Comprehensive CRC Study Guide \*

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Rehabilitation Counseling Program

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I. Counseling Theories

**Adlerian Therapy- Alfred Adler**

* **Founder:** Alfred Adler.
* **Significant developer**: Rudolf Dreikurs.
  + Transplanting Adlerian principles to the United States, especially in applying these principles to education, child guidance, and group work.
* Adler used term Individual Psychology: uniqueness and unity of the individual.
* Understanding whole persons within their socially embedded contexts of family, culture, school, and work
* Social factors- striving for superiority is far more important.
* Natural for a child to feel insecure/inferior and is a driving force of personality.
* Driving force placed on interest.
* Society and the individual are mutually supportive of each other.
* Seeks to develop people who have high social interests and are cooperative.
* Importance of birth order in personality development.
* The youngest child feels "The Baby" according to Alders five psychological positions.
* **Adler’s five psychological positions:**
  + **Oldest child ~** receives more attention, spoiled, center of attention
  + **Second of only two ~** behaves as if in a race, often opposite to first child
    - A second born child is highly involved in characteristics of Rivalry and competition.
  + **Middle ~** often feels squeezed out
  + **Youngest ~** the baby
  + **Only ~** does not learn to share or cooperate with other children, learns   
    to deal with adults
* The older a child is, the amount of time needed to adjust to the divorce of his parents will be longer.
* Social interest is stressed most in Adlerian therapy as it's seen as key to a client success in achieving their goals set by therapist.
* After setting goals, the therapist will provide encouragement to the client in reaching their goals.
* By having a client discuss his or her earliest recollections, an Adlerian counselor hopes to bring unconscious conflicts to the surface.
* The therapist will focus on and examine the clients' lifestyle and the therapist will try to form a mutual respect and trust for each other.
* **Philosophy and Basic Assumptions**
  + Stresses social psychology and a positive view of human nature.
  + Influenced more by social than by biological forces.
  + People are in control of their fate, not victims of it
  + Individuals create a distinctive lifestyle at an early age, rather than being merely shaped by childhood experiences.
* **Key Concepts:**
  + Based on a growth model, stresses the individual’s positive capacities to live fully in society
  + Consciousness, not the unconscious, is the center of personality.
  + Humans are motivated by social interest, or a sense of belonging and having a significant place in society.
  + Feelings of inferiority often serve as the wellspring of creativity, motivating people to strive for competence, mastery, superiority, and perfection.
* **Therapeutic Goals:**
  + Helping clients identify and change their mistaken beliefs about self, others, and life.
  + Enable them to reach their self-defined goals and assist clients in developing socially useful goals.
  + Some specific goals include fostering social interest, helping clients overcome feelings of discouragement, changing faulty motivation, restructuring mistaken assumptions, and assisting clients to feel a sense of equality with others.
  + The aim of therapy is to assist clients in modifying their lifestyles so that they can more effectively navigate each of the life tasks they face
* **Therapeutic Relationship**
  + Described as a collaborative relationship between a client and the therapist.
  + Clients are active parties in a relationship between equals
  + Attention is on examining the client’s lifestyle
  + Therapists frequently interpret this lifestyle by demonstrating a connection between the past, the present, and the client’s future strivings
  + Needs to be solid trust and rapport established at the beginning of the working alliance.
  + The therapist will focus on and examine the clients' lifestyle and the therapist will try to form a mutual respect and trust for each other.
* Te**chniques and Procedures**
  + Adlerian therapist would use collaboration as the main technique with a client to ensure a stable relationship develops with a client.
  + Adlerian pay more attention to the subjective experiences of the client than they do to using techniques.
  + Techniques that go by the names of immediacy, advice, humor, silence, paradoxical intention, acting as if, spitting in the client’s soup, catching oneself, the push-button technique, externalization, re-authoring, avoiding the traps, confrontation, use of stories and fables, early recollection analysis, lifestyle assessment, encouraging, task setting and commitment, giving homework, and terminating and summarizing have all been used.
  + Begin the counseling process with a lifestyle assessment, which focuses on the family constellation and early recollections.
  + Specific techniques they often employ are empathic attending, encouragement, confrontation, the question, summarizing, interpretation of the family constellation, exploring early recollections, suggestion, and homework assignments.
* **Applications**
  + As a growth model, Adlerian theory is concerned with helping people reach their full potential.
  + Applied to areas such as education, parent education, couples counseling, family counseling, and group counseling.
  + Being grounded in the principles of social psychology, it is ideally suited for working with groups, couples, and families.
  + Widely adopted in elementary education, consultation groups with teachers, and child guidance work.
* **Contributions**
  + Adler founded one of the major humanistic approaches to psychology.
  + Adlerian therapy has a psychoeducational focus, a present and future orientation, and is a brief or time-limited approach.
  + There are significant linkages of Adlerian theory with most present-day theories, especially those that view the individual as purposive, self-determining, and striving for growth

**Existential Therapy**

* **Key figures**
  + Søren Kierkegaard, Friedrich Nietzsche, Martin Heidegger, Jean-Paul Sartre, Martin Buber, Ludwig Binswanger, and Medard Boss.
* **Four prominent developers**
  + Viktor Frankl, Rollo May, Irvin Yalom, and James Bugental—all of whom developed their existential approaches to psychotherapy from strong backgrounds in both existential and humanistic psychology.
* **Philosophy and Basic Assumptions**
  + Explores themes such as mortality, meaning, choice, freedom, responsibility, self-determination, anxiety, and aloneness, as these relate to a person’s current struggle
  + Notion that the significance of our existence is never fixed once and for all; rather, we continually re-create ourselves through our projects.
  + We are the authors of our lives.
  + Thrust into a meaningless and absurd world, we are challenged to accept our aloneness and to create meaning in life.
  + Existential anxiety is healthy and is a central part of the therapy process because anxiety can be used as a motivation to change.
  + Anxiety arises from our awareness of freedom and responsibility
* **Key Concepts**
  + 6 propositions
  + (1) We have the capacity for self-awareness.
  + (2) Because we are basically free beings, we must accept the responsibility that accompanies our freedom.
  + (3) We have a concern to preserve our uniqueness and identity; we come to know ourselves in relation to knowing and interacting with others.
  + (4) The significance of our existence and the meaning of our life are never fixed once and for all; instead, we re-create ourselves through our projects.
  + (5) Anxiety is part of the human condition.
  + (6) Death is also a basic human condition, and awareness of it gives significance to living.
* **Therapeutic Goals**
  + Provides an invitation to clients to recognize the ways in which they are not living fully authentic lives and to make choices that will lead to their becoming what they are capable of being.
  + Rather than being concerned with solving problems of living, existential therapy is aimed toward removing roadblocks to meaningful living and helping clients assume responsibility for their actions.
  + (1) to recognize factors that block freedom
  + (2) to challenge clients to recognize that they are doing something that they formerly thought was happening to them
  + (3) to widen clients’ perspectives on choice
  + (4) to accept the freedom and responsibility that go along with action
  + Understand “givens of life” to enable clients to realize that they can live a full and meaningful existence.
* **Therapeutic Relationship**
  + attention is given to the client’s immediate, ongoing experience, especially what is going on in the interaction between the therapist and the client
  + I/Thou encounter offers a context for change
  + It is not the techniques a therapist uses that make a therapeutic difference; rather, it is the quality of the client–therapist relationship that heals
  + Therapy is a collaborative relationship in which both client and therapist are involved in a journey of self-discovery.
* **Techniques and Procedures**
  + Primary emphasis on understanding the client’s current experience, not on using techniques.
  + May use techniques from other theoretical orientations, their interventions are guided by a philosophical framework about what it means to be human.
* **Applications**
  + The approach is especially appropriate for those seeking personal growth.
  + Clients who are experiencing a developmental crisis (career or marital failure, retirement, grief work, transition from one stage of life to another).
  + Clients experience anxiety rising out of existential conflicts, such as making key choices, accepting freedom and the responsibility that goes with it, struggling to find meaning in life, and facing the anxiety of their eventual death.
* **Contributions**
  + It stresses self-determination, accepting the personal responsibility that accompanies freedom, and viewing oneself as the author of one’s life.
  + Provides a perspective for understanding the value of anxiety and guilt, the role and meaning of death, and the creative aspects of being alone and choosing for oneself.

