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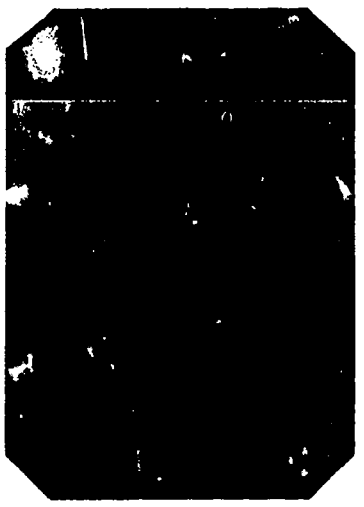
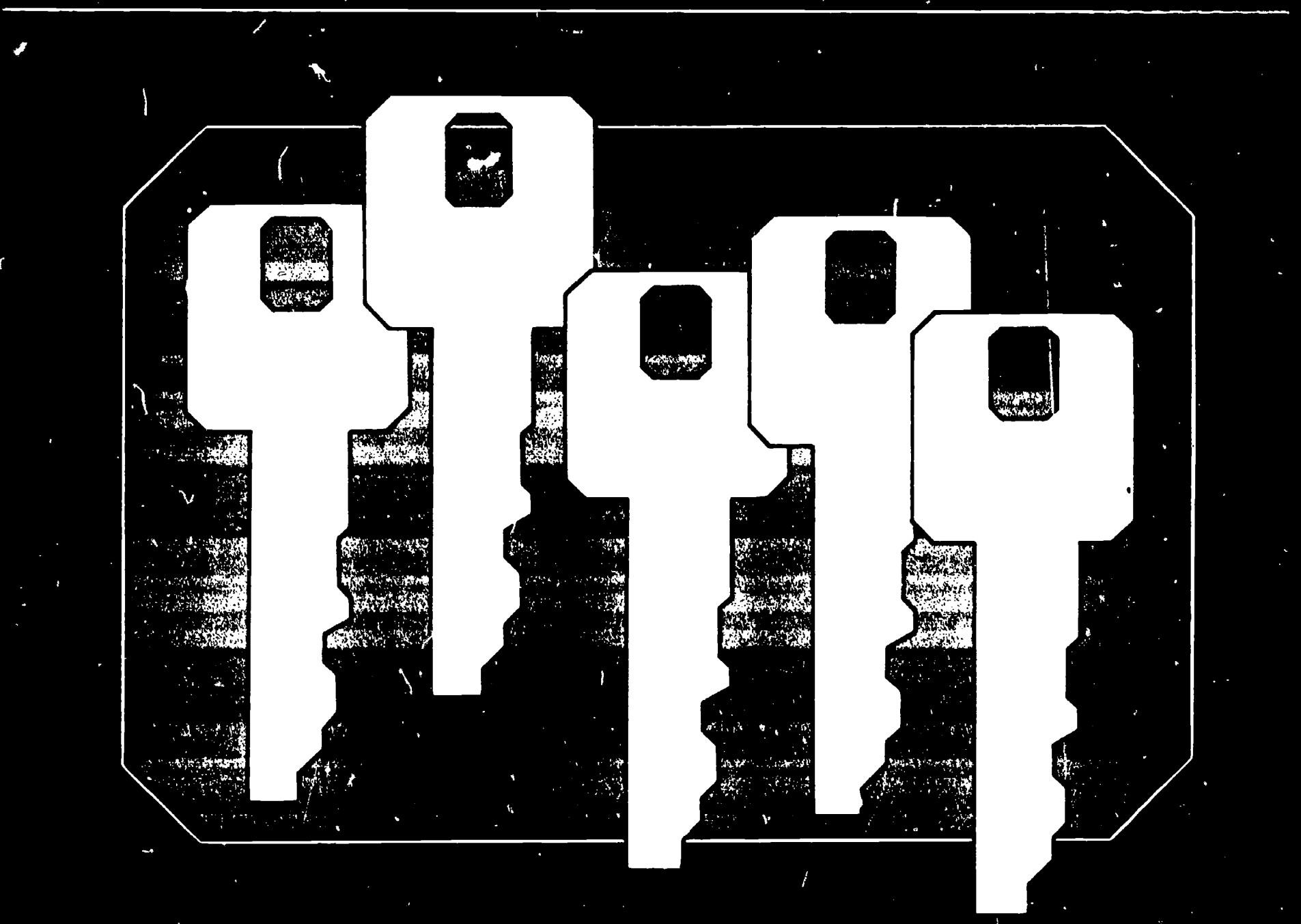
ABSTRACT

This learning module, one in a series of competency-based guidance program training packages focusing upon professional and paraprofessional competencies of guidance personnel, deals with developing a greater understanding of persons with disabilities. Addressed in the module are the following topics: negative assumptions commonly made about individuals with disabilities, ways of identifying one's personal attitudes toward disabled persons and reasons for holding those attitudes, the process of psychological adjustment to acquired disabilities and appropriate responses to such disabilities, career and life obstacles faced by persons with disabilities and guidance approaches to help alleviate some of these obstacles, and strategies for enhancing open communication about disabilities between counselors and disabled clients. The module consists of readings and learning experiences covering these five topics. Each learning experience contains some or all of the following: an overview, a competency statement, a learning objective, one or more individual learning activities, an individual feedback exercise, one or more group activities, and a facilitator's outline for use in directing the group activities. Concluding the module are handouts, a participant self-assessment questionnaire, a trainer's assessment questionnaire, a checklist of performance indicators, a list of references, and an annotated list of suggested additional resources. (MN)

Enhance Understanding of Individuals with Disabilities





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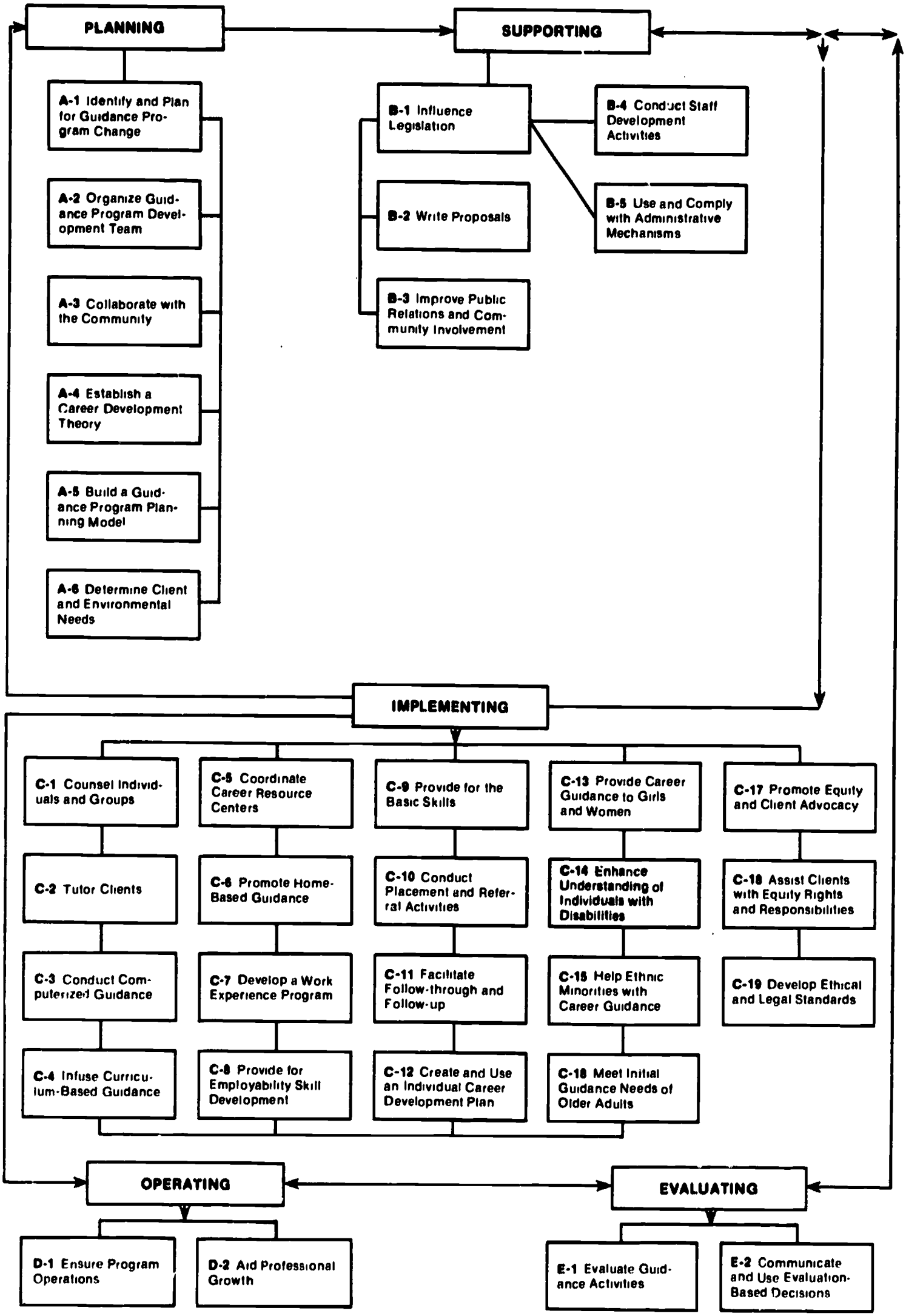

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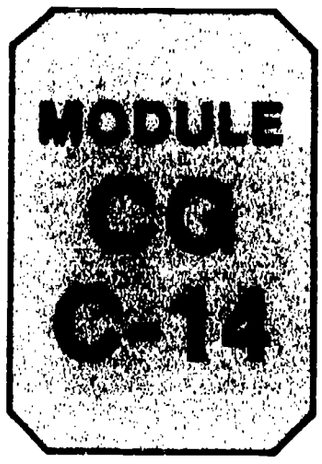

Module CG C-14 of Category C — Implementing
Competency-Based Career Guidance Modules

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FOREWORD

This counseling and guidance program series is patterned after the Performance-Based Teacher Education modules designed and developed at the National Center for Research in Vocational Education, under Federal Number NE-C00-3-77 Because this model has been successfully and enthusiastically recieved nationally and internationally, this series of modules follows the same basic format

This module is one of a series of competency-based guidance program training packages focusing upon specific professional and paraprofessional competencies of guidance personnel The competencies upon which these modules are based were identified and verified through a project study as being those of critical importance for the planning, supporting implementing operating and evaluating of guidance programs These modules are addressed to professional and paraprofessional guidance program staff in a wide variety of educational and community settings and agencies

Each module provides learning experiences that integrate theory and application, each culminates with competency referenced evaluation suggestions The materials are designed for use by individuals or groups of guidance personnel who are involved in training Resource persons should be skilled in the guidance program competency being developed and should be thoroughly oriented to the concepts and procedures used in the total training package

The design of the materials provides considerable flexibility for planning and conducting competency-based preservice and inservice programs to meet a wide variety of individual needs and interests The materials are intended for use by universities, state departments of education, postsecondary institutions, intermediate educational service agencies, JTPA agencies, employment security agencies and other community agencies that are responsible for the employment and professional development of guidance personnel

The competency-based guidance program training packages are products of a research effort by the National Center's Career Development Program Area Many individuals, institutions and agencies participated with the National Center and have made contributions to the systematic development testing and refinement of the materials

National consultants provided substantial writing and review assistance in development of the initial module versions over 1300 guidance personnel used the materials in early stages of their development and provided feedback to the National Center for revision and refinement The materials have been or are being used by 57 pilot community implementation sites across the country

Special recognition for major roles in the direction development, coordination of development, testing and revision of these materials and the coordination of pilot implementation sites is extended to the following project staff Harry N Drier Consortium Director, Robert E Campbell, Linda Pfister, Directors; Robert Bhaerman, Research Specialist Karen Kimmel Boyle, Fred Williams, Program Associates, and Janie B Connell, Graduate Research Associate

Appreciation also is extended to the subcontractors who assisted the National Center in this effort Drs Brian Jones and Linda Phillips-Jones of the American Institutes for Research developed the competency base for the total package, managed project evaluation, and developed the modules addressing special needs Gratitude is expressed to Dr Norman Gysbers of the University of Missouri-Columbia for his work on the module on individual career development plans Both of these agencies provided coordination and monitoring assistance for the pilot implementation sites Appreciation is extended to the American Vocational Association and the American Association for Counseling and Development for their leadership in directing extremely important subcontractors associated with the first phase of this effort

The National Center is grateful to the U S Department of Education, Office of Vocational and Adult Education (OVAE) for sponsorship of three contracts related to this competency-based guidance program training package In particular, we appreciate the leadership and support offered project staff by David H Pritchard who served as the project officer for the contracts We feel the investment of the OVAE in this training package is sound and will have lasting effects in the field of guidance in the years to come

Robert E Taylor
Executive Director
National Center for Research
in Vocational Education

THE NATIONAL CENTER
FOR RESEARCH IN VOCATIONAL EDUCATION
THE OHIO STATE UNIVERSITY
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The National Center for Research in Vocational Education's mission is to increase the ability of diverse agencies, institutions, and organizations to solve educational problems relating to individual career planning, preparation, and progression The National Center fulfills its mission by

- Generating knowledge through research
- Developing educational programs and products
- Evaluating individual program needs and outcomes
- Providing information for national planning and policy
- Installing educational programs and products
- Operating information systems and services
- Conducting leadership development and training programs

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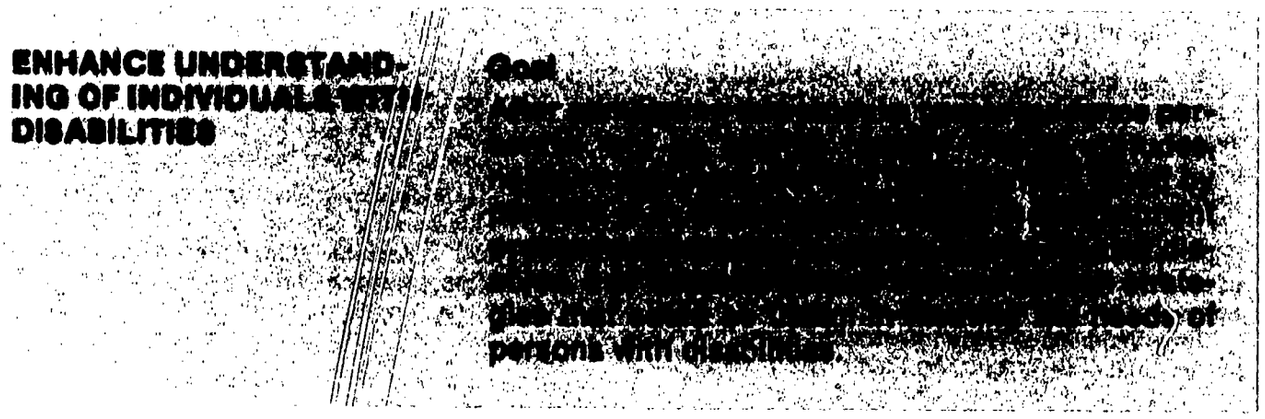
ABOUT THIS MODULE



ABOUT USING THE CBCG MODULES

CBCG Module Organization

The training modules cover the knowledge, skills, and attitudes needed to plan, support, implement, operate, and evaluate a comprehensive career guidance program. They are designed to provide career guidance program implementers with a systematic means to improve their career guidance programs. They are competency-based and contain specific information that is intended to assist users to develop at least part of the critical competencies necessary for overall program improvement.

