave time
- Allow work from home during extremely hot or cold weather
- Maintain the ventilation system
- Redirect air conditioning and heating vents
- Provide an office with separate temperature control

aa) Visual impairment: Possible Accommodations**Reading Printed Materials****Low Vision:**

- Closed circuit television (CCTV) system, which is sometimes referred to as an electronic or video magnifier
- Hand, stand, or portable magnifier
- Information in large print
 - Note: The American Foundation for the Blind (2008c) recommends that the font size be at least 16 point but preferably 18 point.
- Photo copier enlarged paper material
- Color paper, acetate sheet, or overlay to increase color contrast between printed text and document background
- Optical devices such as monoculars or binocular systems, loupes, or prism spectacles
- Frequent breaks to rest eyes when fatigue is a factor

No Vision (individuals with low vision may find the following helpful also):

- Auditory versions of printed document
- Braille formatted document
- Reformatted document that displays as accessible Web page

- The Kurzweil-National Federation of the Blind Reader, which takes a picture of a text document and reads the contents of the printed document in clear synthetic speech
- Optical character recognition (OCR), which scans printed text and provides a synthetic speech output or text-based computer file
- Qualified reader, which may be used to “be the eyes” for a person with a vision impairment
 - Note: There currently is not a standard for providing or hiring readers, and no certification requirements exist.
- Tactile graphic document

Accessing Computer Information:

Low Vision:

- Increased operating system font size with large-size computer monitors
 - Note: Computer users can modify their computer display so that text is shown in large print
- Screen magnification software
- Locator dots and/or large print keyboard labels for keyboard navigation
- External computer screen magnifier
- Flicker-free monitor
- Anti-glare guard and computer glasses to reduce glare
- Frequent breaks to rest eyes when fatigue is a factor

No Vision (individuals with low vision may find the following helpful also):

- Screen reading software
- Computer Braille display
- Qualified reader

Writing Notes and Completing Forms:

Low Vision:

- Closed circuit television (CCTV) system, which is sometimes referred to as an electronic or video magnifier
- Pens that include a bold felt tip or lighted pen
- Paper with tactile lines, bold print, or low glare
- Form/line guide

No Vision (individuals with low vision may find the following helpful also):

- Personal data assistants, notetakers, and laptops with speech output or Braille display
- Cassette or digital recorder
- Braille stylus/Braille slate
- Braille printer or embosser
- Scribe

Accessing a Telephone:

Low Vision:

- Large print/color labels or tactile markings on telephone to identify keys and lines
- Hand/stand magnifier or optical magnifier

No Vision (individuals with low vision may find the following helpful also):

- Telephone light sensor, which is held over a phone line to indicate if a line is lit steady or blinking
 - Note: Line status is indicated by audible or vibrating signal
- Talking telephone console indicators and message displays

Working with Money:

Low Vision:

- Hand/stand magnifier or optical magnifier
- Task lighting or headlamp

No Vision (individuals with low vision may find the following helpful also):

- Talking money identifier, cash register, coin counter/sorter, calculator
- Training on how to fold money for identification purposes

Reading from Instrument or Control Board:

Low Vision:

- Hand/stand magnifier or optical magnifier
- Large print/color labels or tactile markings on telephone to identify keys and lines
- Task lighting
- Glare reduction

No Vision (individuals with low vision may find the following helpful also):

- Braille/tactile labels or indicators
- Qualified reader
- Instrument modification by manufacturer, rehabilitation engineer, or employer

Repairing, Constructing, Assembling Pieces/Parts:

Low Vision:

- Hand/stand magnifier or optical magnifier
- Task lighting
- CCTV

No Vision (individuals with low vision may find the following helpful also):

- Braille/tactile labels or indicators
- Talking multimeter, micrometer, caliper, stud finder, level, tape measure
- Tactile ratchet-action wrench

Mobility:

- Service animal and/or mobility aid (e.g., cane, electronic aid)
- Mobility and orientation training
- Detectable warning surfaces
- Colored and/or textured edges on stairs

- Improved area lighting
- Traveling/evacuation partner
- Tactile map of evacuation and common routes
- Talking landmark or global positioning system

Driving:

- Shift change to daylight hours
- Driver (e.g., hired driver, volunteer, co-worker)
- Public transportation or carpool
- Modified or flexible work schedule to meet public transportation needs
- Reassignment
- Telework

Working with Light Sensitivity:

- Lower wattage of overhead lights
- Task or alternative lighting
- Full spectrum lighting and/or filters
- Flicker free lighting
- Tinted optical wear
- Workstation relocation
- Window treatments

Distinguishing Colors:

- Labels
- X-Chrome lens
- Prescribed glasses for color discrimination
- Colored acetate sheets
- Assistant to identify colors such as a volunteer or co-worker

Other Accommodation Considerations:

- Training materials or company correspondence in alternate format (e.g., large print, Braille, CD-ROM, audiotape)
- Time off for training on adaptive technology, mobility training, and/or service animal training
- Additional training beyond what is typically given to others
- Accessible versions of employee related Web sites or Intranet material

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