**Freud Theory/Psychoanalytic Concepts from CRCExam.Com**

* **Masochist**
  + Derives pleasure from having pain/humiliation inflicted upon him/herself from others.
* **Sadist**
  + Derives pleasure from inflicting pain/humiliation onto others.
* **Oedipus Complex:**
  + A boy becomes fixated on his mother and competes with his father for maternal attention
  + During the phallic stage, a boy experiences an Oedipus complex. Freud saw this as the boy's unconscious wish to have opposite-sex parent (his mother) all to himself by eliminating the same-sex parent (father).
* Freud explained that the that differences between boys and girls in psychosexual development are mainly due to Anatomy
  + Freud maintained that during the oral and anal stages, there is no basic distinction between female and male psychosexual growth. For later psychosexual stages, Freud used the expression, 'anatomy is destiny' to represent his notion that the physical differences between girls and boys are responsible for many significant psychological differences.
* **Secondary narcissism** that occurs in adolescents and adults is not universal.
  + Freud believed that the secondary narcissism that occurs during adolescence and adulthood is not universal. He thought that as the ego develops, children give up their narcissism and develop an interest in other people. However, in puberty, adolescents often redirect their libido back to the ego and become preoccupied with self-interests and personal appearance. Freud called this pronounced behavior to be secondary narcissism, yet he did not believe it to be universal. Freud believed, nonetheless, that a moderate degree of self-love is common to everyone.
* **Psychic Determinism**
  + “Nothing happens by chance”
  + Freud argued that nothing happens by chance, a concept he called psychic determinism. He maintained that there is a reason behind every act, thought, and feeling. In fact, Freud believed that everything we do, think, say, and feel is an expression of our mind - either conscious, preconscious, or unconscious.
* **Counter-Transference**
  + A therapist’s counter-reaction to the client.
  + Counter-transference basically refers to when therapists have transference reactions while treating a client, so counter-transference is, essentially, a therapist's counter-reaction to a client. Technically, counter-transference is the effect that transference has on a person, and how they respond as a result. Therapists should pay attention to counter-transference as they can easily become the target of their clients' affections and, if they are not careful, may respond inappropriately (and in a way, that reinforces rather than acts to resolve their clients' problems).
* **Preconscious** 
  + Includes those things of which we are aware, but where we are not paying attention. We can choose to pay attention to these and deliberately bring them into the conscious mind.
* **Phobias**
  + Psychoanalysts propose that when repression does not work, individuals with phobias displace their anxiety upon a situation or object that is less relevant.
* For Freud, the compulsive behavior of the neurotic is a behavioral manifestation of an instinctual drive repressed in childhood.
* A psychoanalyst offers interpretations of psychodynamic causes of problems. It is through these interpretations, the patient gains 'insight' (i.e., an understanding of the unconscious source of problems). However, the process of psychoanalysis can difficult and often is faced with challenges of: patient resistance, patient transference, and repetition compulsion.

**Person-centered Therapy- Carl Rogers**

* **Founder:** Carl Rogers.
* **Key figure:** Natalie Rogers.
  + **Person-centered expressive arts therapy, in which the expressive arts are used in self-discovery, healing, and growth.**
* A branch of humanistic psychology that stresses a phenomenological approach, person-centered therapy was originally developed in the 1940s as a reaction against psychoanalytic therapy.
* Emphasizes the client’s resources for becoming self-aware and for resolving blocks to personal growth.
* **Philosophy and Assumptions**
  + grounded on a positive view of humanity that sees the person as innately striving toward becoming fully functioning
  + Basic assumption is that it is the therapist’s attitudes and belief in the inner resources of the client that create the therapeutic climate for growth.
  + By participating in the therapeutic relationship, clients’ self-healing capacities are activated, and they become empowered.
* **Key Concepts**
  + Clients have the resourcefulness for positive movement.
  + Capacity for resolving life’s problems effectively without interpretation and direction from an expert therapist.
  + clients value most is being understood and accepted, which results in the creation of a safe place to explore feelings, thoughts, behaviors, and experiences
  + Views mental health as a congruence between what one wants to become and what one is.
* **Therapeutic Goals**
  + Client tends to move toward more openness, greater self-trust, more willingness to evolve as opposed to being a fixed product, and a tendency to live by internal standards as opposed to taking external cues for what he or she should become.
  + Aim of therapy is not merely to solve problems but to assist in the growth process, which will enable the client to better cope with present and future problems.
* **Therapeutic Relationship**
  + Stresses the client–therapist relationship, and techniques are secondary to the therapist’s attitudes.
  + maximizes active listening and hearing, empathic understanding, presence, reflection of feelings, and clarification
  + Therapist strives to accurately understand the subjective world of the client.
  + Focus of therapy is on clients’ perceptions of reality.
* **Applications**
  + The approach has been effectively applied to a wide range of client problems including anxiety disorders, alcoholism, psychosomatic problems, agoraphobia, interpersonal difficulties, depression, cancer, and personality disorders.
  + Especially well-suited for the initial phases of crisis intervention work.
  + Its principles have been applied to administration and management and to working with systems and institutions.
  + Person-centered expressive arts therapy uses various artistic forms—movement, drawing, painting, sculpting, music, writing, and improvisation—toward the end of growth, healing, and self-discovery.
* **Contributions**
  + One of the first therapies to break from traditional psychoanalysis, person-centered therapy stresses the active role and responsibility of the client.
  + Positive and optimistic view and calls attention to the need to account for a person’s inner and subjective experiences.
  + Generated a great deal of clinical research into both the process and the outcomes of therapy, which in turn has led to refining the tentative hypotheses.
* **Three values:**
  + Unconditional positive regard- accepts client regardless of issues s/he brings to session.
  + Empathy
  + Honesty
* People can revise their beliefs and values if using the 3 values in the counseling process.
* Positive view of people.
* Client moves toward increased awareness, spontaneity, trust in self, and inner directedness
* **Humanistic psychology** 
  + A movement often referred to as the “third force,” that emphasizes freedom, choice, values, growth, self-actualization, becoming, spontaneity, creativity, play, humor, peak experiences, and psychological health.
* **Motivational Interviewing (MI)** 
  + A humanistic, client-centered, psychosocial, directive counseling approach that was developed by William R. Miller and Stephen Rollnick in the early 1980s.
* **The MI spirit**
  + The attitudes and skills in MI are based on a person-centered philosophy.
* **Positive psychology** 
  + A movement that has come into prominence, which shares many concepts on the healthy side of human existence with the humanistic approach.
* **Stages of change** 
  + People are assumed to progress through a series of five identifiable stages of motivation and readiness to change in the counseling process.
  + They include the pre-contemplation stage, the contemplation stage, the preparation stage, the action stage, and the maintenance stage.
* **Therapeutic core conditions** 
  + The necessary and sufficient characteristics of the therapeutic relationship for client change to occur.
  + These core conditions include therapist congruence (or genuineness), unconditional positive regard (acceptance and respect), and accurate empathic understanding.
* **“Third force” in therapy** 
  + An alternative to psychoanalytic and behavioral approaches.
  + Under this heading are the experiential and relationship-oriented therapies (existential therapy, person-centered therapy, and Gestalt therapy).
* **Unconditional positive regard** 
  + The nonjudgmental expression of fundamental respect for the person as a human; acceptance of a person’s right to his or her feelings.