These modules provide information and learning activities that are useful for both school-based and nonschool-based career guidance programs.

The modules are divided into five categories.

The GUIDANCE PROGRAM PLANNING category assists guidance personnel in outlining in advance what is to be done.

The SUPPORTING category assists personnel in knowing how to provide resources or means that make it possible for planned program activities to occur.

The IMPLEMENTING category suggests how to conduct, accomplish, or carry out selected career guidance program activities.

The OPERATING category provides information on how to continue the program on a day-to-day basis once it has been initiated.

The EVALUATING category assists guidance personnel in judging the quality and impact of the program and either making appropriate modifications based on findings or making decisions to terminate it.

Module Format

A standard format is used in all of the program's competency-based modules. Each module contains (1) an introduction, (2) a module focus, (3) a reading, (4) learning experiences, (5) evaluation techniques, and (6) resources.

Introduction. The introduction gives you, the module user, an overview of the purpose and content of the module. It provides enough information for you to determine if the module addresses an area in which you need more competence.

About This Module. This section presents the following information:

Module Goal: A statement of what one can accomplish by completing the module.

Competencies: A listing of the competency statements that relate to the module's area of concern. These statements represent the competencies thought to be **most critical** in terms of difficulty for inexperienced implementers, and they are **not** an exhaustive list.

This section also serves as the table of contents for the reading and learning experiences.

Reading. Each module contains a section in which cognitive information on each one of the competencies is presented.

1. Use it as a textbook by starting at the first page and reading through until the end. You could then complete the learning experiences that relate to specific competencies. This approach is good if you would like to give an overview of some competencies and a more in-depth study of others.
2. Turn directly to the learning experiences(s) that relate to the needed competency (competencies). Within each learning experience a reading is listed. This approach allows for a more experiential approach prior to the reading activity.

Learning Experiences. The learning experiences are designed to help users in the achievement of specific learning objectives. One learning experience exists for each competency (or a cluster of like competencies), and each learning experience is designed to stand on its own. Each learning experience is preceded by an overview sheet which describes what is to be covered in the learning experience.

Within the body of the learning experience, the following components appear.

Individual Activity: This is an activity which a person can complete without any outside assistance. All of the information needed for its completion is contained in the module.

Individual Feedback: After each individual activity there is a feedback section. This is to provide users with immediate feedback or evaluation regarding their progress before continuing. The concept of feedback is also intended with the group activities, but it is built right into the activity and does not appear as a separate section.

Group Activity: This activity is designed to be facilitated by a trainer, within a group training session.

The group activity is formatted along the lines of a facilitator's outline. The outline details suggested activities and information for you to use. A blend of presentation and "hands-on" participant activities such as games and role playing is included. A Notes column appears on each page of the facilitator's outline. This space is provided so trainers can add their own comments and suggestions to the cues that are provided.

Following the outline is a list of materials that will be needed by workshop facilitator. This section can serve as a duplication master for mimeographed handouts or transparencies you may want to prepare.

Evaluation Techniques. This section of each module contains information and instruments that can be used to measure what workshop participants need prior to training and what they have accomplished as a result of training. Included in this section are a Pre- and Post-Participant Assessment Questionnaire and a Trainer's Assessment Questionnaire. The latter contains a set of performance indicators which are designed to determine the degree of success the participants had with the activity.

References. All major sources that were used to develop the module are listed in this section. Also, major materials resources that relate to the competencies presented in the module are described and characterized.

INTRODUCTION

True or False?

1. All mental, emotional, and physical problems exhibited by a person with a disability are directly related to the disability.

2. The same sequence of course work, the same kinds of career plans, and the same limitations of life management and leisure goals and activities are appropriate for all individuals possessing a similar type and degree of disability.

3. Persons with disabilities, especially those with severe disabilities, have no needs other than those directly related to their disabilities.

Stated so unconditionally, these assumptions look transparently false. Yet over and over, ineffective guidance relationships reveal incidents of behaviors which fit one of these general **stereotyped statements**. It is not always easy to be aware of the operation of these assumptions, since they are accepted and unchallenged by much of society.

In order for you to provide effective career guidance for your clients with disabilities, your attitudes must be free of those limiting, negative, fearful preconceptions about disability. You must be sure you have thoroughly examined your **own attitudes** and are maintaining your commitment to the basic guidance challenge: to see the total person first, and the problem second. In other words, you must be able to view the individuals you help as **"persons with disabilities" instead of "handicapped persons."** Even though the term "handicapped person" is a common one, the phrase "persons (or individuals) with disabilities" will be used in this module since it stresses the person first and disabling condition last. The definition for persons with disabilities used here is the one that appears in the final regulations of Public Law 94-142, the Education for All Handicapped Children Act of 1975. It includes individuals who are:

> mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, orthopedically impaired, other health impaired, deaf-blind, multihandicapped, or as having specific learning disabilities, who because of those impairments need special education and related services.

Specific definitions for disabilities follow. All are taken from the final regulations of Public Law 94-142.

> **Mentally retarded**--significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period, which adversely affects an individual's educational performance.
>
> **Hard of hearing**--a hearing impairment, whether permanent or fluctuating, which adversely affects an individual's educational performance but which is not included under the definition of "deaf" in this section.
>
> **Deaf**--a hearing impairment which is so severe that the individual is impaired in processing linguistic information through hearing, with or without amplification, which adversely affects educational performance.
>
> **Speech impaired**--a communication disorder, such as stuttering, impaired articulation, a language impairment, or a voice impairment, which adversely affects an individual's educational performance.
>
> **Visually handicapped**--a visual impairment which, even with correction, adversely affects a child's educational performance. The term includes both partially seeing and blind individuals.
>
> **Seriously emotionally disturbed**--a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance: inability to learn which cannot be explained by intellectual, sensory, or health factors; inability to build or maintain satisfactory interpersonal relationships with peers and others; inappropriate types of behavior or feelings under normal circumstances; a general pervasive mood of unhappiness or depression; or a tendency to develop physical symptoms or fears associated with personal or school/work problems. The term includes individuals who are schizophrenic or autistic. The term does not include those who are socially maladjusted, unless it is determined that they are seriously emotionally disturbed.
>
> **Orthopedically impaired**--a severe orthopedic impairment which adversely affects a person's educational performance. The term includes

impairments caused by congenital anomaly (e.g., clubfoot, absence of some member), impairments caused by disease (e.g., poliomyelitis, bone tuberculosis), and impairments from other causes (e.g., cerebral palsy, amputations, and fractures, or burns which cause contractures).

Other health impaired--limited strength, vitality or alertness, due to chronic or acute health problems such as a heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, or diabetes, which adversely affects a child's educational performance.

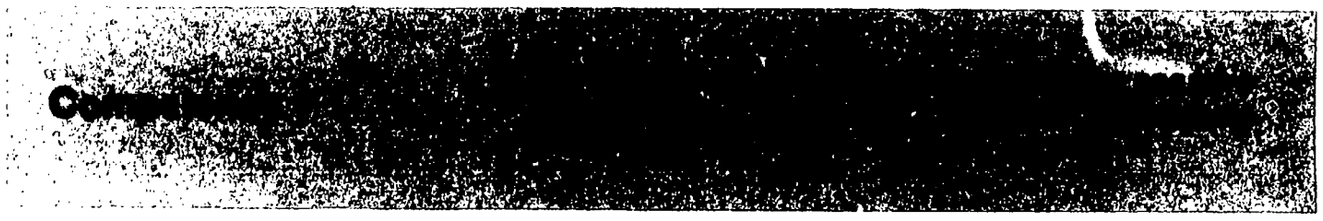
Deaf-blind--concomitant hearing and visual impairments, the combination of which causes such severe communication and other developmental and educational problems that they cannot be accommodated in special education programs solely for deaf or blind individuals.

Multihandicapped--concomitant impairments (such as mentally retarded-blind, mentally retarded-orthopedically impaired, etc.), the combination of which causes such severe educational problems that they cannot be accommodated in special education programs solely for one of the impairments. The term does not include deaf-blind individuals.

Specific learning disability--a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations. The term includes such conditions as perceptual handicaps, brain injury, minimal brain disfunction, dyslexia, and developmental aphasia. The term does not include individuals who have learning problems which are primarily the result of visual, hearing, or motor handicaps, of mental retardation, or of environmental, cultural, or economic disadvantage.

The module stresses general strategies for understanding and counseling persons with disabilities. Due to the comprehensiveness of the topics included, it was not possible to include many important areas such as the effects of federal rehabilitation legislation and the federally required individualized educational plan (IEP). Several of the references and resources listed later in the module provide excellent information on these and other topics. The module also does not outline specific career guidance techniques, but you can refer to modules CG C-1 *Counsel Individuals and Groups*; CG C-12 *Create and Use an Individual Career Development Plan*; CG C-13 *Provide Career Guidance for Girls and Women*; and CG C-5 *Career Resource Centers*, for a variety of these specific methods. In addition, you may wish to refer to modules CG C-18 *Promote Equity and Client Advocacy* and CG A-6 *Determine Client and Environmental Needs* for additional background material appropriate for assisting clients with disabilities.

Negative Assumptions



"Skiing? Blind people skiing? Mentally handicapped couples marrying? Why, that's out of the question!"

Preconceptions, assumptions, and categories shape thinking in every area of people's lives. Indeed, they are probably essential to acquiring patterns of everyday behavior which let individuals function smoothly in their busy lives. Yet because they are generalizations, they are not always accurate when applied to specific individuals. This statement is especially true in this era when everything is changing at an ever-increasing rate--changes that produce benefits as well as disadvantages.

Assumptions and attitudes about people with disabilities are some of the most deeply rooted that exist in our society. Perhaps this is because most persons have very **little experience** with individuals with disabilities. Until very recently, families, schools, employers, and the rest of society kept such persons apart from the nondisabled world, in special classes, sheltered workshops, and so on. Even today, although considerable progress has been made toward integrating persons with disabilities into the mainstream of society, acknowledgement of them as ordinary human beings, co-workers, friends, is still not widespread. This distance allows imagination to fill in the blanks as it will; and people usually fill them in with images of sadness and lack: "helpless," "hopeless," "limited," "tragic."

Not all societies have treated their disabled members as unfortunates. In *The Disab and Their Parents: A Counseling Challenge*, Leo Buscaglia notes contrasting attitudes toward disability in other times and places.

> The Masai Indians murdered their disabled children; the Azand tribe loved and protected theirs.
>
> The Chagga of East Africa used their disabled to ward off evil; the Jukun of the Sudan felt that they were the work of evil spirits and abandoned them to die.
>
> The Sem Ang of Malaysia used their crippled as wise men to settle tribal disputes; the Balanese made them a societal 'taboo.'
>
> The ancient Hebrew saw illness and physical defects as a mark of the sinner; the Nordics made them Gods.*

The ideal situation is one in which those with disabilities are seen as they are: whole people, with strengths and limitations like everyone else.

Assumptions about People with Disabilities

It is usually not difficult for you as a career guidance provider to identify many of the facts about your clients with disabilities. Doctors, family members, psychologists, teachers, and the clients themselves can describe medical and behavioral limitations or problems. Literature and resource materials can offer information on prosthetic devices, life-management aids, and other practical needs. But in order for you as part of the guidance staff, to play a positive role in the client's life, your attitude must be free of limiting, negative, fearful preconceptions about disability. You must be sure you have thoroughly examined your own attitudes and are maintaining your commitment to the basic guidance challenge: to see the person first, and the problem second. In

*Reprinted from Buscaglia, Leo *The Disabled and Their Parents: A Counseling Challenge* Thorofare, NJ Charles B Slack, Inc., 1975. p 171 Reprinted by permission

other words, you must be able to view your clients as "persons with disabilities" instead of "handicapped persons."

Putting this basic commitment into practice in your guidance relationships may require some **searching into the negative assumptions** you have made. Often negative assumptions are unconscious; the "usual" way of behaving towards the person with a particular disability seems logical and justifiable in the situation. But the important thing about dealing with individuals with disabilities is to realize how widely they differ in their functioning--even more than the nondisabled--simply because they are exceptional. They do not fit many norms in behavior, intelligence, emotional adjustment, or physical adaptability.

In order to surmount limiting attitudes and preconceptions, it helps to take a realistic look at certain facts about disabling conditions. The variety of types and extent of disability brings a few **facts** immediately into view.

1. There is a great **variation in functional abilities** among those classified as possessing a particular type of disability.

2. **Technological change** has created vast **new possibilities** for compensating for disabilities.

3. The **individual's attitude** and will to accomplish can bring about achievement that may seem impossible with a given disability.

Variation in Limitations. When people think of disability, it is usually in terms of the "rare exception." But the fact is that over half of the population has some kind of defect that causes a functional limitation: visual problems, speech difficulties, health problems, etc. Milder defects, such as the need for eye glasses, do not usually acquire the label or the stigma of "disability," though the difference is primarily one of degree.

Actual limitations of each person with a disability must be determined by exploring that person and the situation individually. General information, such as "diabetics who are involved in strenuous exercise will need to stop and eat at frequent intervals," offers helpful guidelines; but guidance providers should not automatically assume any specific functional limitations in a client with a disability until all possible information is gathered from the client, from family, medical experts, school or company nurse and/or psychologist, and others with knowledge of the individual.

Technological and Medical Aids. Improvements in medical care have turned some disabilities into virtually nonexistent problems. For instance, through medication, most diabetics and epileptics can control their conditions so that they are not even apparent in their daily lives, much less an interference with their functioning.

Even for those whose disabilities are functionally apparent, tremendous strides have been made in only the last few years toward filling their exceptional needs. For the blind, in addition to Braille styluses and typewriters, Talking Books, and other common aids, new technology has produced talking hand-held calculators and canes equipped with laser beams, which detect obstacles and sound different tones to indicate an obstacle's approximate height. Prosthetic devices of all types are constantly being improved. For example, people with cleft palates can be fitted with plastic devices which nearly close off the palatal opening and make speech training results much more satisfactory. Computer-operated artificial hands and limbs are being developed and improved. Surgical improvements, such as the use of plastic pins instead of traction for setting bones, lessen the duration of recovery from injury and thereby lessen the severity of long-term damage from fractures. Wheelchairs can be equipped with pressure-sensitive motor control mechanisms which allow people with virtually no muscular control to be mobile. Special teletypewriter machines allow deaf people to carry on conversations with hearing or nonhearing individuals over regular telephones, with readouts either on paper or on a screen.

The more promising treatment of mental disabilities has involved intensive educational interventions such as Dr. Marc Gold's "Try Another Way" strategies for teaching daily living and vocational skills to severely mentally disabled individuals, certain drug and megavitamin treatments, and prevention of the disabilities in the first place through education of prospective parents in nutrition, effects of drugs and alcohol, and other pregnancy-related topics.

Researchers continue to explore the potential relationship of nutrition and learning disabilities. Also, through using various educational strategies, including stimulus control and limitation, many individuals are overcoming their disabilities and functioning well in school and in the rest of their environment.

Technological development will continue, of course, and its direction will no doubt continue to enhance the capabilities of those with disabilities. The various associations which have been organized for the benefit of people with particular types of disabilities (such as those listed in Appendix B) are among the best sources of knowledge about new developments. Perhaps these technological and medical innovations will also eventually decrease or eliminate the occurrence of many conditions altogether.

Will and Attitude. The most significant factors in the lives of the people with disabilities are their own attitudes. This attitude is shaped by many factors as the individual grows; the attitudes and behavior of the family and other people close to the individual are among the most significant and may create a positive or negative effect.

The person's attitude forms the crucial difference between a disability and a handicap. **A disability is a true handicap only when it is seen as a significant barrier between the individual and accomplishment of particular goals.**

This does not mean that "anybody can do anything." Certain limitations sometimes do preclude particular activities. But even severe disabilities are usually only handicapping insofar as the person with a disability and others life view them as such. Maria French, a young woman with cerebral palsy involving her entire body, including her speech, writes:

> Part of what I believe is that I am not handicapped in any way. To me, cerebral palsy is not my handicap. The problem does not lie entirely with me, but also with you. The sight of someone who is physically twisted, in a wheelchair, or who has the gait of a drunk, exhibiting contortions and poor balance might elicit in you fears, feelings of inadequacy.... It is sometimes hard to conceive that someone who is really screwed-up physically, with the speech of a drunk, or no speech at all, has **the same human needs as you**, and perhaps, in some cases, a higher intelligence than yourself. This is where the problem lies, and this is mainly why I agreed to do this chapter for Dr. Buscaglia. I am not doing it to gain pity. **Pity is the last thing that I, or individuals like myself need.** I am doing it to make you **aware** that disabilities are but a fraction as disabilitating as attitudes, attitudes that attempt to define, limit, and compare. They are what comprise a handicap (Buscaglia, 1975, p. 235)

Maria French is earning a Master's degree in Rehabilitation Counseling. She also drives a car, camps in the woods with friends, and drinks wine . . . through a straw!

Negative Assumptions about People with Disabilities

Unconscious or unexamined negative assumptions may limit the effectiveness of career guidance workers. The following statements summarize the most common negative assumptions that may be held by a nondisabled person who is trying to help a client with a disability.

Negative Assumption Number 1. All mental, emotional, and learning problems exhibited by a client with a disability are directly related to the disability.

A 14-year-old boy was losing his sight slowly as a complication from diabetes. He suffered from severe and unremitting depression which the career guidance staff attributed to his fear of his growing disablement. He became nearly suicidal before contacts were established by the staff with his parents. It soon became evident that his mother was unable to accept the fact of his coming blindness and was influencing him greatly by her despair. This relationship, and not only the blindness itself, was the major cause of the boy's depression. Counseling for both the boy and his mother helped them both to begin the process of adjustment, of assessing the many things he could do instead of what he could not.

Other clients of all ages may show the results of overprotection by their families or cruel rejection by others in either their educational levels or emotional adjustment. These may be difficult problems, but they do not necessarily relate directly to the degree of disability at all. Instead they may stem from the attitudes which other people in the person's life have taken or are taking towards that disability. They may even stem from a different, perhaps undetected problem.

It is worth noting at this point that the process of counseling persons with disabilities will virtually always mean also counseling with the parents and/or others in the home. They are the ones with the deepest concerns for the person and the largest impact upon that individual's development. They are also a good source of knowledge and

insight into their family member and the greatest potential power for helping. Their knowledge about the individual's problem and their attitudes toward it may be either aiding or hindering the person's development, and it is part of your job as a career guidance helper to learn about the whole situation. But in either case, understanding the client's family members, learning from their knowledge, and helping them with their problems cannot be left out of a vital, responsive guidance process.

Negative Assumption Number 2. The same sequence of course work, the same kinds of career plans, and the same limitations on career and life management goals and activities are appropriate for all individuals possessing a similar type and degree of disability.

This is an obviously poor approach to counseling anybody, either with a disability or without. But it is all too common for people with disabilities to be viewed in terms of their limitations first, instead of their strengths and desires, and for plans for their futures to be developed on such bases. (Blind students end up in the fields of radio broadcasting and piano tuning much more frequently than the general population.) Often, especially for people with severe disabilities, these limitations create assumptions about their ability to ever assume independent status and productivity in society. A lifetime of dependence on the family or a sheltered workshop may be the only option even considered by both the family and the guidance staff. Yet growing numbers of people with disabilities are proving that they can function independently: setting up their own homes, alone or with others; learning to deal with architectural and other physical barriers; learning to use public transit, transportation services, or their own vehicles; and holding down jobs of every sort.

Of course some limitations are unchangeable at the current level of expertise, and clients must be helped to acknowledge the facts of their limitations if this has not already happened. But jumping too soon to such conclusions may eliminate the possibility of seeing other ways to the desired goal and confine guidance staff to seeing only the common ways. People in wheelchairs may not be able to walk but they are able to play basketball--as long as no one insists they do it the usual way.

Negative Assumption Number 3. Individuals with disabilities, especially those with severe disabilities, have no needs other than those directly related to their disabilities.

When you look at a man in a wheelchair, unable to walk, speak coherently, or even hold his hands steady, it is easy for the obvious needs connected with his physical condition to blot out awareness of other needs he might have. Sexual needs are an important example. Since their social relationships may not be comfortable and communicative, many people with disabilities may have neither the chance to talk about nor the chance to satisfy their sexual needs. Parents may not have been able to discuss the subject fully or at all, and teachers or other professionals may not have been able to deal with a client's needs for special information and reassurance. One reason for this, on the part of both parents and professionals, may be an aversion (conscious or unconscious) to associating sexuality with deformity or defect. But the needs remain, and unless clients can be helped to understand and accept their needs and situations in this fundamental area, problems of personal unhappiness and/or unacceptable public behavior are all but assured.

Other common human needs are often overlooked in comparison to evident problems. The needs for friendship, for intellectual stimulation, for excelling at something, and for physical exercise are as strong in those with disabilities as in those without. As well as providing or encouraging fulfillment of these needs, you may also be able to work with parents, spouses, teachers, coworkers, and peers of clients to develop settings in which these needs can be fulfilled. Parents can be encouraged to invite the client's classmates to social or study gatherings; spouses and friends can be sensitized to the needs and situations of people with disabilities in classes taught by counseling staff or in specially planned groups. All those who care about the client can be encouraged to be aware of subjects and activities that can fit in with, stimulate, and increase the individual's interests, skills, and self-esteem.

Your Own Attitudes

Competency 2

Identify your own attitudes in various situations toward people with disabilities and your reasons for holding those attitudes.

As you encounter more and more clients with disabilities, any preconceptions and stereotypes will have a special impact.

1. Such **preconceptions and stereotypes are usually limiting**. They create automatic boundary lines in your mind, beyond which it may never occur to you to look.

2. They are **usually negative**. "A blind person cannot attempt this vocation." "The paralyzed polio victim cannot have a sexually fulfilling marriage." "Who would hire an emotionally disturbed person?"

3. They **often reflect unacknowledged fears** on the part of career guidance personnel. "I'm just not good at dealing with handicaps" may mean "I'm afraid I will be contaminated with the same defect this person bears, or with the stigma it projects."

The following is designed to help you get in touch with your own attitudes toward people with disabilities. Jerry (choose male or female) is your spouse, who has recently become disabled. Visualize the following series of events.

Imagine Jerry out doing last-minute Christmas shopping on Christmas Eve, rushed and harried. Jerry has one more gift to buy (yours) at a store across the street and dashes into the street to go there. Jerry hears a screech of brakes and whirls around to see a car only inches away . . .

You get a telephone call and rush to the hospital. Bars and tubes are all around, and a nurse is standing over your mate. You whisper "what happened?" and she says, "Just a minute, I'll be right back," and disappears. She comes back soon with a doctor, and you ask her the same question. She says, "Jerry's been in an accident, hit by a car. Jerry will make it okay but was hurt pretty bad." She stops for a minute. Then she says, "There was damage to the spinal cord. We don't believe Jerry's legs or right arm will be of much use anymore."

Jerry is in the hospital for about eight weeks, during which it is confirmed that lifetime paralysis of the affected limbs is virtually certain. Jerry's legs cannot be moved at all, the right shoulder can be rotated to a limit of about ten degrees. The fingers do not move at all. You watch the muscles of these limbs shrink to two-thirds of their former size. Jerry acquires a motorized wheelchair but does not navigate it too well when the time comes to leave the hospital. Jerry is brought home and taken to your front door by ambulance attendants--home to resume a "normal" life.

Consider an ordinary day in your life and imagine your activities in as much detail as possible, beginning with helping Jerry out of bed in the morning. Picture every change you can think of that would occur in your own activities.

Imagine being confronted with this situation. What would your reaction be when Jerry arrived home? After three days? A week? A month? What practical frustrations might you face? Would you and the others communicate openly with Jerry or bottle up your feelings? What feelings do you think you might have when looking at nonfunctioning limbs? Upon having to change your image of Jerry's physical abilities?

Consider Jerry's friends and coworkers. How might they react? How might Jerry's functioning at work be limited? How might your friends react toward you? What types of reactions can you foresee?

There are several types of common negative reactions you could have. These include the following:

> **Frustration**, often displayed as anger at the special difficulties caused by a disability; **overprotection** or oversolicitousness;

demands for unattainable achievement; and **embarrassment** and nervousness.

Here are some examples of situations you could face with Jerry:

1. **Frustration**--Jerry awakens in the middle of the night needing to use the bathroom. You have to get up to help even though you are totally exhausted from your job, the housework, and almost all the responsiblity for the kids.

2. **Overprotection**--A close friend comes to visit and insists on doing everything for you, not letting Jerry move to get anything and even insisting on helping him/her eat. You are aware that Jerry has overheard the friend say, "Poor thing will need total care for the rest of his (her) life."

3. **Demands**--Your 11-year-old son says to Jerry, "Aw, if you can't catch the ball for me, the least you could do is try to throw it right!"

4. **Embarrassment**--On your first day back in your office several of your colleagues say hello and then don't seem to be able to find any other words.

Other common reactions by you or others include **ignoring** or avoiding Jerry; assuming that Jerry is totally **incompetent** to do or decide anything; **pity** or sympathy instead of empathy; **revulsion**; and, in the case of physical or sensory disability, assuming Jerry is also **mentally disabled**.

It is difficult to anticipate your reactions unless you have had these experiences firsthand, but perhaps this experience has helped you get in touch with some of your own attitudes toward disabilities. Keep these reactions in mind as you continue the learning activities, and share any concerns you have with some of your colleagues, including any who have disabilities.

Acquired Disabilities

Competency 3

Describe the process of psychological adjustment to acquired disabilities and describe how you could appropriately respond to needs exhibited by individuals who have had this experience.

Disabilities can be congenital (present at or during birth) or acquired (developed or experienced later in life). The individual who has always lived with a disability will have a different attitude toward it and will adjust differently to society than will an individual who has always been without disability and then one day is faced with it. This section will present some ideas for working with the latter individual. Although the content will be relevant for all acquired disabilities, it is most applicable to acquired physical and sensory disabilities.

Various individuals have discussed the process of adjustment to disability, including Peter Leech, a clinical social worker and counselor trainer at the Center for Independent Living in Berkeley, California. Some years ago he contracted polio and now requires a wheelchair for mobility. From his own experience and study and that of others, and from the need to help his counselor trainees experience some of the life situations of those with disabilities, he has evolved a model of the adjustment process which is unique in some aspects. This model and its implications for guidance and counseling efforts will be presented in some depth.

Of course emotional reactions and corresponding behaviors do not conform to simple and precise formulas. A theoretical "model" must be somewhat artificial, since it vastly oversimplifies and rigidifies a process which may be complicated and distorted by many factors. Nevertheless, separating the process into single elements can be an aid in better understanding the roots of certain behaviors, in choosing more effective responses to behavior, and in deciding how much

and what kind of service a client is likely to need from you and others on the guidance staff.

A Model of the Adjustment Process

According to Leech, the fundamental perception of disability or loss is the **comparison of the person's actual state with the standard of the community**. This standard may differ; for instance, professional football players and professional teachers may have basically different perceptions of the "disability" caused by paralysis of the legs. It is at the moment of perception of this difference from the standard of the community that the process of adjustment begins. This is true for those with congenital disabilities as well as for those with acquired disabilities. For instance, the congenitally blind child may not understand what "blind" means when it is first told about it. The critical psychological moment comes when the person perceives that "blindness," whatever it may be, makes him or her different from the "normal." This realization may occur within the environment of an accepting family, or it may be brought about by the taunts of peers; but at some point, every person with a disability, congenital or newly acquired, will have to encounter his or her difference from the standard of the society or the social context.

Leech proposes a **model** of the adjustment process consisting of **five fundamental stages**:

1. Shock
2. Sadness
3. Anger
4. Vulnerability
5. Acknowledgment

This progression of "stages" is not meant to be interpreted as a rigid prescription for any individual reaction pattern. Any kind of reaction may vary in the intensity, the duration of the process, or the direction of moment-to-moment change in feeling--that is, feelings of anger may be followed by the need to express sadness in crying. Indeed, this "interpenetration" of stages is probably the rule, not the exception. But Leech feels that the above model is an accurate description of the general direction of development. It is also a generally accurate picture of the normal sequence of behavior a person with a disability will exhibit after the difference from the standard is realized--if, and only if, the person's true feelings are expressed and validated as they naturally occur. This conditional statement will be explored more fully later. The following is a description of the five stages and their expressions in behavior.

Shock. The first stage, shock, may be manifested **physically and psychologically**. The body frequently does not experience anything right after the moment of trauma or loss. Similarly, the mind may simply not be able to comprehend loss or make meaningful the juxtaposition of the image of self and the image of disability. This is not denial, in the classic sense of refusal to admit the truth. It is rather an initial temporary stage of inability to integrate two previously separate images into a single new image. A state of "unfeeling," a temporary numbness, is the most common description of this period by people who have experienced disability.

Sadness. The next stage, after perception of the new reality has begun to occur, is sadness at the **loss of something valued**. This comprehension of the changed self is often not an "all-at-once" experience; the new state seems alternately real and unreal. In the case of disability later in life, the loss is twofold: the body part or function and the image of the self as meeting the standard of society. In the case of those disabled from birth, the latter realization of loss is the main, or only, cause of sadness. The natural expressions of this state are crying and conversation about the lost facility and the pain of loss.

Anger. The third stage is anger. Anger may have **several sources**. These may include outrage at the loss of functioning and/or self-image, accompanied by the anguished question, "Why me?"; rejection of the imperfect self and the newly perceived role it will be asked to play; or both. Frustration over tasks, often even very simple tasks, which cannot be accomplished in the way they once were (or at all) will add to the difficulties of those disabled later in life. Guilt or shame may be evidenced as a reaction to others' opinions, or to what the person imagines others' opinions are. This anger is not necessarily rational or selective about its targets. It may be shown in the form of lashing out at and rejection of the people who would most like to help, especially if there is any possible connection between those people and the fact of disability. "The doctors didn't help enough; my parents didn't try hard enough; my

counselor really thinks of me as handicapped." Anger at God may be expressed; anger at objects the person cannot effectively manipulate may result in destruction and tantrums; anger at the handicapped role which society will impose upon the individual may be directed at anyone, similarly disabled or nondisabled, deserved or not.