**Gestalt Therapy**

* The whole is greater than the sum of its parts.
* **Founders:** Frederick (“Fritz”) Perls and Laura Perls
* **Other key figures:** the late Miriam Polster and Erving Polster.
* An experiential therapy that stresses here-and now awareness and integration of the fragmented parts of the personality.
* It focuses on the “what” and “how” of behavior and on the role of unfinished business from the past in preventing effective functioning in the present.
* **Philosophy and Assumptions**
  + Existential–phenomenological approach based on the premise that individuals must be understood in the context of their ongoing relationship with the environment.
  + Help people experience the present moment more fully and gain awareness of what they are doing.
  + Experiential in that clients come to grips with what they are thinking, feeling, and doing as they interact with the therapist.
  + I/thou therapeutic relationship is the context for designing experiments that grow out of the moment-to-moment experience.
* **Key Concepts**
  + The here and now, direct (as opposed to talked-about) experiencing, awareness, and bringing unfinished business from the past into the present.
  + Energy and blocks to energy, contact and resistances to contact, attention to the body, and nonverbal cues.
  + **Five major channels of resistance** are challenged in Gestalt therapy: introjection, projection, retroflection, confluence, and deflection.
  + **Introjection** 
    - The uncritical acceptance of others’ beliefs and standards without assimilating them into one’s own personality.
  + **Projection** 
    - The process by which we disown certain aspects of ourselves by ascribing them to the environment; the opposite of introjection.
  + **Retroflection** 
    - The act of turning back onto ourselves something we would like to do (or have done) to someone else.
  + **Confluence** 
    - A disturbance in which the sense of the boundary between self and environment is lost.
  + **Deflection** 
    - A way of avoiding contact and awareness by being vague and indirect.
  + **Principles** 
    - Holism, field theory, the figure-formation process, and organismic self-regulation.
    - **Holism** 
      * Attending to a client’s thoughts, feelings, behaviors, body, and dreams.
    - **Field** 
      * A dynamic system of interrelationships.
    - **Field theory** 
      * Paying attention to and exploring what is occurring at the boundary between the person and the environment.
    - **Figure** 
      * Those aspects of the individual’s experience that are most salient at any moment
    - **Figure-formation process**
      * Describes how the individual organizes the environment from moment to moment and how the emerging focus of attention is on what is figural.
    - **Organismic self-regulation** 
      * An individual’s tendency to take actions and make contacts that will restore equilibrium or contribute to change.
* **Therapeutic Goals**
  + Attaining awareness and expanding choices.
  + Awareness, choice, and responsibility are cornerstones of practice.
  + Initial goal is for clients to expand their awareness of what they are experiencing in the present moment.
  + Awareness includes knowing the environment and knowing oneself, accepting oneself, and being able to make contact.
  + With awareness the client can recognize denied aspects of the self and proceed toward reintegration of all its parts.
* **Therapeutic Relationship**
  + Stresses I/thou relationship.
  + Focus is not on the techniques employed by the therapist but on who the therapist is as a person and what the therapist is doing.
  + Contemporary Gestalt therapy (or relational Gestalt therapy) stresses factors such as presence, authentic dialogue, gentleness, more direct self-expression by the therapist, decreased use of techniques, and a greater trust in the client’s experiencing.
  + Clients are viewed as the experts on their own experience.
  + assists clients in experiencing all feelings more fully and lets them make their own interpretations
  + Does not interpret for clients but focuses on the “what” and “how” of their behavior.
  + Clients identify their own unfinished business from the past that is interfering with their present functioning by re-experiencing past situations as though they were happening at the present moment.
* **Techniques and Procedures**
  + Although the therapist functions as a guide and a catalyst, presents experiments, and shares observations, the basic work of therapy is done by the client, who is expected to be active.
  + They create experiments within a context of the I/Thou dialogue in a here-and-now framework.
  + Use active methods and personal engagement with clients to increase their awareness, freedom, and self-direction rather than directing them toward preset goals.
  + Therapist suggests experiments; this is a collaborative process with full participation by the client which are the cornerstone of experiential learning.
  + Gestalt experiments take many forms:
    - Setting up a dialogue between a client and a significant person in his or her life; reliving a painful event; or carrying on a dialogue between two conflicting aspects within an individual.
  + Clients often engage in role playing.
  + By playing out all the various parts and polarities alone, often through the empty-chair technique, clients gain greater awareness of the conflicts within themselves.
  + **Emotion-focused therapy (EFT)** and process-experiential therapy are similar in some respects to organic therapy.
    - Blends the relational aspects of the person-centered approach with the active phenomenological awareness experiments of Gestalt therapy.
* **Applications**
  + The techniques are most effectively applied to overly socialized, restrained, and constricted individuals, and they can be useful in working with couples and families.
  + In a group context there is emphasis on direct experiencing and action, rather than merely talking about problems or feelings.
  + Experiments are means of moving from talking about into action-oriented approach.
  + The focus of a Gestalt group is on awareness, contact, and experimentation.
* **Contributions**
  + Its focus is on recognition of one’s own projections and emphasizes doing and experiencing as opposed to merely talking about problems in a detached way.
  + Gestalt therapy gives attention to nonverbal and body messages.
  + It provides a perspective on growth and enhancement, not merely a treatment of disorders.
  + The method of working with dreams is a creative pathway to increased awareness of key existential messages in life.
* **Relational Gestalt therapy** 
  + A supportive, kind, and compassionate style that emphasizes dialogue in the therapeutic relationship, rather than the confrontational style of Fritz Perls.
* **Empty-chair technique** 
  + A role-playing intervention in which clients play conflicting parts. This typically consists of clients engaging in an imaginary dialogue between different sides of themselves.
* **Unfinished business** 
  + Unexpressed feelings (such as resentment, guilt, anger, grief) dating back to childhood that now interfere with effective psychological functioning; needless emotional debris that clutters present-centered awareness.
* **Impasse** 
  + The stuck point in a situation in which individuals believe they are unable to support themselves and thus seek external support

**Bandura**

* Bandura asserts that a common mechanism found in each of his treatment strategies (resulting in their effectiveness) is cognitive mediation - when clients use cognition to increase self-efficacy, they become convinced that they can perform difficult behaviors. This, in turn, raises their perceptions of self-efficacy when dealing with fear producing situations in the future and allows them to cope with previously intimidating situations.
* **Reciprocal Determinism:**
  + Suggests there are 3 interacting factors contributing to behavior:
    - External stimulus events
    - External Reinforcement
    - Cognitive meditational processes.
  + Psychological fixing= reciprocal interaction b/w behavior, cognition, and environment.
* **3 factors contributing to self-regulation:**
  + **Self-Observation:** We regulate our behavior by monitoring our own performance and adjusting our behavior accordingly. The self-observed factors depend partially on the environment
  + **Judgmental Process:** A subjective evaluation of the consequences of our behavior. Many ways to make these judgments
    - **Personal Standards:** evaluate our performance without comparing it to others.
    - **Standard of Reference:** Comparing our performance to the performance of others, or to a "norm" (an external standard)
    - **Performance Attribution:** how we explain success and failure in our life. Internal attributions of success will lead to extended effort in times of difficulty, while external attributions can lead to
      * **Affective Self-Reaction:** We provide self-reinforcement or self-punishment depending upon our standards and our behavior. Affective Self-reaction helps show how cognitions help drive behavior and why human behavior is not solely a function of our environment.
* The treatment approach of covert or cognitive modeling involves modeling by visualization where the therapist has the client imagine modeling the behavior before attempting it. This strategy is most effective when combined with a performance-oriented approach.
* Bandura believes that behavior stems from a reciprocal influence of external and internal factors. He maintains that the one of the three internal requirements for self-regulation consists of the judgmental process. We determine the worth of our actions based on the goals we have set. This is done by judging or evaluating our performance and is dependent on our own personal standards, referential performances, and valuation of activity and performance attribution.
* A phobia is an irrational fear to an object. Bandura would argue that phobias are learned by direct contact inappropriate generalization, and observational experiences. Once learned, phobias are maintained by negative reinforcement, as the person is reinforced for avoiding fear-producing situations.
* **The goal of social cognitive therapy is self-regulation.**
  + Bandura outlined three steps of treatment: induction of change, generalization of change to other appropriate situations, and maintenance of newly acquired functional behaviors.
* Social persuasion involves listening to a trusted person's encouraging words. The efficacious power of suggestion is directly contingent upon the perceived status and authority of the persuader. One's level of self-efficacy tends to be increased when a person (who an individual believes or respects) convinces the individual that he/she has the capability to perform an activity.
* The use of environmental planning in self-control therapy involves having the client take the information learned from his behavioral charts and diaries to begin to change his environment. The client can remove or avoid some of the cues that lead to his habit behaviors.
* Bandura's ideas behind self-regulation have been integrated into a therapy technique called self-control therapy. This therapy has been successful in ending habit-type issues, like smoking, overeating, and study habits.
* Bandura proposed three internal requirements for self-regulation; he maintains that the one of these internal requirements consists of the judgmental process where we determine the worth of our actions based on the goals we have set. Judgments are affected by the value an individual places on a task or skill as values help to determine where and how people focus their efforts. The judgmental process is also made-up of personal standards (how people evaluate their performance without comparing it to others); standards of reference (comparing one's performance to the performance of others or to a "norm" - an external standard), and performance attribution (how people judge the causes of their behavior).