Vulnerability. The fourth stage, a sense of vulnerability, arises from the person's **uncertainties** about a new, or newly perceived, state. Just how limited is the person now, and how much aid will be needed and will there be the ability and opportunity to function in the world? What are the specific attitudes the person may expect to encounter in others? What does the person's future look like in terms of education, social contacts, employment? The person's capacity to meet these new situations is untested, and the knowledge of how different or painful they may be is slight; the person may feel and act helpless to control the future or even to visualize it.

Acknowledgment. The fifth stage, acknowledgment, includes the person's **awareness** of both the limitations and possibilities of the new situation. It is the beginning of a realistic approach to meeting actual needs: working within limitations, exploring strengths, and investigating opportunities for new ways of productivity and fulfillment.

These five stages comprise a model of the underlying feeling states of a person who acquires or becomes aware of a difference from the standard. Leech asserts that if each feeling state can be perceived by the person as it actually is, expressed straightforwardly to a trusted listener, and most importantly, validated and supported by others, denial and depression will not occur. If these states do occur, it means that certain states of feeling were not validated when they occurred. Perhaps the person's own life situations have trained this individual to avoid fully experiencing and identifying such feeling states; or perhaps the feelings were denied by well-meaning or apprehensive family members, friends, or educators.

Typical Behaviors When Feelings Are Repressed

Many behavior problems that arise are at least partially due to **denial of natural feelings**; the problems are lessened when such feelings are allowed expression. Someone who is constantly told, "Don't cry," may bottle up and repress sadness over loss; inability to express these feelings will often result in classic denial, and the stage of expression of anger may never be reached. Similarly, depression and apathy are common results of unexpressed or unvalidated anger, perhaps repressed because someone close to the person insists "Anger won't do any good--don't be angry!" Depression and apathy are different states from sadness, Leech maintains; they are not fundamental feeling states in themselves, but the result of repressing a natural feeling state because it is unacceptable to the individual or to others. Acting out anger at inappropriate targets or levels is another type of response when natural anger has been previously hidden.

The stage of vulnerability may be mistakenly seen by some as laziness or lack of "guts." Denial of the validity of the vulnerability stage may result from exhortations to "Get on with it!" or similar pressures and may result in unrealistic choices or in fear of making any choice at all. This sort of pressure from others may result from their own anxiety about disabilities and their desire to avoid them. Pressure from others to "accept" a disability may arise from the same source; this is why Leech prefers the term "acknowledgment" for the eventual state of healthy adjustment. Acknowledgment implies a realistic grasp of the situation, including its lacks; acceptance, when imposed as a goal by others, may actually arise from another's desire to avoid the anxiety-producing subject of disability.

Significance of the Adjustment Model

This adjustment model is important for you as a career guidance provider because it can help you to understand the behavior of a client with an acquired disability and to use your interpersonal skills most effectively to aid the client's growth. The model suggests (as do many theories of counseling) that acceptance, support, and validation of the person's feelings and the right to feel them are fundamental. It also suggests that the client may not be fully aware of the feelings underlying personal behavior and that you may **need to explore** and direct the person into new levels of thinking and feeling. In some cases, it is a unique experience for the individual merely to have someone acknowledge the feeling and discuss it openly. Also, the types of behavior the client displays may offer **clues** about the extent of help that may be needed. For example, a client who exhibits a lot of denial or depression is likely

to need more or longer assistance than one who displays a great deal of uncertainty. In addition to helping clients understand their feelings, you will want to assist them to learn new behaviors. A publication edited by Dr. Thomas H. Hohenshil (1978) outlines several strategies you can use (see References).

Many individuals with disabilities, of course, have reached the stage of **realistic acknowledgment**. They may have had open and supportive family environments, previous counseling, or strong personalities before disablement. However, progress toward acknowledgment for those clients with disabilities who do exhibit problems may be facilitated by the insights the model offers. Does the person deny limitations and seek the impossible by setting "normal" achievement as a standard? Perhaps sadness should be tapped to initiate the helping process. Does the individual show anger which seems unwarranted or depression and apathy? Buried anger, or perhaps both sadness and anger may need to be explored and validated as very natural, reasonable feelings. Does the person hesitate to make choices or engage in activities? The newly disabled or those disabled for a long period may need to work through feelings of vulnerability, uncertainty, and helplessness.

A further reason for the significance of the **model** is that it serves as a **reference point** for the client's family's emotional adjustment as well. Much of the individual's emotional development even as an adult is learned from the family's modeling and nurturing of emotional patterns, healthy or otherwise. The succession of stages of feelings of the family (parents, siblings, spouse, children) often parallels the stages of a disabled person's feelings at recognition of personal difference from the standard of the community. The family members may not express their feelings in the same terms as does the client. The family members' stages of feelings may not coincide with those experienced by the client. Still, if they are recognized and validated, it is likely that the family member's feelings of shock and numbness, sadness, anger, uncertainty, and acknowledgment will form an interwoven yet progressive pattern similar to the feelings of the client. If not expressed and validated, those feelings that they have repressed are likely to cause behavior that may have profound negative effects on the client. If family members have not worked through their feelings and acknowledged both the limitations and the strengths of the client, they may pressure the individual toward impossible achievement, reject him or her, or become far too protective. These considerations imply that family members also may need help in dealing with their underlying feelings about the client's disability in order to provide a positive influence.

Other Kinds of Difficulties

Problematic emotional responses connected with disabling conditions are not uncommon. However, an important caution in this regard is to avoid assuming emotional maladjustment as the root of all problems of those with disabilities and their families. Clients with disabilities **need** what nondisabled clients need: **career information, career assistance, and help in relating to others**. Many of the problems those with disabilities and their families face are very concrete difficulties in obtaining information and services and their resulting frustration and anger may be very appropriate responses. A mother writes:

> [Counselors] must be able to understand that these two people have searched, have wept, have pleaded, have been subjected to embarrassment, have received conflicting opinions about their child and demeaning judgments about themselves.... How often have counselors (or in the counseling role, teachers or social workers or psychologists or doctors) been heard to say, 'That child's worst problem is his mother--or his father.' How pat and how inaccurate! That mother's and/or father's problem is that kid, and she/he/they have been doing her/his/their utmost to resolve the problem long before landing in that particular counseling situation. Indeed, had their efforts been successful, they would not now be seated in those hard, uncomfortable chairs! (Buscaglia, 1975, p. 138).

Emotional adjustment to loss is a difficult process, and it occurs to some degree at some time in the life of virtually every person with an acquired disability and everyone close to that person. Understanding the nature and possible behaviors associated with the process may help you be more helpful to the client and the family; but basic to that possibility, as always, is a clear understanding of that individual situation and the actual source of the problem.

Career-Life Obstacles

Competency 4 — **Identify career-life obstacles faced by persons with disabilities, and identify two guidance approaches to help alleviate some of these obstacles.**

The career-life problems faced by those with disabilities are not all related to the disabilities themselves. The environments of such people throw into their paths daily difficult situations over which they have little or no control. These situations are of two types: physical obstacles and social obstacles. A number of authors (Burkhead, Domeck, Price, 1979; Buscaglia, 1975; Flanagan and Schoepke, 1978; Kolstoe, 1977; Phillips, 1977) have identified some of the more important ones.

Physical Obstacles

Physical structures are frequently constructed with no thought of those other than nondisabled people. A woman with a physical disability points out--

> I am really angry at modern architects. . . . Sublime examples of modern architecture abound on every university campus designed by unthinking men with two good legs and two good eyes who have never had to consider the mechanics of getting themselves from one place to another. I wish that every architect who has ever designed a round building would have to try to navigate in it blindfolded. (Buscaglia, 1975, p. 252).

Stairways and steps, revolving doors or doors which require a strong push to open, and narrow lavatory cubicles pose no problem to those who move easily but may be utterly unusable to a person in a wheelchair. Similarly, thick carpets and street curbs make moving difficult for wheelchairs; decorative cobblestones can interfere with the mobility of those with chairs or crutches and also with that of the visually impaired. The hard-of-hearing cannot perceive doorbells, telephones, or warning sirens unless visual signals accompany their sounds. Complicated written instructions can pose problems for mentally disabled and some learning disabled individuals.

Social Obstacles

Earlier a distinction was made between "disability" and "handicap." A large part of what makes a handicapping condition is the attitudes of those around the person to the disability. If these attitudes are pitying, denigrating, and condescending, and if they form the main emotional basis of the person's life, then the self-image of the person with a disability cannot help but absorb this type of "reflection of the self."

Pity and condescension may show in the family's behavior as overprotection or impatience with the individual's efforts at accomplishment. Rather than encouraging such efforts, the family may actually restrict the person's activities because they feel the activities are too difficult (e.g., an individual in a wheelchair taking a bus to work or school) or too inconvenient (e.g., a child lacking muscle control making a mess of the table while eating).

Even if the family and others close to the person possess positive attitudes, the individual will still have to face the widespread attitudes of society as reflected in the reactions of strangers. Raymond Goldman, whose legs were paralyzed when he was four, writes in his book, *Even the Night*, of his first day in school:

> One of them (the other boys) stopped to look me over . . . "This kid can't walk. He says he can crawl real fast though."
>
> "I can even crawl up and down steps," I told them.
>
> "They won't let me crawl here because I'd get dirty."
>
> The boys began to laugh. I wondered what was funny about that statement. Through my mind flashed the weeks and weeks of efforts before that feat had been accomplished. Now my boast--and I had really said it boastingly--was greeted with laughter.
>
> . . . One of the boys leaned down and touched my leg.

"Look how skinny!" he shouted triumphantly. "I can wrap it with two fingers!"
"Let's see!"
"Sure 'nough!"
"Gee, what skinny old legs!"
A feeling of inferiority began to batter against the bulwark of my illusions. I sensed the ridicule before I comprehended it. I had never been fully conscious of the fact that my legs were emaciated. Now I looked down at them and then at the legs of the other boys. The damnable hammer of comparison beat the truth into my consciousness.*

Other responses, more common to adults than ridicule, are just as effective at denying the humanity of those with disabilities. For example, making too great a fuss over a physically disabled person who falls can be extremely embarrassing.

The special problems which everyday situations pose for those with disabilities are often not obvious to those who are not disabled. Hopefully, spending some time considering the perspectives of those with disabilities will help you better work with their frustrations and problems. (See Learning Experience 4.)

Open Communication

Competency 5 **Enhance open communication about disabilities between yourself and persons with disabilities.**

No one has totally avoided difficulty in dealing with others. Everyone has experienced rejection, embarrassment, and the occasional moody or tactless reactions of others. For individuals with disabilities, however, these reaction patterns may form most of their experience with others. This kind of background can be especially detrimental to the development of skills relating to others.

One set of skills which the disabled need, which is both different from those needed by the nondisabled and basic to ease of communication, is in the area of naming, discussing, and giving information about their disability openly and comfortably.

Skills in Talking Openly about the Disability.

The ability to communicate openly about a disability is fundamental to the person's adjustment because most disabilities are, at some point, noticeable to others. Often the other sees the disability first and foremost. In fact, sometimes the other sees **only** the disability and not the human being at all. Persons with a disability must acknowledge these realities and deal with them, just personal limitations may have to be acknowledged. Only if they are comfortable and open with the fact of the disabling condition--that is, can see it as one aspect of many which make up their "personhood"--can others be influenced to see the whole person too.

Most people with disabilities can perceive from experience the uncertainty and lack of ease others feel. It will often be up to the **disabled** to dispel that uncertainty by **bringing up the topic** of the disabling condition, offering appropriate information on its cause, extent, or implications, or openly talking about the other's discomfort. For instance, the epileptic may volunteer, "I have what is called psychomotor epilepsy. Sometimes I talk strangely and don't remember things. But it passes and all you need to do is wait a minute or two." Being able to choose to do something like this may require individuals to first deal with their own anger at constant negative or uncomfortable reactions from others. The realization that negative reactions arise from widespread social norms and expectations which are largely unexamined, not from conscious personal intent, is a step toward managing this anger.

Among your most effective tools in helping persons with disabilities are your abilities to model and to encourage **comfortable communication**. In order to accomplish this, you must behave in a

*Raymond Goldman *Even the Night* New York The MacMillan Company, 1947, pp 35-37 quoted by Goffman, Erving *Stigma--Notes on the Management of Spoiled Identity* Englewood Cliffs, NJ Prentice-Hall, Inc , 1963

comfortable manner when discussing the disability. You must be able to use the terms descriptive of the condition easily, without pausing or stumbling. You must be able to look at and touch the individual without hesitation or embarrassment. It is especially helpful if you can model using humor appropriately to ease tension and facilitate discussion of the condition--or on occasion to serve as a rude awakening. The following are some of the specific **skills** you should have in order to communicate openly with a disabled person about a disability.

1. Appropriately **bringing up the topic** of the disability.

2. Using **terms descriptive** of the condition without hesitation or stumbling.

3. Looking straight **into the eyes** of the client with the disability.

4. Looking straight **at the disabled parts** of the client's body, if these are apparent.

5. **Touching the client** comfortably and without hesitation, when appropriate.

6. **Touching the disabled parts** of the body, if appropriate. (Caution: Sensitivity to the client's readiness to have the disabled part touched is important.)

7. **Questioning the client** without hestiation or embarrassment concerning the full extent of the limitations and difficulties related to the disability.

8. **Focusing** on the client's **strengths**, while at the same time acknowledging limitations.

9. **Helping the client compensate** for lacks in functioning or communicating, frankly and without excessive solicitousness (e.g., guiding a blind boy past an obstacle, telling a speech-impaired individual you do not understand her and would like her to repeat more slowly what she said).

10. Using **humor** appropriately (Caution: Great care and tact are needed in sensing what kinds of humor are appropriate and what kinds may be offensive. When in doubt, leave it out!)

Skill and ease in talking about disabilities with persons who have disabilities comes with practice, and you may be awkward at first. Learning Experience 5 in this module will provide some oportunities for you to build your skills and confidence in this area.

Learning Experience 1

Negative Assumptions

OVERVIEW

COMPETENCY	Identify and, where appropriate, challenge negative assumptions commonly made about individuals with disabilities.
READING	Read Competency 1 on page 7.
LEARNING OBJECTIVE	Describe three negative assumptions commonly made about persons with disabilities, possible reasons for these assumptions, and a strategy for challenging them.
INDIVIDUAL ACTIVITY	Paraphrase three negative assumptions and at least one reason why each is often made.
INDIVIDUAL FEEDBACK	Compare your paraphrased versions with the originals and check your reasons against the listed examples.
GROUP ACTIVITY	Discuss a six-part strategy and then apply it to several assumptions.

INDIVIDUAL ACTIVITY Paraphrase three negative assumptions and at least one reason why each is made.

Review the reading for Competency 1 on page 7. Then paraphrase three negative assumptions and provide a reason why each assumption is made.