**Behavior Therapy**

* **Key figures:** **B. F. Skinner, Joseph Wolpe, Arnold Lazarus, and Albert Bandura.**
* developed in the 1950s and early 1960s as a radical departure from the psychoanalytic perspective
* **Four major phases in the development of behavior therapy**
  + (1) classical conditioning
  + (2) operant conditioning
  + (3) social learning theory
    - According to the social learning theory approach, psychological functioning involves a reciprocal interaction among Behavior, cognitive factors and environmental influences.
  + (4) cognitive behavior therapy
* Attending to a situation and retaining what is observed are two key elements of the observational learning process.
* Challenging, via reality testing, can be especially helpful with younger children while they are still able to think very concretely and cannot move too quickly into abstract thoughts.
* **“Third wave”**
  + Dialectical behavior therapy, mindfulness-based stress reduction, mindfulness-based cognitive therapy, and acceptance and commitment therapy.
  + **DBT**
    - **Marsha Linehan** developed dialectical behavior therapy (DBT), which is a comprehensive cognitive behavioral treatment for people with borderline personality disorders.
    - Effective in reducing suicidal behaviors, psychiatric hospitalization, and in treating substance abuse, anger, interpersonal difficulties, and other dysfunctional behaviors.
  + **Victoria Follette,** who has used mindfulness and acceptance-based approaches in the treatment of trauma
  + **Steven Hayes**- application of language and cognition to alleviating human suffering
* **Philosophy and Assumptions**
  + Behavior is the product of learning.
  + We are products and producers of our environment.
  + Central characteristics unite the field of behavior therapy: a focus on observable behavior, current determinants of behavior, learning experiences to promote change, and rigorous assessment and evaluation.
* **Key Concepts**
  + Emphasize current behavior as opposed to historical antecedents, precise treatment goals, diverse therapeutic strategies tailored to these goals, and objective evaluation of therapeutic outcomes.
  + Focus on behavior change in the present and generating action programs.
  + Specific behaviors are measured before and after an intervention to determine whether behavior changed as a result of a procedure
* **Therapeutic Goals**
  + Identification of specific goals at the outset of the therapeutic process.
  + The general goals are to increase personal choice and to create new conditions for learning.
  + Aim is to eliminate maladaptive behaviors and learn more effective behavior patterns.
  + Client and therapist collaboratively specify treatment goals in concrete, measurable, and objective terms.
* **Therapeutic Relationship**
  + Clients make progress primarily because of the specific behavioral techniques used, but a good working relationship is an essential precondition for effective therapy.
  + Emphasize the importance of establishing a collaborative working relationship and use a flexible repertoire of relationship styles to enhance treatment outcomes.
  + Conceptualize problems behaviorally and make use of the therapeutic relationship in bringing about change.
  + Therapist’s role is primarily to explore alternative courses of action and their possible consequences.
  + Teach concrete skills through the provision of instructions, modeling, and performance feedback.
  + Therapists tend to be active and directive and to function as consultants and problem solvers
  + Clients must also be actively involved in the therapeutic process from beginning to end, and they are expected to cooperate in carrying out therapeutic activities, both in the sessions and outside of therapy.
* **Techniques and Procedures**
  + Interventions are individually tailored to specific problems experienced by different clients.
  + Techniques aimed at producing behavior change, a few of which are relaxation methods, systematic desensitization, exposure therapies, eye movement desensitization reprocessing, social skills training, self-modification programs, and multimodal therapy.
  + Role playing, behavior rehearsal, coaching, guided practice, modeling, feedback, learning by successive approximations, and homework assignments.
  + Some newer behavioral interventions include meditation, learning to be present in the moment, mindfulness, exploring spirituality, and acceptance.
* **Applications**
  + Phobic disorders, social fears, depression, anxiety disorders, sexual disorders, substance abuse, eating disorders, pain management, trauma, hypertension, children’s disorders, and the prevention and treatment of cardiovascular disease.
  + deeply enmeshed in geriatrics, pediatrics, stress management, self-management, sports psychology, rehabilitation, behavioral medicine, business and management, gerontology, and education,
  + Behavioral practitioners make use of a brief, active, directive, structured, collaborative, psychoeducational model of therapy
  + Behavioral group leaders adopt a teaching role and encourage members to learn and practice skills in the group that they can apply to everyday living.
  + Group leaders are expected to assume an active, directive, and supportive role in the group and to apply their knowledge of behavioral principles and skills to the resolution of problems.
  + Group leaders model active participation and collaboration by their involvement with members in creating an agenda, designing homework, and teaching skills and new behaviors.
* **Contributions**
  + Emphasizes research into and assessment of the techniques used, thus providing accountability.
  + Fit well with managed care mental health programs.
  + The therapist is an explicit reinforcer, consultant, model, teacher, and expert in behavioral change.
* **ABC model** 
  + This model of behavior posits that behavior (B) is influenced by some events that precede it, called antecedents (A), and by certain events that follow it called consequences (C).
* **Acceptance and commitment therapy (ACT)** 
  + A mindfulness-based program that encourages clients to accept, rather than attempt to control or change, unpleasant sensations.
* **Antecedent events** 
  + Ones that cue or elicit a certain behavior.
* **Applied behavior analysis (ABA)**
  + Another term for behavior modification; this approach seeks to understand the causes of behavior and address these causes by changing antecedents and consequences.
* **Assertion training** 
  + A set of techniques that involves behavioral rehearsal, coaching, and learning more effective social skills; specific skills training procedures used to teach people ways to express both positive and negative feelings openly and directly.
* **Classical conditioning**
  + Also known as Pavlovian conditioning and respondent conditioning. A form of learning in which a neutral stimulus is repeatedly paired with a stimulus that naturally elicits a particular response. The result is that eventually the neutral stimulus alone elicits the response.
  + The neobehavioristic approach emphasizes classical conditioning of responses of the autonomic nervous system.
  + A conditioned stimulus is something that, after time, elicits the conditioned response because the pairing has become so successful.
* **Cognitive behavior therapy (CBT)** 
  + An approach that blends both cognitive and behavioral methods to bring about change. Emphasis on the interaction among affective, behavioral, and cognitive dimensions.)
* **Consequences** 
  + Events that take place as a result of a specific behavior being performed.
* **Discrimination**
  + Discrimination is when an individual knows how to change his or her own behavior depending on the situation
* **Dialectical behavior therapy (DBT)** 
  + A blend of behavioral and psychoanalytic techniques aimed at treating borderline personality disorders; primarily developed by Marsha Linehan.
* **Exposure therapies** 
  + Treatment for fears and other negative emotional responses by carefully exposing clients to situations or events contributing to such problems.
* **Extinction** 
  + When a previously reinforced behavior is no longer followed by the reinforcing consequences, the result is a decrease in the frequency of the behavior in the future.
    - If a crying child is ignored, when in the past it had been picked up or attended to this is called extinction.
* **Eye movement desensitization and reprocessing (EMDR)** 
  + An exposure-based therapy that involves imaginal flooding, cognitive restructuring, and the use of rhythmic eye movements and other bilateral stimulation to treat traumatic stress disorders and fearful memories of clients.
* **Flooding** 
  + Prolonged and intensive in vivo or imaginal exposure to highly anxiety-evoking stimuli without the opportunity to avoid or escape from them.
* **In vivo desensitization** 
  + Brief and graduated exposure to an actual fear situation or event.
* **In vivo exposure**
  + Involves client exposure to actual anxiety-evoking events rather than merely imagining these situations.
* **In vivo flooding** 
  + Intense and prolonged exposure to the actual anxiety-producing stimuli.
* **Mindfulness** 
  + A process that involves becoming increasingly observant and aware of external and internal stimuli in the present moment and adopting an open attitude toward accepting what is, rather than judging the current situation.
* **Mindfulness-based cognitive therapy (MBCT)** 
  + A comprehensive integration of the principles and skills of mindfulness applied to the treatment of depression.
* **Mindfulness-based stress reduction (MBSR)** 
  + This program applies mindfulness techniques to coping with stress and promoting physical and psychological health.
* **Multimodal therapy** 
  + A model endorsing technical eclecticism; uses procedures drawn from various sources without necessarily subscribing to the theories behind these techniques; developed by Arnold Lazarus.
* **Negative punishment** 
  + A reinforcing stimulus is removed following the behavior to decrease the frequency of a target behavior.
* **Negative reinforcement** 
  + The termination or withdrawal of an unpleasant stimulus as a result of performing some desired behavior.
* **Operant conditioning** 
  + A type of learning in which behaviors are influenced mainly by the consequences that follow them.
* **Positive punishment** 
  + An aversive stimulus is added after the behavior to decrease the frequency of a behavior.
* **Positive reinforcement**
  + A form of conditioning whereby the individual receives something desirable as a consequence of his or her behavior; a reward that increases the probability of its recurrence.
* **Positive reinforcement** 
  + An event whose presentation increases the probability of a response that it follows.
* **Primary Reinforcement**
  + Primary reinforcers include such things as objects, food, and shelter.
* **Secondary Reinforcement**
  + Secondary reinforcers include verbal praise, eye contact, and varying word choice to show pride or excitement.
  + Secondary reinforcers are those that a person is conditioned to or learns to appreciate.
* **Progressive muscle relaxation** 
  + A method of teaching people to cope with the stresses produced by daily living. It is aimed at achieving muscle and mental relaxation and is easily learned.
* **Punishment** 
  + The process in which a behavior is followed by a consequence that results in a decrease in the future probability of a behavior.
* **Reinforcement** 
  + A specified event that strengthens the tendency for a response to be repeated. It involves some kind of reward or the removal of an aversive stimulus following a response.
* **Self-efficacy** 
  + An individual’s belief or expectation that he or she can master a situation and bring about desired change.
* **Social learning approach** 
  + A perspective holding that behavior is best understood by taking into consideration the social conditions under which learning occurs; developed primarily by Albert Bandura.
* **Social skills training** 
  + This training involves a broad category that deals with an individual’s ability to interact effectively with others in various social situations. A treatment package used to teach clients skills that include modeling, behavior rehearsal, and reinforcement.
* **Systematic desensitization** 
  + A procedure based on the principles of classical conditioning in which the client is taught to relax while imagining a graded series of progressively anxiety arousing situations. Eventually, the client reaches a point at which the anxiety-producing stimulus no longer brings about the anxious response