Paraphrase Assumption #1:

Reasons why you think this assumption is commonly made:

Paraphrase Assumption #2:

Reasons why you think this assumption is commonly made:

Paraphrase Assumption #3:

Reasons why you think this assumption is commonly made:

INDIVIDUAL FEEDBACK

Compare your paraphrased versions with the originals and check your reasons against the listed examples.

You should have at least one reason for each assumption. Here are a few sample reasons you may have listed:

1. **All problems relate to the disability:** Disability most obvious; limited exposure to disabled persons who are successfully managing problems.

2. **Similar career-life goals and activities for similar disabilities:** Easier to plan and implement group programs rather than individualized ones; lack of exposure to differences among similarly disabled persons.

3. **No other needs besides those relating to disability:** Other needs not as obvious and possibly not mentioned by client with disability; lack of skills of helper in assisting client to meet certain needs (e.g. sexual fulfillment).

GROUP ACTIVITY

Discuss a six-part strategy, and then apply it to several assumptions.

Note: The Individual Activity must be completed before this Group Activity. The following outline is to be used by the workshop facilitator.

Facilitator's Outline	Notes
A. Starting Point	
1. Have participants complete the Individual Activity if they have not already done so and discuss the results.	If there is time, have a few participants share the reasons they listed.
2. Ask them to read and then paraphrase in their own words the challenging strategy.	
B Sharing Information	
1. With the group as a whole, apply the six questions in "Challenging Strategy" to the sample situation presented on page 25. Ask different par-	Allow at least 30 minutes analyzing the remaining assumptions and 15 minutes for unit group reports.

Facilitator's Outline	Notes
ticipants to apply the questions, and encourage discussion and debate among members of the group. 2. Spend about 15 to 20 minutes on the sample situation. Here are some suggested answers for the sample: • The boy stutters; he apparently has few, if any friends; he appears to be self-conscious about his stuttering. • Assumption 1 and 3 • Perhaps he hasn't been involved in activities where he could make friends. Maybe he has very few social skills. He may be too busy to make friends. He may have friends but be concerned about other problems (e.g., his family, a particular girl, speaking situations in general). • Talk to the boy to determine what his real needs and goals are. Speak with his family or others to get more perceptions of him. Observe him in action. • This boy appears to have some problems concerning a lack of friends. The problems may or may not be related to the fact that he stutters. 3. Ask the participants (individually or in pairs) to apply the challenging strategy to the remaining assumptions. If time permits, ask them to also present and challenge other negative assumptions and stereotypes they have encountered. 4. Give each group two minutes to report on its findings. C. Wrap Up 1. Ask one or more participants to summarize the six parts of the strategy.	Encourage participants to apply the strategy once they leave the session.

NOTES

Handout

Challenging Strategy

Instead of accepting these and other negative assumptions about persons with disabilities at face value, you will serve your clients better if you actively challenge those assumptions. Here is a six-part strategy that you can use to test the validity or truth behind the negative statements you encounter in the future. The strategy requires you to ask and answer six questions:

1. What facts about the situation does the statement reveal?

2. Which of the three negative assumptions presented in the text (or others generated by participants) would you say it reflects?

3. Which specific parts of the statement express the underlying assumptions?

4. What other factors (besides the disability) could be causing the situation to occur?

5. How could you and/or other career guidance helpers go about proving or disproving the parts of the statement that express the assumption?

6. How could this statement be changed so it states facts and does not express any negative assumption?

For practice, apply the six questions to the following negative assumption stated by a guidance worker to a colleague. (Check your answers with those provided in the answer key.)

"This boy's got problems. He hasn't really got any friends. His self-consciousness about his stuttering must color his whole life."

1. What facts about the situation does the statement reveal?

2. Which of the three negative assumptions presented in the text (or others generated by participants) would you say it reflects?

3 Which specific parts of the statement express the underlying assumptions?

4. What other factors (besides the disability) could be causing the situation to occur?

5. How could you and/or other career guidance helpers go about proving or disproving the parts of the statement that express the assumption?

6. How could this statement be changed so it states facts and does not express any negative assumption?

Now apply the strategy to each of the following.

1. A guidance staff member says to a teacher, "Maria's muscular dystrophy has finally confined her to bed. I advised her parents not to let her know much about what's going on in school; I think it would just hurt her to hear what she's missing."

   a. What facts about the situation does the statement reveal?

b. Which of the three negative assumptions would you say it reflects?

c. Which specific parts of the statement express the underlying assumption?

d. What other factors (besides the disability) could be causing the situation to occur?

e. How could you and/or other career guidance helpers go about proving or disproving the parts of the statement that express the assumption?

f. How could this statement be changed so it states facts and does not express any negative assumption?

2. A college counselor says to a student, "I think, Sally, we should choose music courses for your fine arts requirement. I know you can see a little, but I don't think you could succeed in an art course."

a. What facts about the situation does the statement reveal?

b. Which of the three negative assumptions would you say it reflects?

c. Which specific parts of the statement express the underlying assumption?

d. What else could be causing the situation?

e. How could the career guidance staff member go about proving or disproving the parts of the statement that express the assumption?

f. How could this statement be changed so it states facts and does not express any negative assumption?

3. A personnel officer says to another office staff member, "Sherry's sure not a very energetic woman. I guess being blind really limits her confidence in her ability to move--because even a small movement may mean she gets hurt or bumped or she trips or something."

a. What facts about the situation does the statement reveal?

b. Which of the three negative assumptions would you say it reflects?

c. Which specific parts of the statement express the underlying assumption?

d. What other factors (besides the disability) could be causing the situation to occur?

e. How could you and/or other career helpers go about proving or disproving the parts of the statement that express the assumption?

4. A nurse says to a hospital volunteer, "Cindy came in this morning and said Walt tried to kiss her. She was really upset; his paralysis and his drooling made her sick. How could he even think about touching such a pretty woman?"

a What facts about the situation does the statement reveal?

b Which of the three negative assumptions would you say it reflects?

c Which specific parts of the statement express the underlying assumption?

d. What other factors (besides the disability) could be causing the situation to occur?

e. How could you and/or other guidance helpers go about proving or disproving the parts of the statement that express the assumption?

f. How could this statement be changed so it states facts and does not express any negative assumption?

5. A JTPA staff member says to a parent, "I don't see how Pat could become a nurse with her hearing problem. She couldn't hear patients call for help, or use equipment which transmits information by sound. I think we should skip that option as a possible career for her."

a. What facts about the situation does the statement reveal?

b. Which of the three negative assumptions would you say it reflects?

c. Which specific parts of the statement express the underlying assumption?

d. What else could be causing the situation to occur?

e. How could you and/or other career helpers go about proving or disproving the parts of the statement that express the assumption?

f. How could this statement be changed so it states facts and does not express any negative assumption?

NOTES

Learning Experience 2

Your Own Attitudes

OVERVIEW

COMPETENCY	Identify your own attitudes in various situations toward people with disabilities and your reasons for holding those attitudes.
READING	Read Competency 2 on page 11.
LEARNING OBJECTIVE	State two positive and two negative attitudes you have had at once had about persons with disabilities, and describe at least one incident that reinforced these attitudes.
INDIVIDUAL ACTIVITY	Complete a self-check on your reactions to situations involving persons with disabilities.
INDIVIDUAL FEEDBACK	Compare your answers to those provided.
GROUP ACTIVITY	Discuss attitudes and incidents that reinforced them with the other members of the group.

INDIVIDUAL ACTIVITY

Complete a self-check on your reactions to situations involving persons with disabilities.

Review the reading for Competency 2 on page 11. When you have finished the reading, complete the following self-check on how you would react in some hypothetical situations involving persons with disabilities. Be certain to answer the items on the basis of how you feel right now, not how you would have felt in the past.

Interacting with Individuals with Disabilities

Personal Self-Check

Imagine encountering a person with an evident disability whom you do not know, in some nonstructured setting (e.g., a party, visiting a friend in the hospital, riding on an airplane or bus).

1. Would you be afraid to meet the person's eyes?

   ____ Yes ____ No ____ I don't know

2. Would you have trouble thinking of anything to talk about?

   ____ Yes ____ No ____ I don't know

3. Would you be afraid to touch the person?

   ____ Yes ____ No ____ I don't know

Think of encountering a person with some evident disability in a coworking relationship.

4. Would you feel apprehensive that discussion might drift away from work-related topics?

   ____ Yes ____ No ____ I don't know

5. Would you be embarrassed at any inadvertent reference to the disability, e.g., "For Pete's sake, Bill, look at the figures!"

   ____ Yes ____ No ____ I don't know

Imagine yourself counseling a 25-year-old blind woman. She shows no facial expression while talking, uses no gestures, her head wobbles, her eyes wander aimlessly, and she does not sit up straight.

6. Do you think you could comfortably bring up the subject of her lack of communication skills?

   ____ Yes ____ No ____ I don't know

7. Do you think you could comfortably show her physically, by touching her, having her touch you, etc., what you mean and how she could utilize more of the ordinary communication skills?

___ Yes ___ No ___ I don't know

Imagine yourself with a severely involved cerebral palsied boy of 14. His speech is sometimes unintelligible, his arms, legs, and head are pulled into unusual positions, movements are uncontrolled and flailing, and his facial contortions are frequent, including some drooling. His intelligence and achievement levels are in the average range. He requires a wheelchair for movement and, though he feeds himself, it is a messy process for him and the table.

8. Do you think you could comfortably sit through a meal with him and his ungraceful, though effective, manner of eating?

___ Yes ___ No ___ I don't know

9. Do you think you could consider a career future with this boy in which no possibility was ruled out without some consideration?

___ Yes ___ No ___ I don't know

10. Do you think you could conduct a class for nondisabled persons on the problems of those with disabilities, if you were required to use this boy as an example (verbally, not with the boy present) in discussing "a person with a disability, not a disabled person?"

___ Yes ___ No ___ I don't know

11. Do you remember ever thinking or saying to another person a thought or statement about a person with a disability that reflected any of the negative assumptions in Competency 1?

___ Yes ___ No ___ I don't know

12. Was this situation one in which you had enough actual facts to justify your statement, or do you feel, in retrospect, that you were making one of the three negative assumptions we have discussed?

a. ___ I had sufficient facts for my conclusion

b. ___ I was making an assumption which may have been unfounded (or proved to be)

c. ___ I don't know

Imagine that a 22-year-old woman classified as moderately mentally retarded comes to you for career guidance. Her behavior indicates that she is having great difficulty concentrating on what you are saying.

13. Do you think you could comfortably conduct one or more career counseling sessions with her?

___ Yes ___ No ___ I don't know

14. Are you clear in your own mind what types of opportunites you would encourage her to investigate?

___ Yes ___ No ___ I don't know

15. Do you think you would feel at ease conducting a group career counseling session with this woman and other mentally handicapped adults?

___ Yes ___ No ___ I don't know

INDIVIDUAL FEEDBACK

Compare your answers to those provided below.

Although there are no right or wrong answers to the self-check for each item there is a "more desirable" answer in terms of your stage of comfort in working with individuals with disabilities. The suggested "more desirable" answers are as follows:

1. no
2. no
3. no
4. no
5. no
6. yes
7. yes
8. yes
9. yes
10. yes
11. yes or no (past actions are excusable!)
12. a or b
13. yes
14. yes
15. yes

If you had at least 10 "more desirable" answers, you are probably quite comfortable interacting with individuals with disabilities. If you had nine or less, you may want to concentrate on improving your skills and confidence in this area.

GROUP ACTIVITY

Discuss attitudes and incidents that reinforced them with the other members of the group.

Note: The Individual Activity should be completed before this Group Activity. The following outline is to be used by the workshop facilitator.

Facilitator's Outline	Notes
A. Starting Point	
1. Have participants complete the Individual Activity if they have not already done so, and discuss the results in pairs or with the group as a whole.	Encourage participants to be open about their fears and uncertainty. You might use self disclosure yourself to set the tone for the group.
2. Divide the participants into groups of three each.	
B. Sharing Information	
1. Ask each participant to recall a very **specific** critical incident involving him or her and a disabled person in which the participant displayed (or secretly held) a negative attitude toward the other person.	Give some examples of a very specific incident in your life.
2. Ask the first detector in each group to interview the first detectee about his or her incident. Some of the questions that could be asked include:	Urge participants to recall as much **detail** as possible.
• What were the circumstances leading up to the incident?	
• What did you say?	
• What was the other person's exact reaction?	
• How did you feel then?	
• What else happened? What were the results?	
• Why was this such an important incident to you?	
• What is your current attitude on this?	

Facilitator's Outline	Notes
3. Ask the process observer to take notes and to share with the other two after the interview is complete. The observer should comment on verbal as well as nonverbal communication.	
4. Have several participants share their reactions with the group.	
C. Wrap Up	
1. List attitudes mentioned on a piece of newsprint or chalkboard.	Point out those attitudes that seem most prevalent. Tie discussion to Learning Experience 1, which dealt with negative assumptions.
2. Discuss ways that the participants' attitudes have been changed and/or strategies they could use to change persisting negative attitudes in others.	Strategies could include spending time with a person with a disability; acquiring a disability for 24 hours; reading more about disabilities and strategies for overcoming problems.

NOTES

Learning Experience 3

Acquired Disabilities

OVERVIEW

COMPETENCY	Describe the process of psychological adjustment to an acquired disability, and describe how you could appropriately respond to needs exhibited by individuals who have had this experience.
READING	Read Competency 3 on page 12.
LEARNING OBJECTIVE	Describe an adjustment-to-loss process experienced by individuals and appropriate career guidance behaviors exhibited during each phase of the process.
INDIVIDUAL ACTIVITY	List the five stages of the adjustment process, and behaviors likely to be present in each stage.
INDIVIDUAL FEEDBACK	Compare your list with the samples provided.
GROUP ACTIVITY	Participate in problem solving of five possible career guidance situations involving individuals who have acquired disabilities.

INDIVIDUAL ACTIVITY

List the five stages of the adjustment process and indicate behaviors likely to be present in each stage.

Review the reading for Competency 3 on page 12. Complete the following as you read

Stage of Adjustment to Loss	Typical Behaviors Exhibited by a Person in This Stage
Stage 1.	
Stage 2.	
Stage 3.	
Stage 4.	
Stage 5.	

INDIVIDUAL FEEDBACK

Compare your answers with the answers provided.

You should have at least one behavior for each stage. The following are examples of behaviors:

Stage 1. **Shock:** Refusing to discuss situation; making flippant or casual remarks about the disability; denying that the situation is real; remaining silent.

Stage 2. **Sadness:** Crying; constantly talking about loss and pain.

Stage 3. **Anger:** Lashing out at others; rejecting help; swearing; criticizing helpers and self.

Stage 4. **Vulnerability:** Expressing fear about future services available and others with similar difficulties.

Stage 5. **Acknowledgment:** Describing disability in realistic terms; making plans; sharing experiences with others in an effort to help; make jokes about oneself.

GROUP ACTIVITY

Participate in problem solving of five possible career guidance situations involving individuals who have acquired disabilities.

Note: The Individual Activity must be completed before this Group Activity. The following outline is to be used by the workshop facilitator.

Facilitator's Outline	Notes
A. Starting Point	
1. Have participants complete the Individual Activity if they have not already done so.	Ask volunteers to share individual experiences with acquired disabilities.
2. Explain that they will participate in a problem-solving activity.	
3. Divide the participants into groups of at least three each.	
B. Sharing information	
1. Review the five basic stages of the model of adjustment described in the reading for Competency 3 on page 12	

Facilitator's Outline	Notes
2. Ask participants to get into their subgroups and to select at least one of the problem-solving situations described in the handout Acquired Disabilities on page 41. 3. Have subgroups prepare five-minute presentations on what they would do in the problem-solving situation they have selected. 4. Ask each group to present its strategy while the other groups provide a critique and suggestions for making the problem solving more effective.	Allow approximately 20 to 30 minutes for the groups to work.

Handout

Acquired Disabilities

Below are descriptions of behaviors that career guidance helpers might encounter in clients with acquired disabilities. For each example provided, answer the following questions:

- What stage does this behavior best reflect?
- Describe how you would respond to the statement, either generally or in specific words, and explain why you feel your response is appropriate to this stage.
- Outline career guidance interventions you might use with this client.

1. Ann is 35 and recently lost her sight in an accident. She shows little desire to succeed at anything. When encouraged to try anything new, her response is "I don't want to. It's too much trouble," and an expressionless stare.

2. Chin, 19, has been profoundly deaf since birth and his speech is difficult to understand. He does not want to enter a regular college classroom for any subject, though he lipreads well. He says, "The work will be too hard for me. I don't know the professor--I'll bet she's hard. I'll bet she's the hardest professor in the college."

3. Lois, 21, has recently had polio and is paralyzed from the waist down. She is not expected to walk again. She insists, "I can walk. I know I can walk. I know I can stand as straight as anyone. All it takes is to try hard enough."

4. Ken is a 17-year-old who has lost his leg at the knee in a motorcycle accident. Two days after the accident he says, "I gotta be out of the hospital in two weeks for the start of baseball practice!"

5. Carlos, 25, has just been released from full-time psychiatric care in an institution following severe emotional problems after the death of his fiancee. He is now being seen as an outpatient and is interested in leaving his teaching career. He states, "I want to find a job where I can totally bury myself in my work and not get involved with any more women."

6. Bonnie, 36, has muscular dystrophy and is no longer able to work on a full-time basis. She refuses to see the rehabilitation counselor and insists, "There's no use in my working. I'm just going to die, get weaker and weaker until I'm dead. Don't even let that counselor in the front door!"

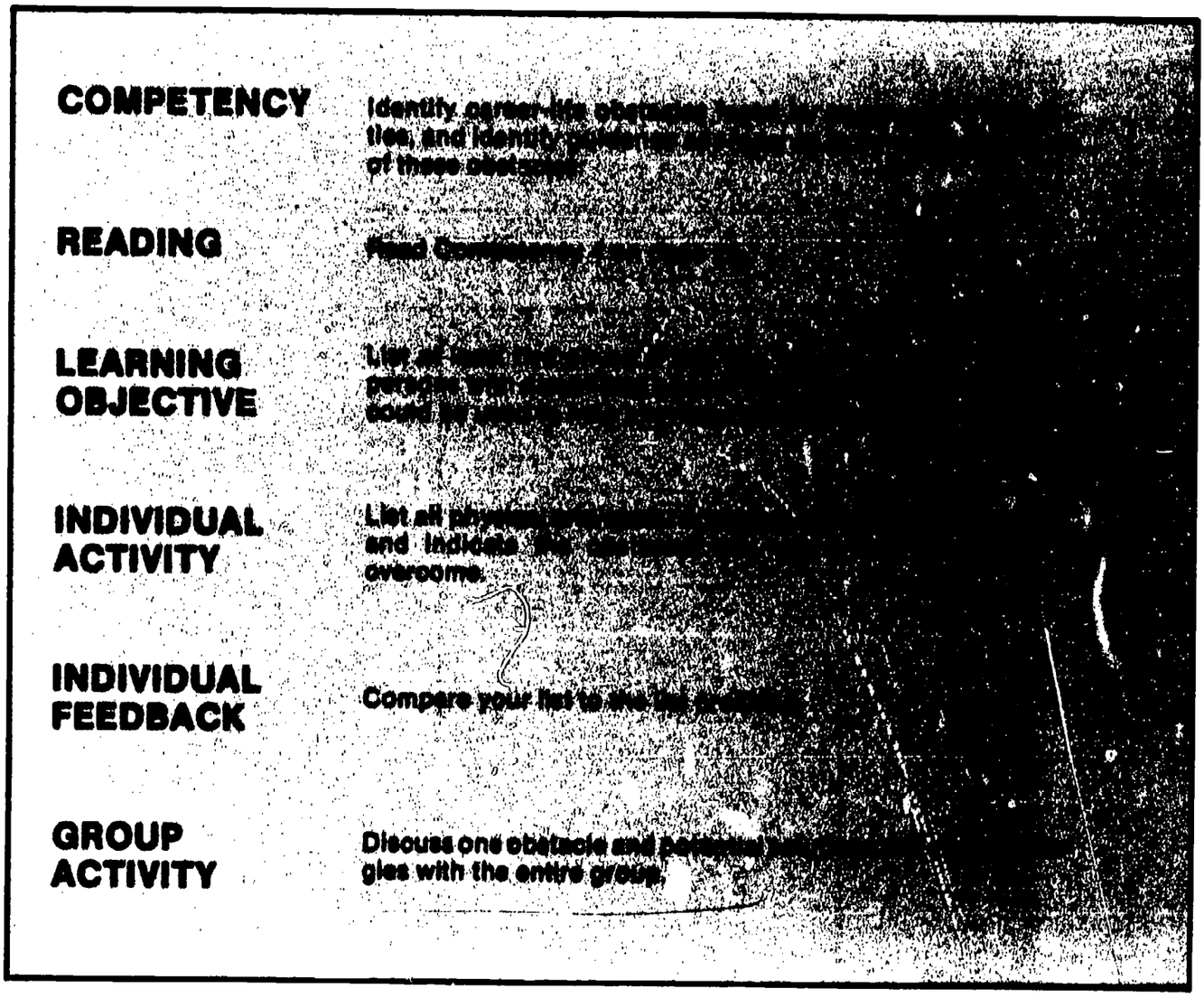
7. Michael, 16, was recently diagnosed as learning disabled. He sees this as an excuse not to try anymore in school. He says to you, "I'm glad I can drop that dumb reading class. I'll just get a job this summer and drop out of school completely."

NOTES

Learning Experience 4

Career-Life Obstacles

OVERVIEW



INDIVIDUAL ACTIVITY

List all physical and social obstacles that come to your mind, and indicate the obstacles that seem most important to overcome.

Read Competency 4 on page 16.

List as many physical and social obstacles as you can for each of the following groups. (See the Introduction for definitions of disabilities.)

Group	OBSTACLES	
	Physical	Social
A. Physically Disabled Orthopedically Disabled Other Health Impaired		
B. Sensory Disabled Hard of Hearing Deaf Speech Impaired Visually Disabled Deaf or Partially Sighted Deaf - Blind		

Group	OBSTACLES	
	Physical	Social
C. Emotionally Disabled		
D. Mentally Disabled		
E. Learning Disabled		
F. Multiply Disabled		

INDIVIDUAL FEEDBACK

Compare your list to the list provided.

A. **Physical Disability:**

Physical--Curbs, stairs, rough paths and roads, narrow doors, out-of-reach shelves, switches, telephones, drinking fountains, steep grades; long distances to negotiate.

Social--Assumption that physical disability also means sensory or mental disability; lack of awareness of nondisal led of needs and capabilities of disabled.

B. **Sensory Disabled:**

Physical--Prevalence of "normal" sound and visual requirements for communication everywhere; curbs, etc. for blind.

Social--Lack of skills in communicating (e.g., using sign language) on part of nondisabled; assumption that mental disability must also be present.

C. **Emotionally Disabled:**

Physical--Probably none unless disability is so severe that person could harm self with objects or self.

Social--Fear of society about disability, its recurrence, etc.

D. **Mentally Disabled:**

Physical--Depending on severity, complex documents, objects, tools, equipment, and tasks.

Social--Pessimistic attitude of society toward potential.

E. **Learning Disabled:**

Physical--Excess sensory stimuli, lack of appropriate written, printed, or audio learning materials, complex reading tasks.

Social--Disbelief or scepticism of people about the disability; lack of recognition for some funding sources; ridicule.

F. **Multiply Disabled:**

Physical and **Social**--Depending on the combination, all of the above obstacles plus difficulties related to "Which category fits me?"

GROUP ACTIVITY

Discuss one obstacle and potential solutions and share strategies with the entire group.

Note: The following outline is to be used by the workshop facilitator.

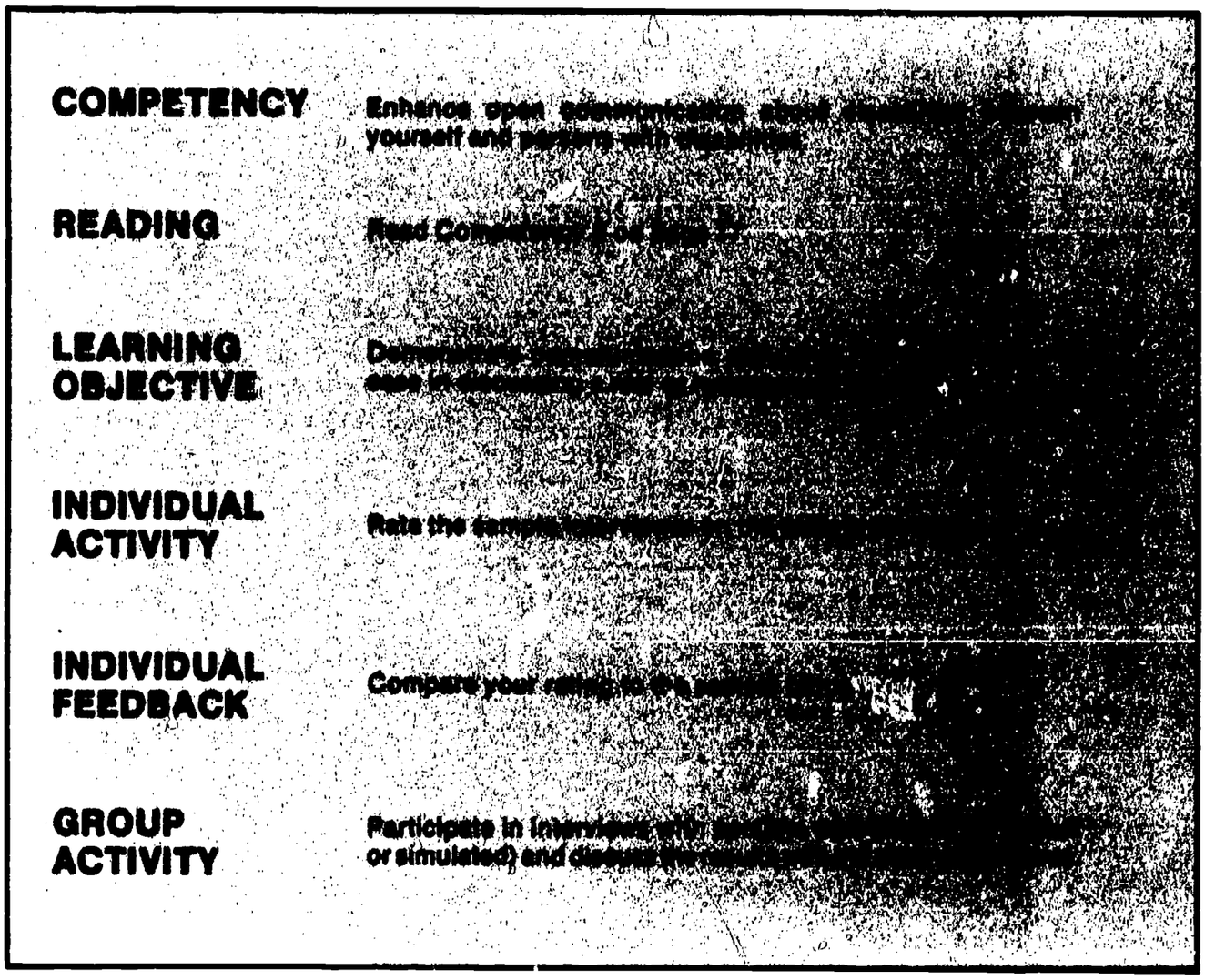
Facilitator's Outline	Notes
A. Starting Point	
1. Have participants complete the Individual Activity if they have not already done so and discuss the results.	Spend as much time as necessary (up to an hour) on discussing the many obstacles facing persons with disabilities. If possible invite one or more persons with disabilities to attend and participate.
2. Explain the Group Activity.	
3. Divide the participants into groups of three or more.	
B. Sharing Information	
1. Have subgroups select one or more priority obstacles to discuss in-depth including their own strategies that could be used by either a guidance advocate or a person with a disability to help alleviate the obstacle.	Stress the point that self-advocacy for individuals with disabilities is increasing and desirable. Allow about 45 minutes for the group activity.
2. Ask each group to present their strategies to the entire group in any manner they prefer (e.g., skit, newsprint display, panel discussion).	
C. Wrap Up	
1. Summarize the major obstacles faced by persons with disabilities.	Strategies could include joining a group that focuses on needs of persons with disabilities; studying module CG C-18 *Promote Equity and Client Advocacy*; taking courses; working on an action project to remove a particular obstacle.
2. Discuss ways in which guidance helpers and clients can gain skills in alleviating obstacles.	

NOTES

Learning Experience 5

Open Communication

OVERVIEW



INDIVIDUAL ACTIVITY

Rate the sample interviewer on the criteria provided.

Review the reading for Competency 5 on page 17, noting in particular the skills needed to communicate effectively with a disabled person about a disability. Read the following sample interview and critique the guidance staff member using the Interview Evaluation Checklist on page 52.

Sample Interview

G = Guidance staff member: Mr. Renner, Joanne's counselor.

C = Client: Joanne, 13 years old and in the eighth grade; gradually paralyzed on the left side, she uses a cane for walking.

G: Hi, Joanne.

C: Hi, Mr. Renner. Are you busy?

G: Not really. What can I do for you?

C: I just want to talk.

G: Sure. Stay there, I'll put the chair next to you.

C: Thanks. (sits slowly)

G: Is there some problem?

C: Yeah.

G: Can you tell me about it?

C: Well--I'm supposed to be going to my English class right now--but I just couldn't make myself go. (drops face into hand, perhaps crying)

G: (Touches her left arm or shoulder briefly.) It seems to bother you a lot to have to go to that class.

C: It's not just that class. It's all my classes.

G: All your classes?

C: Yeah. (pause) Even coming to school is just so hard I can hardly stand it.

G: Do you have any idea why?

C: Well--I just hate having anybody look at me. (silence)

G: You hate people looking at you.

C: Yeah. I just feel I must be so--awful to look at. I walk into the room and I feel like everybody's thinking, "Ugh, there's Joanne. How ugly."

G: Do you feel like people think you're ugly because of your paralysis?

C: Yeah. (pause) And I especially hate boys to look at me.

G: Being partly paralyzed means boys won't think you're an attractive girl, is that it?