**Cognitive Therapy**

* **Founders:** Aaron Beck (Judith Beck)
* **Philosophy and Assumptions**
  + Active, directive, time-limited, present-centered, structured approach used to treat various disorders such as depression, anxiety, and phobias.
  + Insight-focused therapy that emphasizes recognizing and changing negative thoughts and maladaptive beliefs.
  + Cognitions are the major determinants of how we feel and act.
  + Internal dialogue of clients plays a major role in their behavior and feelings.
  + Changing thoughts is the path to changing behaviors and feelings.
* **Key Concepts**
  + Psychological problems stem from commonplace processes such as faulty thinking, making incorrect inferences on the basis of inadequate or incorrect information, and failing to distinguish between fantasy and reality.
  + Changing dysfunctional emotions and behaviors by modifying inaccurate and dysfunctional thinking.
  + Techniques are designed to identify and test the client’s misconceptions and faulty assumptions.
* **Therapeutic Goals**
  + Change the way clients think by using their automatic thoughts to reach the core schemata and begin to introduce the idea of schema restructuring.
  + Changes in beliefs and thought processes 🡪 changes in the way people feel and how they behave.
  + Through a Socratic dialogue with the therapist, clients in CT are encouraged to gather and weigh the evidence in support of their beliefs.
  + Clients learn to discriminate between their own thoughts and the events that occur in reality.
* **Therapeutic Relationship**
  + Emphasizes a collaborative effort.
  + Therapist and client frame the client’s conclusions in the form of a testable hypothesis.
  + Continuously active and deliberately interactive with the client.
  + Quality working alliance=quality outcomes.
* **Techniques and Procedures**
  + Guided discovery- the CT practitioner functions as a catalyst and guide who helps clients understand the connection between their thinking and the ways they feel and act.
* Applications
  + Depression and anxiety.
  + Managing stress and parent training.
  + PTSD, schizophrenia, bipolar disorders, and various personality problems.

**Rational Emotive Behavior Therapy (REBT)-** Albert Ellis

* **Founders:** Albert Ellis who is the grandfather of other cognitive behavioral approaches
* **Philosophy and Assumptions**
  + Highly didactic approach that stresses the role of action and practice in combating irrational, self-indoctrinated ideas
  + Focuses on the role of thinking and belief systems as the roots of personal problems.
  + Thinking, evaluating, analyzing, questioning, doing, practicing, and re-deciding are at the base of behavior change.
  + Didactic and directive model.
  + Therapy is a process of reeducation.
* **Key Concepts**
  + Although emotional disturbance is rooted in childhood, people keep telling themselves irrational and illogical sentences.
  + A-B-C theory of personality: A = actual event; B = belief system; C = consequence.
  + Emotional problems are the result of one’s beliefs, which need to be challenged by a variety of different methods.
  + Cognitive restructuring involves detecting and debating faulty thinking and substituting negative self-talk with constructive beliefs and thoughts.
* **Therapeutic Goals**
  + Eliminate a self-defeating outlook on life and acquire a more rational and tolerant philosophy.
  + Clients are taught that the events of life themselves do not disturb us; rather, our interpretation of events is what is critical.
  + Clients are taught how to identify and uproot their “shoulds,” “musts,” and “oughts.”
* **Therapeutic Relationship**
  + A warm relationship between the client and the therapist is not essential.
  + Clients still need to feel unconditional positive regard.
  + Does not blame or condemn clients; rather, he or she teaches them how to avoid rating and condemning themselves.
  + Therapist functions as a teacher; the client functions as a student.
  + Clients need to actively practice changing their self-defeating behavior and converting it into rational behavior.
* **Techniques and Procedures**
  + Cognitive techniques include disputing irrational beliefs, cognitive homework, changing one’s language, cognitive role playing, and the use of humor.
  + Emotive techniques include rational emotive imagery, role playing, and shame attacking exercises.
  + Behavioral techniques include operant conditioning, self-management strategies, and modeling.
  + Techniques are designed to induce clients to critically examine their present beliefs and behavior.
* **Applications**
  + Ongoing group therapy, marathon encounter groups, brief therapy, marriage and family therapy, sex therapy, and classroom situations.
  + Clients with moderate anxiety, neurotic disorders, character disorders, psychosomatic problems, eating disorders, poor interpersonal skills, marital problems, poor parenting skills, addictions, and sexual dysfunctions.
  + Most effective with those who can reason well and who are not seriously disturbed.
* Clients mistake the event (A) for the source of their emotional-behavioral consequence (B) and between the emotional and behavioral consequences is their belief system (C).
* Belief system- true cause of emotional-behavioral consequence.
* 11 irrational beliefs

**Cognitive Behavioral Modification**

* **Founder:** Donald Meichenbaum
* **Philosophy and Assumptions**
  + More effective to behave our way into a new way of thinking, than to think our way into a new way of behaving.
  + Self-instructional training and stress inoculation training—focuses more on helping clients become aware of their self-talk and the stories they tell about themselves.
  + Helping clients interrupt the downward spiral of thinking, feeling, and behaving, and teaching them more adaptive ways of coping using the resources they bring to therapy.
  + Stress inoculation training is a preventive and treatment approach.
* **Key Concepts**
  + For clients, as a prerequisite to behavior change, must notice and become aware of how they think, feel, and behave, and the impact they have on others.
  + For change to occur, clients need to interrupt the scripted nature of their behavior so that they can evaluate their behavior in various situations.
* **Therapeutic Goals**
  + Stress inoculation training involves collaborative goal setting that nurtures hope, direct-action skills, and acceptance-based coping skills.
  + Coping skills are designed to be applied to both present problems and future difficulties.
* **Techniques and Procedures**
  + Three-stage model for stress inoculation training: (1) the conceptual-educational phase, (2) the skills acquisition and skills consolidation phase, and (3) the application and follow-through phase.
  + Educate clients about ways of responding to a variety of stressful situations, learning a new set of coping self-statements, practicing relaxation methods, and practicing new self-statements and applying new skills.
* **Applications**
  + Remediation and prevention.
  + Anger control, anxiety management, assertion training, improving creative thinking, treating depression, and dealing with health problems.
  + (PTSD) and with veterans and combat-related PTSD.

**Cognitive-Behavioral Therapy (CBT)- Donald Meichenbaum /Aaron Beck/Albert Ellis?**

* Thoughts influence our feelings and behaviors and therapy works on correcting those faulty cognitive processes.
* Emphasizing the interaction among behavioral, cognitive, and affective dimensions.
* Emphasis on problem-solving and skill development.
* Faulty thinking leads to emotional and behavioral disturbances.
* Cognitive behavior therapy (CBT) A treatment approach that aims at changing cognitions that are leading to psychological problems.
* Reorganization of one’s self-statements will result in a corresponding reorganization of one’s behavior.
* Our thoughts, sometimes automatic, influence what emotion we might feel.
* A behavior that is punished will occur less frequently or will cease to occur.
* Schemas are the cognitive constructions or core beliefs of a person.
* Catastrophizing can be defined as thinking the worst possible thing will happen at any given time, regardless of previous outcome or present circumstances.

**Transactional Analysis- Erice Berne**

* “Poor man’s therapy”- straight forward and similar to Freud’s Ego, Super-ego, and Id.
* Taught people to understand themselves in constructs and terminology.
* Structural, transactional, and game analysis.
* Game analysis- social-roles people play w/ each other that lead to pain and emotional feelings.
* Life analysis- a script someone plays out in life.
* **4 positions**
  + “I’m ok, you’re ok.”
  + “I’m ok, you’re not ok.”
  + “I’m not ok, you’re ok.”
  + “I’m not ok, you’re not ok.”

**Reality Therapy- William Glasser**

* Eclectic and versatile approach.
* Evaluating actions and behaviors from the perspective of responsibility.
* Certain actions have predictable consequences in different problem situations that you encounter over the course of life.
* Focuses on present problems and behaviors and evaluates them from the perspective of acting responsibly vs irresponsibly.
* Based on choice theory- focus on subjective view of clients’ perceptions and reactions to their world from an internal locus of evaluation.
  + We are self-determined beings.
* Behavior is purposeful and closes gap b/w what we want and what we perceive we are getting; and specific behaviors are generated from this gap.
* We can choose our own destiny.
* **The process of reality therapy has 5 components in this process:**
  + Involvement
  + Current behavior and evaluation;
  + Planning successful behavior;
  + commitment to the plan;
  + No excuses
* The teaching of responsibility is the most important task of all higher animals, man most certainly included.
* The severity of the symptom reflects the degree to which the individual is unable to fulfill his needs.
* Why questions imply that the reasons for the patient's behavior make a difference in therapy, but they do not.
* Control theory attempts to explain why students are performing less in school as well as makes changes to the structure of the classroom to fix it.
* seven caring habits that teachers should have in the classroom. These are supporting, encouraging, listening, accepting, trusting, respecting and negotiating differences.
* Present Reality Therapy is based on the concept that our brain works as a control system.
* The client needs to zero in on the client's current behavior rather than past experiences
* **Philosophy and basic assumptions**
  + **Choice theory:**
    - We are self-determined beings.
    - We Choose our total behavior, we are responsible for how we are acting, thinking, feeling, and for our physiological states.
    - All behavior is aimed at satisfying the needs for survival, love and belonging, power, freedom, and fun.
    - Focus on therapy: acting and thinking are chosen behaviors.
    - Changing our acting/thinking 🡪 influence how we feel/physiological state.
    - Explains how we attempt to control the world around us.
    - Teaches us ways to satisfy our wants and needs more effectively.
  + Accepting personal responsibility and gaining more effective control.
  + People take charge of their lives rather than being the victims of circumstances beyond their control.
  + Teaches clients to focus on what they are able and willing to do in the present to change their behavior.
* **Key Concepts**
  + Behavior is our attempt to control our perceptions of the external world, so they fit our internal and need-satisfying world.
  + Total behavior= acting, thinking, feeling, and the physiology that accompanies all our actions.
  + No matter how dire the circumstances, people always have a choice.
  + Assuming personal responsibility and on dealing with the present.
  + Rejects medical model, psychoanalytic theory, and key concepts such the focus on the past, the exploration of dreams, dwelling on feelings or insight, transference, and the unconscious.
* **Therapeutic Goals**
  + Find better ways to meet their needs for survival, love and belonging, power, freedom, and fun.
  + Making more effective and responsible choices related to their wants and needs.
  + Behavior changes 🡪 satisfaction of basic needs.
  + Personal growth, improvement, enhanced lifestyle, and better decision making.
  + Accept personal responsibility for their lives and assist them in learning ways to regain control of their lives and to live more effectively.
  + challenged to examine what they are doing, thinking, and feeling to figure out if there is a better way for them to function.
  + Evaluating their own behavioral direction, specific actions, wants, perceptions, level of commitment, possibilities for new directions, and action plans.
  + Therapist does not determine what behaviors clients should change.
  + Clients make this decision and then formulate a plan to facilitate desired changes.
* **Therapeutic Relationship**
  + Becoming involved with the client and creating a warm, supportive, and challenging relationship.
  + Involvement with and concern for the client are demonstrated throughout the entire process.
  + Confronts clients with the reality and consequences of their actions.
  + Avoids criticism, refuses to accept clients’ excuses for not following through with agreed-on plans, and does not easily give up on clients.
  + Assist clients in the continual process of evaluating the effectiveness and appropriateness of their current behavior.
* **Techniques & Procedures**
  + Clients are motivated to change (1) when they determine that their current behavior is not getting them what they want and (2) when they believe they can choose other behaviors that will get them closer to what they want.
  + **“WDEP” model**
    - **W =** wants: exploring wants, needs, and perceptions.
    - **D =** direction and doing: focusing on what clients are doing and the direction that this is taking them.
    - **E =** evaluation: challenging clients to make an evaluation of their total behavior.
    - **P =** planning and commitment: assisting clients in formulating realistic plans and making a commitment to carry them out.
* **Applications**
  + Youth offenders in detention facilities.
  + People w/ behavioral problems and need for relationship enhancement.
  + Teaching and administration for youth.
  + Crisis intervention, institutional mgmt., and community development.
  + Military clinics treatment of drug & alcohol dependence.

**Narrative Therapy – www.crcexam.com**

* **Founders:** Epston and White
* The Narrative Family Therapy approach is mainly concerned with the way in which people construct meaning.
* The Narrative approach is based on the premise that experience is created.
  + Experience is not discovered.
* In narrative therapy, the stability of the problem depends on the dominant story of the problem.
  + Narrative therapists, like many others, tend to look for the exception, so that they are able to point out that the story has not always been the same.
* Narrative family therapists could work with couples who are arguing or not satisfied with each other by focusing on the way they narrate their exchange.
* Narrative family therapists are not interested in family's impact on problem rather the problem's impact on the family.
  + Narrative family therapists are interested in the problem's impact on the family, keeping the externalized view of the problem as something that is outside the system.
* While Narrative family therapists avoid making assumptions about people, there are certain basic assumptions that Narrative family therapists make about normal families.
* In Narrative therapy, problems are always personified and portrayed as unwelcome invaders.
* Narrative therapists believe that the stories clients tell themselves mirror and shape their lives.
* According to Narrative theory, problems arise due to people being trained into having narrow and self-defeating views of the world and themselves.
* Epston believed that a way to help clients to maintain their new narratives was by writing them letters.
* According to the NFT approach, life stories serve as filters.
* Narrative Therapists ask questions that are non-imposing and respectful. They use questions toward a respectful approach to challenge assumptions and create a new story.
* “What does depression want your life to look like?”
  + This is an example of externalizing which involves name in a problem so that a person can assess it and learn more about how it operates in his or her life as well as, ultimately, choose the relationship she or he wants to have with it.
* When clients are stuck in unhelpful and rigid narratives they can become more vulnerable to destructive emotional states.
* Many Narrative therapists have an appreciation for the creation and use of documents, such as a certificate (i.e. Graduation from the Blues) to use when someone creates a new story for them.
* Deconstruction in the narrative therapy process means questioning assumptions.
  + Deconstruction is the focus on questioning assumptions, which is part of the work that Narrative Therapists see as political in that they are freeing people from oppressive cultural assumptions and empowering them to be in charge of their lives.
* Narrative therapists begin by asking families to tell their problem saturated story. They ask families to tell their problem-saturated story, and the more they hear, the more openings that may be created for times the family resisted the problem.
* When initiating therapy, Narrative therapists believe in situating themselves with their clients.
* Externalization is used in Narrative family therapy to assist clients in changing their perceptions of themselves and to change their perception of other family members, so they can better interact with each other.
* Narrative family therapists look for the source of problems in the effects of the cultural narratives that govern people's lives.
* Narrative therapists use the term "situate" to describe when therapists disclose to clients, during the initiation of treatment, about the beliefs that inform their therapy, so clients can know what they are getting into.

2. Counseling Techniques

(www.crcexam.com)