C: Um-hm--(drops her head again and doesn't move)

G: You know, Joanne, I don't know a lot about your paralysis. Tell me how it occurred.

C: When I was little, a car hit me in the street, and the doctors said my muscles were injured permanently.

G: I see. And how much can you use your arm? (lifts her arm)

C: I can move my shoulder a little, but I can't use my hand.

G: How about your leg? Can you walk without the cane?

C: Yeah, but I fall easy without it.

G: You know, when I see you walk around campus I really don't notice that you walk much differently than others.

C: No, I don't limp much.

G: And even though you can't move your arm much, it's shaped pretty normally. Your hand is too; in fact, both your hands are pretty. Are there many things you can't do on account of your paralysis?

C: Well, lots of sports are out--but I play softball. I can pitch O.K., and bat with my right, just bracing it with my left. Then someone else runs for me.

G: How do you feel about that? You're not embarrassed playing ball?

C: No, I guess not. I've always done it.

G: Do boys ever play with you?

C: Sometimes after school. Usually they watch instead of play.

G: Does it bother you to have them watch?

C: Not really. I never think of it.

G: It sounds like there are some things you can't do, but lots of things you can. It also sounds like there are some situations where you hate the fact that you're paralyzed and others where it doesn't bother you much. Sometimes it's even an advantage: the glory of hitting a base hit without all the hard work of running it!

C: (Smiles) Yeah.

Interview Evaluation Checklist

Did the guidance staff member--

1. appropriately bring up the topic of the disability? Yes ___ No ___ Unknown ___
2. use terms descriptive of the condition without hesitation or stumbling? Yes ___ No ___ Unknown ___
3. look straight in the eyes of the "client with a disability"? Yes ___ No ___ Unknown ___
4. touch the "client" comfortably and without hesitation when appropriate? Yes ___ No ___ Unknown ___
5. look straight at the disabled parts of the body, if these are apparent? Yes ___ No ___ Unknown ___
6. touch the disabled parts of the body, if appropriate? Yes ___ No ___ Unknown ___
7. question the "client" without hesitation or embarrassment concerning the extent of the limitations and difficulties related to the disability? Yes ___ No ___ Unknown ___
8. focus on the "client's" strengths while at the same time acknowledging the limitations? Yes ___ No ___ Unknown ___
9. help the "client" compensate for lacks in functioning or communicating frankly and without excessive solicitousness? Yes ___ No ___ Unknown ___
10. use humor appropriately? Yes ___ No ___ Unknown ___

Comments

INDIVIDUAL FEEDBACK

Compare your rating with the sample rating provided.

The following are the appropriate answers for the rating.

1. Yes
2. Yes
3. Unknown
4. Yes
5. Unknown
6. Yes
7. Yes
8. Yes
9. Yes
10. Yes

GROUP ACTIVITY

Participate in interviews with persons with disabilities (actual or simulated) and discuss the results with the other participants.

Note: The Individual Activity must be completed before this Group Activity. The following outline is to be used by the workshop facilitator.

Facilitator's Outline	Notes
A. Starting Point	
1. Have participants complete the Individual Activity if they have not already done so and discuss the results.	Allow about 15 minutes for group discussion.
2. Review the list of communication skills listed in the reading, and explain the interview process.	Allow about 10 minutes.
3 Divide participants into subgroups of three or more persons each.	

Facilitator's Outline	Notes
B. Sharing Information	
1. Demonstrate an interview or ask two participants to demonstrate. Lead a group critique of the interview.	Be certain to point out **strong** points of the interview as well as areas needing improvement.
2. Identify "disabled" interviewees. If persons with actual disabilities are not available to come to the session, assign participants the various roles that appear on the handout "Open Communication" on page 55.	Allow about 25 minutes for the small group activity.
3. Ask the participants to interview one another, paying attention to the criteria on the "Role Play Evaluation Checklist" on page 57.	
4. Ask those serving as observers to evaluate the "guidance staff members" not the "clients" using the checklist. Observers should share their observations within their subgroups.	
C. Wrap Up	
1. Ask volunteers to comment on their experiences in the activity.	Possible strategies: sessions such as this with person(s) with real disabilities; videotaped interviews with feedback afterward.
2. Discuss ways that guidance helpers can improve their skills in communicating with clients with disabilities and ways that clients can enhance their own communication with non-disabled persons.	

Handout

Open Communication

Role of Client 1

You are a seventh grade student who is moderately deaf and who lip reads adequately. You have been attending your junior high for a couple of months now. Your parents have always been very protective and are worried about your going to a new school. You are adjusting pretty well and wish they'd stop bugging you, but you don't know how to handle them and have come to the guidance center to talk about the problem.

If you would like, take a couple of minutes to think about some specific situations or interactions which have made you come to the guidance center, but don't try to imagine every detail in advance. Let yourself be inventive as the situation unfolds. Before beginning the role play, however, you should decide as specifically as you can how and how much your "disability" affects you. Remember, your partner is practicing skills in openly discussing the disability. Try to give your partner opportunities for this practice. Use the list of nine skills in the "Role Play Evaluation Checklist" to help you; try to give your partner an opportunity to display each one. As you talk, really try to "act your part"; try to visualize real situations you might have gotten into in your role and to feel and project the emotions you might have genuinely experienced in these situations. The role play should occupy three to seven minutes. The observers will provide feedback for discussion when the role play is completed.

Role of Client 2

You are a first-year community college student who was identified as learning disabled when you were 15. You have always had a great deal of difficulty in school because you can't read very well and because you find it difficult to concentrate for extended periods. You haven't had much contact with other young people in the past. Most other students avoid you, and you are lonely. You are talking to this guidance staff person because you don't know how to handle this loneliness, you are afraid that people will find out you can't read, and you have no idea what career to pursue.

If you would like, take a couple of minutes to think about some specific situations or interactions which have made you come to the guidance center, but don't try to imagine every detail in advance. Let yourself be inventive as the situation unfolds. Before beginning the role play, however, you should decide as specifically as you can how and how much your "disability" affects you. Remember, your partner is practicing skills in openly discussing the disability. Try to give your partner opportunities for this practice. Use the list of nine skills in the "Role Play Evaluation Checklist" to help you; try to give your partner an opportunity to display each one. As you talk, really try to "act your part"; try to visualize real situations you might have gotten into in your role and to feel and project the emotions you might have genuinely experienced in these situations. The role play should occupy three to seven minutes. The observers will provide feedback for discussion when the role play is completed.

Role of Client 3

You are a 29-year-old employee with epilepsy who has occasional grand mal seizures. Your boss seems to be very afraid of your condition and has excluded you from several office activities and assignments. Your seizures are not fully controlled but are rare, and they can be dealt with by anyone willing to protect your head or limbs from damage. You are afraid to talk to the boss but have come to the Personnel Office to see a counselor.

If you would like, take a couple of minutes to think about specific situations or interactions which have made you come to the Personnel Office but don't try to imagine every detail in advance. Let yourself be inventive as the situation unfolds. Before beginning the role play, however, you should decide as specifically as you can how and how much your "disability" affects you. Remember, your partner is practicing skills in openly discussing the disability. Try to give your partner opportunities for this practice. Use the list of nine skills in the "Role Play Evaluation Checklist" to help you; try to give your partner an opportunity to display each one. As you talk, really try to "act your part"; try to visualize real situations you might have gotten into in your role and to feel and project the emotions you might have genuinely experienced in these situations. The role play should occupy three to seven minutes. The observers will provide feedback for discussion when the role play is completed.

Role of Client 4

You are a veteran who lost both legs in a grenade explosion in Vietnam. You have been fitted with artificial legs, and you alternate between using your crutches and your electric wheelchair. You are frustrated because of the many physical and social barriers you keep encountering. You want to talk to someone about your feeling that others, not you, are in charge of your life.

If you would like, take a couple of minutes to think about some specific situations or interactions which have made you come to the guidance center, but don't try to imagine every detail in advance. Let yourself be inventive as the situation unfolds. Before beginning the role play, however, you should decide as specifically as you can how and how much your "disability" affects you. Remember, your partner is practicing skills in openly discussing the disability. Try to give your partner opportunities for this practice. Use the list of nine skills in the "Role Play Evaluation Checklist" to help you; try to give your partner an opportunity to display each one. As you talk, really try to "act your part"; try to visualize real situations you might have gotten into in your role and to feel and project the emotions you might have genuinely experienced in these situations. The role play should occupy three to seven minutes. The observers will provide feedback for discussion when the role play is completed.

Role Play Evaluation Checklist

"Guidance staff member": _____ _____

Observer: _____

Did the guidance staff member--

1. appropriately bring up the topic of the disability? Yes ___ No ___ Unknown ___
2. use terms descriptive of the condition without hesitation or stumbling? Yes ___ No ___ Unknown ___
3. look straight in the eyes of the "client with a disability"? Yes ___ No ___ Unknown ___
4. touch the "client" comfortably and without hesitation when appropriate? Yes ___ No ___ Unknown ___
5. look straight at the disabled parts of the body, if these are apparent? Yes ___ No ___ Unknown ___
6. touch the disabled parts of the body, if appropriate? Yes ___ No ___ Unknown ___
7. question the "client" without hesitation or embarrassment concerning the extent of the limitations and difficulties related to the disability? Yes ___ No ___ Unknown ___
8. focus on the "client's" strengths while at the same time acknowledging the limitations? Yes ___ No ___ Unknown ___
9. help the "client" compensate for lacks in functioning or communicating frankly and without excessive solicitousness? Yes ___ No ___ Unknown ___
10. use humor appropriately? Yes ___ No ___ Unknown ___

Comments

NOTES

EVALUATION

PARTICIPANT SELF-ASSESSMENT QUESTIONNAIRE

1 Name (Optional) _____ 3. Date _____

2 Position Title _____ 4. Module Number _____

Agency Setting (Circle the appropriate number)

6 Elementary School
7 Secondary School
8 Postsecondary School
9 College/University
10 JTPA.
11 Veterans
12 Church
13. Corrections.
14 Youth Services.
15. Business/Industry Management
16. Business/Industry Labor.
17. Parent Group.
18. Municipal Office.
19. Service Organization.
20. State Government.
21. Other.

Workshop Topics	PREWORKSHOP NEED FOR TRAINING *Degree of Need* (circle one for each workshop topic). None	Slight	Some	Much	Very Much	POSTWORKSHOP MASTERY OF TOPICS *Degree of Mastery* (circle one for each workshop topic). Not Taught	Little	Some	Good	Outstanding
1. Identifying negative assumptions made about individuals with disabilities.	0	1	2	3	4	0	1	2	3	4
2. Challenging negative assumptions made about individuals with disabilities.	0	1	2	3	4	0	1	2	3	4
3. Identifying own attitudes toward persons with disabilities.	0	1	2	3	4	0	1	2	3	4
4. Identifying own reasons for attitudes toward persons with disabilities.	0	1	2	3	4	0	1	2	3	4
5. Developing a resource selection checklist based on established selection criteria.	0	1	2	3	4	0	1	2	3	4
6. Responding to needs of persons with acquired disability.	0	1	2	3	4	0	1	2	3	4
7. Identifying physical and social obstacles faced by persons with disabilities.	0	1	2	3	4	0	1	2	3	4
8. Identifying guidance strategies for alleviating obstacles.	0	1	2	3	4	0	1	2	3	4
9. Identifying skills needed for open communication about disabilities with individuals with disabilities.	0	1	2	3	4	0	1	2	3	4
10 Facilitating open communication about disabilities with individuals with disabilities.	0	1	2	3	4	0	1	2	3	4

Overall Assessment on Topic of Enhancing Understanding of Individuals with Disabilities

0 1 2 3 4 0 1 2 3 4

Comments:

Trainer's Assessment Questionnaire

Trainer: _____ Date: _____ Module Number: _____

Title of Module: _____

Training Time to Complete Workshop: _____ hrs. _____ min.

Participant Characteristics

Number in Group _____ Number of Males _____ Number of Females _____

Distribution by Position

_____ Elementary School	_____ Youth Services
_____ Secondary School	_____ Business/Industry Management
_____ Postsecondary School	_____ Business/Industry Labor
_____ College/University	_____ Parent Group
_____ JTPA	_____ Municipal Office
_____ Veterans	_____ Service Organization
_____ Church	_____ State Government
_____ Corrections	_____ Other

PART I

WORKSHOP CHARACTERISTICS—Instructions: Please provide any comments on the methods and materials used, both those contained in the module and others that are not listed. Also provide any comments concerning your overall reaction to the materials, learners' participation or any other positive or negative factors that could have affected the achievement of the module's purpose.

1. *Methods:* (Compare to those suggested in Facilitator's Outline)

2 *Materials:* (Compare to those suggested in Facilitator's Outline)

3 *Reaction:* (Participant reaction to content and activities)

PART II

WORKSHOP IMPACT—Instructions: Use Performance Indicators to judge degree of mastery. (Complete responses for all activities. Those that you did not teach would receive 0.)

	Group's Degree of Mastery				
	Not Taught	Little (25% or less)	Some (26%-50%)	Good (51%-75%)	Outstanding (over 75%)
	Note: Circle the number that best reflects your opinion of group mastery.				
Learning Experience 1					
Group	0	1	2	3	4
Individual	0	1	2	3	4
Learning Experience 2					
Group	0	1	2	3	4
Individual	0	1	2	3	4
Learning Experience 3					
Group	0	1	2	3	4
Individual	0	1	2	3	4
Learning Experience 4					
Group	0	1	2	3	4
Individual	0	1	2	3	4
Learning Experience 5					
Group	0	1	2	3	4
Individual	0	1	2	3	4

Code:

Little: With no concern for time or circumstances within training setting if it appears that less than 25% of the learners achieved what was intended to be achieved.

Some: With no concern for time or circumstances within the training setting if it appears that less than close to half of the learners achieved the learning experience.

Good: With no concern for time or circumstances within the training setting if it appears that 50%-75% have achieved as expected

Outstanding: If more than 75% of learners mastered the content as expected

PART III

SUMMARY DATA SHEET—Instructions: In order to gain an overall idea as to mastery impact achieved across the Learning Experiences taught, complete the following tabulation. Transfer the number for the degree of mastery on each Learning Experience (i.e., group and individual) from the Workshop Impact form to the columns below. Add the subtotals to obtain your total module score.

GROUP		INDIVIDUAL	
Learning Experience		Learning Experience	
1 = score (1-4)	_____	1 = score (1-4)	_____
2 = score (1-4)	_____	2 = score (1-4)	_____
3 = score (1-4)	_____	3 = score (1-4)	_____
4 = score (1-4)	_____	4 = score (1-4)	_____
5 = score (1-4)	_____	5 = score (1-4)	_____
Total (add up)	_____	Total (add up)	_____

Total of the GROUP learning experience scores and INDIVIDUAL learning experience scores = _____. Actual Total Score _____ Compared to Maximum Total* _____.

*Maximum total is the number of learning experiences taught times four (4).