**Behavioral**

* **Biofeedback**
  + The client is given feedback about what brain waves, sympathetic nervous system (i.e. heart rate, blood pressure, muscle tension) are doing to engage a relaxation response by the client through providing feedback to the client through visual or auditory means.
* **Behavioral Observation**
  + This technique involves objectifying a specific behavior and observing the behavior in the client's natural environment. This is most common in institutional settings, such as hospitals, schools, or treatment centers, where the clinician or others who can be trained as observers (i.e. parents, teachers, aids, nurses) are present and can count or objectively observe and analyze the data.
* **Behavioral Extinction**
  + A therapy technique where the client's rewards are removed to stop an undesirable behavior.
* **Aversion Therapy**
  + A technique where the client is exposed to a stimulus while also being exposed to some type of discomfort. The objective is to pair the stimulus with the unpleasant sensations resulting in the stopping of the undesirable behavior.
* **Assertiveness and Social Skills Training**
  + This involves the teaching of specific skills and tools to enable the client to act and interact with greater success. The mechanism for this is often modeling, role-playing, and behavioral rehearsal.
* **Behavioral Scheduling**
  + This is useful in the treatment of depression. Activity Scheduling is done with a chart using short word descriptions (one to three words), according to a hierarchy of easiest to hardest, including both necessary and enjoyable tasks. The client is to follow the planned activities and document any activities that were not pre-planned each week, rating the activities according to level of pleasure, until the client has resumed his/or her normal schedule.
* **Chaining**
  + Involves the series of smaller behaviors that are linked to the desired complex behavior. Each step is prompted and reinforced, strengthening all the parts of the chain that move toward the desired behavior.
* **Diversion**
  + When anxious, a classic technique is to help divert one's attention from anxiety, both in the short -term and in the long-term. Longer term examples are things like physical activity and hobbies, and shorter-term examples are focusing on the immediate worlds around you (counting the bricks in the wall, looking for individuals wearing green or with red hair, inventing stories about the people around you), or working a puzzle.
* **Exposure Therapy**
  + This is a technique targeted for anxiety disorders involving exposure of the client to the feared object or the feared situation without any danger and for overcoming their anxiety response.
* **Graded Task Assignment**
  + This Technique breaks larger tasks down into smaller, 'baby steps' and may be easily combined with Activity Scheduling. This is particularly useful for clients who have complex or complicated tasks with deadlines that are important for the client to achieve (i.e. for work, disability rating).
* **Guided Imagery**
  + This is a symbolic recreation of the problematic situation, rather than simply talking about the issue. While imagining the situation is occurring, the client verbalizes thoughts that arise.
* **Hypothesis Testing**
  + The therapist and client identify an issue and set up an experiment to test the situation, as exceptions to the hypothesis, to nullify the hypothesis. For example, if an individual believes they are unlovable and will always be rejected, the individual is encouraged to go out and speak with people, after being given specific skills and tools for coping with stressful situations.
* **Modeling**
  + The demonstration of a behavior- either live, in books, television or recorded source for an individual to emulate or imitate.
* **Physiological Recording**
  + An instrument monitors psychophysiological reaction to objectively measure any number of problems.
* **Problem Identification and Assessment**
  + The initial task is to have a clear understanding of the presenting problem, including initial occurrence, frequency, and severity. The therapist also needs information on what has been attempted to address the issue thus far, as well as any client thoughts about the problem.
* **Response Cost**
  + Involves giving a negative consequence for a behavior that in not wanted.
* **Role Playing/Rehearsal**
  + This is an artificial engagement of a situation to allow for observation of the problem behavior as well as better assessment of the interpersonal issue. It may also be used to prepare for a situation, as in rehearsal.
* **Self-Control Procedures (Biofeedback, Progressive Relaxation, Specific Goals)**
  + This is a useful technique for addressing issues like impulsivity, excessive anger, insomnia, tension headaches, pain and stress, and encouraging the individual to maintain a new behavior through self-reinforcement.
* **Self-Monitoring**
  + A client may be asked to keep detailed accounts of a specific event or reaction, such as noting all caloric intake or amount of time spent studying.
* **Shaping**
  + This is a basic operant in which behaviors that approximate or move toward the desired behavior are reinforced.
* **Systematic Desensitization**
  + This technique is sometimes referred to as exposure therapy and is commonly used to address phobias and anxiety-related issues. Systematic Desensitization establishes a hierarchy of increasingly anxiety producing stimuli, teaches relaxation or other coping skills, and the individual begins with the least difficult situations and works toward the most anxiety-producing over time, with the goal of neutralizing the reaction to the stimulus.
* **Thought Stopping**
  + This technique forces the self to stop thinking in an unproductive way, such as wearing a rubber band on one's wrist and popping the band as a method to assist in redirection of thoughts, a means of telling one's self to "stop!" and ultimately to retrain the way one thinks and is able to redirect thinking patterns.
* **Token Economy**
  + Three elements are present, including
    - 1) tokens (a symbol) for a valued item
    - 2) the back-up reinforcer (i.e. material item such as candy, services such as going to a sporting event, or privileges such as to get video game time)
    - 3) a target or desired behavior being shaped or reinforced.
  + Additional elements to the token economy may include social reinforcement, shaping, immediacy of reinforcement (token now for reward later), planning (i.e. saving tokens for a larger reward), and group contingencies (a reward for the entire ward or class if the entire group achieves at a particular level)

**CBT**

* **Behavioral Rehearsal & Role Playing**
  + The client imagines a target situation, and the therapist guides the client through a step-by-step process of successfully coping with the situation. The client then practices the steps in a �mental rehearsal' in a variety of ways.
* **Behavioral Experiments**
  + The client experiments with experiencing, reflecting, observing, planning, testing thoughts, and discovery to target specific thoughts or behaviors under consideration for change or challenge.
* **Cognitive Restructuring**
  + This involves identifying, challenging, and changing faulty beliefs and distortions in thinking through examining logic, testing the truth of the thought or belief, and finding alternative explanations. This commonly involves "looking for the evidence" of whether the thought or belief is true or false, with a logical analysis of "evidence for" and "evidence against."
* **De-catastrophizing (aka “What If”)**
  + When using this technique, the therapist would have the client state his/or her feared consequence of a situation and then identify strategies for coping.
* **Decentering**
  + This is helpful with anxious clients who believe they are the focus of others. The technique is to set up experiments to challenge the client's belief and assist them to see that others are not focused upon the client, but rather daydream, attend to children, drive, bite their nails, or whatever the situation discloses.
* **Homework**
  + To enable cognitive restructuring, clients are given homework to reinforce learning through monitoring automatic thoughts and/or behavioral activation, reviewing the previous therapy session or preparing for the next session.
* **Modeling**
  + This technique involves demonstrating something for the client and having the client replicate the desired behavior. Subsequent role-play may be appropriate, depending on the desired behavior.
* **Problem-Solving**
  + With this technique, the counselor teaches the client problem-solving skills, and an identified problem (described in clear, concrete, goal-oriented terms) is explored by generating solutions to the situation, evaluating each potential alternative for short and long-term consequences, and finally selecting a course of action and following up on that course of action after implementation.
* **Psychoeducation**
  + This provides the client with information, education or skills training on specific areas to facilitate change, such as parenting, obesity, smoking, or medication management.
* **Reattribution**
  + This technique takes a situation and examines the automatic thought by considering alternatives for the events under consideration. For example, the client may see themselves as the cause of an event (i.e. why he did not call, why the marriage failed) when in fact, this is an unreasonable assumption because a single person is rarely the only reason for an event occurring.
* **Redefining**
  + This involves assisting the client in making the problem more specific, concrete, and individual to the client's behavior. An example is restating "nobody notices me" to "I need to reach out to others."
* **Self-Monitoring**
  + This is sometimes called "diary work" and is used to document the degree and amount of targeted thoughts and behaviors occurring between sessions or during a given event or timeframe.
* **Socratic Dialogue**
  + This technique involves the use of questions to point out the client's maladaptive thoughts and stuck points. Primary categories of questions are: clarification (i.e. "Can you give me an example of what you mean?"), probing assumptions, probing reasons, or evidence (i.e. "What evidence supports your position?"), questioning viewpoints or perspectives (i.e. "What are the pros and cons of this path?"), analyzing outcomes (i.e. "What are the implications of making this change?"), and questions about questions (i.e. "what would getting an answer, regardless of the outcome, mean to you?").
* **Stress-Inoculation Training**
  + This technique combines relaxation skills with self-talk, role playing, rehearsal, and/or systematic desensitization to help individuals master highly stressful events or circumstances. The primary categories are 1) preparation for the stressor, 2) confrontation and direct management of the stressor, 3) coping with the stressor, and 4) reinforcement.
* **Systematic Desensitization** 
  + This involves the pairing of relaxation with exposure to something the client reports as stressful. The client is taught to relax in response to the anxiety-producing situation, altering the previously paired response.