NOTES

Performance Indicators

As you conduct the workshop component of this training module, the facilitator's outline will suggest individual or group activities that require written or oral responses. The following list of **performance indicators** will assist you in assessing the quality of the participants' work:

Module Title: *Enhance Understanding of Individuals with Disabilities*

Module Number: CG C-14

Group Learning Activity	Performance Indicators to Be Used for Learner Assessment
Group Activity Number 1:	
Review strategy to challenge assumptions, discuss and apply it.	1. Did the group apply all parts of the strategy? 2. Were individuals able to transform negative statements?
Group Activity Number 2:	
Discuss attitudes and incidents that reinforced them.	1. Are individuals able to provide personal examples? 2. Do they include enough detail in their descriptions so that others can perceive the experience?
Group Activity Number 3:	
Problem solving of hypothetical guidance situations.	1. Do the groups apply a logical problem-solving approach to the situations? 2. Do the solutions appear desirable and feasible?
Group Activity Number 4:	
Discuss obstacle(s) and solutions.	1. Do the groups use facts (as opposed to assumptions) to describe their obstacles? 2. Do the solutions appear desirable and feasible?
Group Activity Number 5:	
Interview individuals with real or hypothetical disabilities	1. Do the individuals demonstrate at least 75% of the communication skills presented in the activity? 2. Does it seem likely that 50% of the individuals will comfortably conduct at least one real interview in the future?

NOTES

REFERENCES

Burkhead, E. Jane; Domeck, Anne W.; and Price, Mary Ann. *The Severely Handicapped Person: Approaches to Career Development*. Working Paper No. 2, Lifelong Career Development Project. Columbia: University of Missouri-Columbia, 1979.

Buscaglia, Leo. *The Disabled and Their Parents: A Counseling Challenge*. Thorofare, NJ: Charles B. Slack, Inc., 1975.

Flanagan, W. Malcolm, and Schoepke, Jo Ann M. *Lifelong Learning and Career Development Needs of the Severely Handicapped*. Working Paper No. 1, Lifelong Career Development Project. Columbia: University of Missouri-Columbia, 1978.

Goffman, Erving. *Stigma--Notes on the Management of Spoiled Identity*. Englewood Cliffs, NJ: Prentice-Hall, Inc., 1963.

Hohenshil, Thomas H., ed. "Counseling Handicapped Persons and Their Families." (Special Issue) *Personnel and Guidance Journal* 58 (1979): 4.

Kolstoe, Oliver P. *Implications of Research Findings on Vocational and Career Education for the Mentally Handicapped*. Occasional Paper No. 33. Columbus: The National Center for Research in Vocational Education, The Ohio State University, 1977.

Phillips, Linda L. *Barriers and Bridges*. Sacramento: California Advisory Council on Vocational Education, 1977.

ADDITIONAL RESOURCES

Abeson, A. C ; Bouie, N.; and Haas, J. *A Primer on Due Process--Education Decisions for Handicapped Children*. Reston, VA: Council for Exceptional Children, 1975.

Details the rights of children and their parents in the educational decision-making process, including access to all records, the right to participate in the placement decision, and the opportunity for a hearing if they are not in agreement with the education agency's decision.

Black, Eugene E., M.D., and Nagel, Donald A., M.D., eds. *Physically Handicapped Children: A Medical Atlas for Teachers*. New York: Grune & Stratton, Inc., 1975.

This book offers educators a deeper view into the medical aspects of physical disabilities than more general texts have on the subject. It begins with a chapter on basic parts and terms of the nervous and musculoskeletal systems, and includes a chapter on parent counseling. It defines conditions; examines their causes development, symptoms, medical treatment procedures, and prognosis; and in some cases discusses educational implications. Though it omits detailed discussions of a few common physical disabilities, such as tuberculosis and multiple sclerosis, it is a thorough and up-to-date source of medical knowledge for the non-physician.

Brolin, Don. *Competency-Based Career Education for Elementary and Secondary Handicapped Students*. Olympia, WA: Office of the Superintendent of Public Instruction, n.d.

This curriculum guide presents a complete step-by-step approach to establishing a K-12 career education program for individuals with disabilities. Included are competencies for learners to achieve and literally hundreds of learning activities.

California Governor's Committee on Employment of the Handicapped. *A Different Approach*. Sacramento, CA, n.d.

This excellent film portrays through humor the stereotypes held about individuals with disabilities and forces viewers to take a hard look at their own attitudes. Several well known actors make cameo appearances, and the quality of production is superb. It would be an excellent opener for almost any training or awareness meeting related to individuals with disabilities.

Dahl, Peter R.; Appleby, Judith; and Lipe, Dewey. *Mainstreaming Guidebook for Vocational Educators*. Washington, DC: Capitol Publications, 1978.

This book is designed for vocational educators, special educators, employers, and all others who are concerned about the occupational success of individuals with disabilities. It includes strategies for helping students realize their potential. Topics include developing positive staff and student attitudes, eliminating architectural barriers, assessing the individual handicapped student, modifying the curriculum, eliminating equipment and work barriers, and placing handicapped students in jobs.

Foster, June C.; Szoke, Claire Olsen; Kapisovsky, Peggy M.; and Kriger, Leslie S. *Guidance, Counseling, and Support Services for High School Students with Physical Disabilities*. Cambridge, MA: Technical Education Research Centers, Inc., 1977.

This comprehensive manual is a useful resource for establishing a guidance program primarily aimed at secondary students. Sections are included on the nature of physical disabilities, service coordination, inservice training, personal adjustment strategies, educational planning, career development and guidance, vocational assessment, psychometric testing, job placement, parent involvement, and resources.

Jones, H., and Farr, R. *Realities of the Physically Handicapped*. Tulsa, OK: Instructional Media Inc., n.d.

This audio cassette program was developed by two "enablers" for physically limited students at De Anza College in Cupertino, California, both of whom have disabling conditions themselves. It covers a number of attitudinal and environmental problems that those with disabilities face, among them accepting a disability; how society relates to the disabled; information seeking; defining jargon; architectural barriers and housing; transportation for the handicapped; activities of daily living; sexuality, marriage, and parenthood; and success stories and recreation. (6 cassettes)

Phelps, L. Allen, and Lutz, Ronald J. *Career Exploration and Preparation for the Special Needs Learner*. Boston, MA: Allyn and Bacon, 1977.

This text is designed primarily for individuals who want to begin or improve career development programs for special learners. In addition to providing background on learners' needs and on career education, including examples from the authors' and clients' lives, the book offers numerous concrete strategies for planning, implementing, and evaluating programs.

Directory of Organizations Related to Individuals with Disabilities

Alexander Graham Bell Association for the Deaf
3417 Volta Place, N.W.
Washington, DC 20007

American Association for Counseling and Development
5999 Stevenson Ave.
Alexandria, VA 22304

American Association of Mental Deficiency
5201 Connecticut Avenue, N.W.
Washington, DC 20015

American Association for Rehabilitation Therapy, Inc.
P.O. Box 93
North Little Rock, AK 72116

American Association of Workers for the Blind, Inc.
1511 K Street, N.W.
Washington, D.C. 20005

American Cancer Society, Inc.
219 East 42nd Street
New York, NY 10011

American Coalition of Citizens with Disabilities
1346 Connecticut Avenue, N.W.
Room 817
Washington, DC 20036

American Foundation for the Blind, Inc.
15 West 16th Street
New York, NY 10011

American Medical Association
Department of Environmental, Public, and Occupational Health
535 N. Dearborn Street
Chicago, IL 60610

American Medical Association Education and Research Foundation
535 N. Dearborn Street
Chicago, IL 60610

American Orthotic and Prosthetic Association
1440 N. Street, N.W.
Washington, DC 20005

American Physical Therapy Association
1156 15th Street
Washington, DC 20005

American Podiatry Association
20 Chevy Chase Circle
Washington, DC 20015

American Printing House for the Blind, Inc.
1839 Frankfort Ave.
Louisville, KY 40216

American Speech and Hearing Association
9030 Old Georgetown Road
Washington, DC 20014

American Vocational Association
2020 N. 14th Street
Arlington, VA 22201

The Arthritis Foundation
1212 Avenue of the Americas
New York, NY 10036

Association for Children with Learning Disabilities (ACLD)
5225 Grace Street
Pittsburgh, PA 15236

Boy Scouts of America, Scouting for the Handicapped Division
Boy Scouts of America
North Brunswich, NJ 08902

Bureau of Education of the Handicapped
U S Department of Education
400 Maryland Ave. S.W.
Washington, DC 20202

Closer Look: National Information Center for the Handicapped
Box 1492
Washington, DC 20013

Council of Organizations Facilities Serving the Deaf
P. O. Box 894
Columbia, MD 21044

The Council for Exceptional Children
1920 Association Drive
Reston, VA 22091

Disabled American Veterans
3725 Alexandria Pike
Cold Spring, KY 41076

Education Commission of the States
300 Lincoln Tower
1860 Lincoln Street
Denver, CO 80203

Epilepsy Foundation of America
1828 L Street, N.W.
Washington, DC 20036

Federation of the Handicapped, Inc.
211 West 14th Street
New York, NY 10011

Girl Scouts of the U.S.A., Scouting for Handicapped Girls Program
830 Third Avenue
New York, NY 10022

ICD Rehabilitiation and Research Center
(Formerly Institute for the Crippled and Disabled)
340 East 24th Street
New York, NY 10022

The Industrial Home for the Blind Inc.
57 Willoughby Street
Brooklyn, NY 11201

International Association of Laryngectomees
219 East 42nd Street
New York, NY 10017

International Association of Rehabilitation Facilities, Inc.
5530 Wisconsin Avenue #955
Washington, DC 205542

Library of Congress
Division for the Blind and Physically Handicapped
Washington, DC 20542

Muscular Dystrophy Associations of America, Inc.
810 Seventh Avenue
New York, NY 10019

National Association of the Deaf
814 Thayer Avenue
Silver Spring, MD 20910

National Association of Hearing and Speech Agencies
814 Thayer Avenue
Silver Spring, MD 20910

National Association of the Physically Handicapped, Inc.
6473 Grandville Avenue
Detroit, MI 48228

National Association for Retarded Citizens
2709 Avenue E East
P.O. 6109
Arlington, TX 76011

National Center for a Barrier Free Environment
7315 Wisconsin Avenue
Washington, DC 20014

National Center for Law and the Handicapped
1236 N. Eddy Street
South Bend, IN 46617

The National Center for Research in Vocational Education
The Ohio State University
1960 Kenny Road
Columbus, OH 43210

National Congress of Organizations of the Physically Handicapped
7611 Oakland
Minneapolis, MN 55423

National Easter Seal Society for Crippled Children and Adults
2023 West Ogden Avenue
Chicago, IL 60612

National Federation of the Blind
Suite 212, 1346 Connecticut Avenue, N.W.
Washington DC 20036

The National Foundation/March of Dimes
1275 Mamaroneck Avenue
White Plains, NY 10605

The National Hemophilia Foundation
25 West 39th Street
New York, NY 10018

National Inconvenienced Sportsmen's Association
3738 Walnut Avenue
Carmichael, CA 95608

National Information Center for the Handicapped, Closer Look
P. O. Box 1492
Washington, DC 20013

National Industries for the Blind
1455 Broad Street
Bloomfield, NJ 07003

National Institute on Mental Retardation
Kinsman NIMR Building
York University Campus
4700 Keele Street
Downsview, (Toronto)
Ontario, Canada M3J 1P3

National Multiple Sclerosis Society
257 Park Avenue South
New York, NY 10010

National Paraplegia Foundation
333 N. Michigan Avenue
Chicago, IL 60601

National Rehabilitation Counseling Association
5203 Leesburg Pike
Falls Church, VA 22041

National Society for the Prevention of Blindness Inc.
79 Madison Avenue
New York, NY 10016

National Therapeutic Recreation Society
(A Branch of the National Recreation and Park Association)
1601 Kent Street
Arlington, VA 22209

Paralyzed Veterans of America
7315 Wisconsin Avenue
Suite 301-W
Washington, DC 20011

Physical Education and Recreation for the Handicapped, Information, and Research Utilization Center
1201 Sixteenth Street, N.W.
Washington, DC 20036

The President's Committee on Employment of the Handicapped
Washington, DC 20210

President's Committee on Mental Retardation
7th and D Streets, S.W.
Washington, DC 20201

Professional Rehabilitation Workers with the Adult Deaf, Inc.
814 Thayer Avenue
Silver Spring, MD 20910

Rehabilitation Services International USA
17 East 45th Street
New York, NY 10017

Rehabilitation Services Administration
330 C Street, S.W.
Washington, DC 20201

Sister Kenny Institute
1800 Chicago Avenue
Minneapolis, MN 55404

United Cerebral Palsy Associations, Inc.
66 East 34th Street
New York, NY 10016

United Ostomy Association, Inc.
1111 Willshire Blvd.
Los Angeles, CA 90017

NOTES

KEY PROJECT STAFF

The Competency-Based Career Guidance Module Series was developed by a consortium of agencies. The following list represents key staff in each agency that worked on the project over a five-year period.

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Robert Bhaerman ..... Research Specialist
Karen Kimmel Boyle ..... Program Associate
Fred Williams ..... Program Associate

American Institutes for Research

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Norman C Gysbers ..... Project Director

American Association for Counseling and Development

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David Pritchard ..... Project Officer
Holli Condon ..... Project Officer

A number of national leaders representing a variety of agencies and organizations added their expertise to the project as members of national panels of experts. These leaders were--

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Government and Public Affairs
American Society for Training and Development

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AFL-CIO

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Competency-Based Career Guidance Modules

CATEGORY A: GUIDANCE PROGRAM PLANNING
- A-1 Identify and Plan for Guidance Program Change
- A-2 Organize Guidance Program Development Team
- A-3 Collaborate with the Community
- A-4 Establish a Career Development Theory
- A-5 Build a Guidance Program Planning Model
- A-6 Determine Client and Environmental Needs

CATEGORY B: SUPPORTING
- B-1 Influence Legislation
- B-2 Write Proposals
- B-3 Improve Public Relations and Community Involvement
- B-4 Conduct Staff Development Activities
- B-5 Use and Comply with Administrative Mechanisms

CATEGORY C: IMPLEMENTING
- C-1 Counsel Individuals and Groups
- C-2 Tutor Clients
- C-3 Conduct Computerized Guidance
- C-4 Infuse Curriculum-Based Guidance
- C-5 Coordinate Career Resource Centers
- C-6 Promote Home-Based Guidance
- C-7 Develop a Work Experience Program
- C-8 Provide for Employability Skill Development
- C-9 Provide for the Basic Skills
- C-10 Conduct Placement and Referral Activities
- C-11 Facilitate Follow-through and Follow-up
- C-12 Create and Use an Individual Career Development Plan
- C-13 Provide Career Guidance to Girls and Women
- C-14 Enhance Understanding of Individuals with Disabilities
- C-15 Help Ethnic Minorities with Career Guidance
- C-16 Meet Initial Guidance Needs of Older Adults
- C-17 Promote Equity and Client Advocacy
- C-18 Assist Clients with Equity Rights and Responsibilities
- C-19 Develop Ethical and Legal Standards

CATEGORY D: OPERATING
- D-1 Ensure Program Operations
- D-2 Aid Professional Growth

CATEGORY E: EVALUATING
- E-1 Evaluate Guidance Activities
- E-2 Communicate and Use Evaluation-Based Decisions

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