**REBT**

* **Blow Up Technique**
  + Have the client imagine the worst-case scenario of what he/or she fears occurring, then blow the event out of proportion until the client cannot help but find amusement in it.
* **Bibliotherapy**
  + The therapist assigns any number of self-help books to enhance the specific issue being addressed to immerse the client in information and to aid the client in re-education.
* **Devil’s Advocate**
  + The therapist adopts the client's belief and adamantly argues for the position while the client works to convince the therapist why the belief is dysfunctional. It is most useful when the client can see that his/or her position is irrational but is struggling with understanding.
* **Double Standard Dispute**
  + When the client is self-downing or holding a 'should' statement about his/or her own behavior, ask whether the client would hold another person (e.g. best friend, sister) to the same standard or label for doing the same thing, or recommend that the client hold the demanding belief for that person.
* **Exposure**
  + Assist with coping skills (e.g. breathing exercises, progressive relaxation, positive self-talk), then have the client enter the feared situation that he/or she avoids in a planned, deliberate way using applicable coping skills. Exposure assists the client in learning that the fear may be survived, builds confidence in coping, and increases tolerance for discomfort.
* **Homework**
  + The client must use what he/or she learns in sessions to find success. Sessions are viewed as training sessions. Homework is designed to try out new skills and to do self-analysis on beliefs and affective responses in context of the client's life. Worksheets are given to assist the client in analyzing activating events, consequences, beliefs, new preferred way to feel or behave, and disputing rational beliefs and further actions needed to fall into the same irrational beliefs.
* **Paradoxical Behavior/Stepping Out of Character**
  + The therapist will assist the client in changing a dysfunctional tendency by behaving in a contradictory manner. For example, a perfectionist is asked to do something less than their usual standard three times between sessions.
* **Postponing Gratification**
  + To combat low frustration tolerance, ask a client to deliberately delay gratification (eating sweets, smoking, responding to his/or her spouse when angry) for a period of time.
* **Reframing**
  + This technique has more than one application. The bad event can be re-evaluated from an 'awful', 'impossible', or 'intolerable' irrational belief to a 'disappointing', 'difficult', or 'uncomfortable' (i.e. in perspective) one. Another option is to assist the client in identifying the positives that result from the negative event by listing them. It is important that the client does not conceive the therapist is implying that the bad event is a good event.
* **Risk-Taking**
  + This technique assists the client in challenging beliefs. Have the client engage in a task where there is a reasonable chance of not meeting his/or her expectations or of failing. For example, a person that fears rejection is asked to speak with a person to whom they are attracted, or a perfectionist starts a task at which they are not proficient.
* **Shame Attacking**
  + Expose the client to the fear of shame by acting in a way that anticipates disapproval while engaging cognitive, behavioral, and emotional coping skills. For example, have the client put on a jacket and misalign the buttons or switch his/or her shoes to the wrong feet then walk around the building for a few minutes while disputing the shame-induced thinking.
* **Skills Training**
  + Using this technique, the therapist provides education, in vivo demonstration and practice of social skills, relaxation training (e.g. progressive relaxation, guided imagery), breathing exercises, etc.
* **Tape Recording Sessions**
  + The therapist will have the client record the therapy session (tape record or on a smart phone) and listen to the session at least one time before the following session to reinforce learning, gain insight, or analyze his/or her own level of awareness and change.
* **Time Projection**
  + Ask the client to visualize the feared or difficult event occurring. Then ask the client to imagine himself/or herself one week after the event, then one month, then six months, then one year, and so forth. At each time point, ask how the client envision himself/or herself feeling and being at each point.

**Person-Centered**

* **Active Listening**
  + When the client makes a statement, rephrase it back. This can be done verbatim, to ask for additional information, or clarify the emotional state. For example: Joan says, "I had an argument with my mom and we haven't spoken in two weeks." The therapist replies, "You had an argument and you guys are not talking." Joan says, "Yes, we fought because I want her to come to my house for Thanksgiving, but she says it is just much better at her house because it's always been there. I was angry when it happened, but now I feel almost sad because things are changing for her since dad died." The therapist says, "You were arguing about how to spend the time together as a family, but now with some thought about what the holiday has always meant to your mom, you feel sad."
* **Congruence**
  + The therapist acts as a role model for the client and models the human struggle toward greater realness and a space in which the "real" self and "ideal" self are the same.
* **Empathy**
  + The therapist engages the client by understanding and sharing the feelings of the client, expressed through body language, eye contact, and general sensitivity.
* **Reflect the Feeling/Paraphrasing Nonverbals**
  + With this technique, the therapist moves from the content of what the client is saying and focuses on the underlying feeling in the client's message without judgment. For example, Brian says, "My roommate is always late with his part of the rent, never cleans up after himself, and thinks he can just eat my food without replacing anything. What a pig!" The therapist responds, "You sound exasperated because he does not respect your boundaries or take his responsibilities seriously."
* **Unconditional Positive Regard**
  + The therapist accepts the client without judgment. The therapeutic relationship is primary. To accomplish this task, the therapist must listen without interrupting, listen actively, and avoid giving advice.

**Gestalt**

* **Body Awareness**
  + This involves raising awareness of where in the body feelings are associated through breathing techniques or reflecting inconsistencies between verbal reports and body language. For example, the therapist may notice the client tense his shoulders each time he talks about his spouse, so the therapist assists the client in a breathing technique and enhances the client's awareness of his body functions to gain greater awareness and control.
* **Dream Work**
  + This technique does not involve the therapist interpreting or analyzing the dream, rather it assists the client in bringing the dream to life as if it were happening now with the client as part of the dream. The client details the dream with each entity, event, and mood, and then becomes each part (or parts are selected), and the client acts each one out as fully as he or she can, engaging dialogue with the parts. The dream is assumed to be a projection, with individual parts as the individual’s own contradictory and inconsistent elements and engaging each allows for unfinished business to be addressed and resolved.
* **Empty Chair**
  + The client addresses an empty chair as if another person (typically someone significant to them) or aspect of themselves (i.e. feeling, personality element) were present. A role-playing format ensues, allowing exploration of the self. The client may assume more than one role and may move back and forth between chairs, depending on the issue, situation, and context.
* **Exaggerating a Behavior**
  + When using this technique, the counselor will have the client exaggerate specific movements to aid in understanding feelings. For example, if the client is talking about his teenage son, have him move like he does, which will intensify the client's awareness and feelings about the son.
* **Fantasy Approaches**
  + The therapist will walk the client through a guided imagery of a triggering event and encourage the client to share what is felt in the moment, increasing awareness of feelings through the triggering event.
* **Game of Dialogue**
  + This is a technique in which the therapist joins with the client in a discussion, not by controlling the discussion, but by participating in the same manner as the client, consistent with Phenomenological Philosophy. The goal is to be fully present, commit to the dialogue, and to live the dialogue, such as in psychodrama, making the experience "come alive" with emotion, thoughts, beliefs, and anything the client might bring internally to the encounter if it were real.
* **Internal Dialogue Exercise**
  + The client role-plays the conflict he/or she experiences, being both the controlled and the controlling element at the same time.
* **Making the Round**
  + This exercise assists the client in learning confrontation skills, taking risks, and self-disclosure. The client either engages with a group of people or it may be done in a formal therapy group, and the client is to speak with each member or do something with each member, such as ask about weekend plans, give a compliment, or ask for the time.
* **Playing the Projection**
  + The therapist will ask the client to play the role of the individual with whom they are not connecting. This can be done with a dialogue, Empty Chair, drama, or any creative medium to assist in dropping defenses and allowing the client to connect with the here-and-now experience.
* **Rehearsal Exercise**
  + The client will rehearse out loud with the therapist a specific task or dialogue. The client provides direction, and the work in the moment allows for mastery and building of confidence, eliminating the past feelings brought to present, thus allowing the future to unfold as the client desires.
* **Reversal Technique**
  + When using this technique, the therapist will ask the client to do the opposite of his/or her behavior, acting out a scenario in the opposite to gain insight and understanding in the here-and-now.

**Psychoanalytic Therapy**

* **Analysis of Resistance and Defenses**
  + Interpreting how the patient avoids or manages pain is key to Psychoanalytic Therapy. Pointing out any behaviors the patient uses to resist exploring specific issues or therapy in general (i.e. silence, lateness, deflecting) assist the patient in gaining insight about these issues.
* **Active Imagination**
  + One identifies an entity (i.e. shadow figure, anima, maternal figure, male), through a dream or other scene, and activates attention to the figure through meditation. The client is invited to enter the scene and dialogue with the entity, usually one that has qualities opposite the ego, thereby accessing rejected elements and availing them to the conscious mind. This may be done in writing, art, sculpting, dance, or other medium.
* **Dream Analysis/Interpretation**
  + This theory considers analysis of dreams to be the pathway to the unconscious. Examining dreams assists in discovering psychic content - latent ideas full of repressed drives and emotions within the unconscious mind.
* **Free Association**
  + This method is engaged by encouraging the client to talk about whatever comes to mind as the therapist reads a list of words (i.e. father, school). Through this process, repressed memory fragments are to emerge unless the client has resistance. However, resistance may be evidence there is important information requiring further probing.
* **Transference**
  + This naturally occurs when the client responds to the therapist as though he/or she were someone significant from the client's past (i.e. a parent). Working through the memories, attitudes, motives, perceptions feelings, fantasies, or other issues in the here-and-now gives the client a new experience.

**Jungian Therapy**

* **Analysis of Transference**
  + With this theory, four stages are addressed, including: 1) the client's personal history projections onto the therapist, 2) the client differentiates his/or her own unconscious from the collective, 3) the therapist's reality is differentiated from the superimposed images, 4) the achievement of greater knowledge and insight within the self, having worked through the transference and into an authentic relationship with the therapist.
* **Dream Analysis**
  + This theory believes that images reflect something within the person, and that the dream world could allow the individual access to the unconscious within the self, specific to the dreamer.
* **Individuation**
  + This process involves the development of the individual's personality via making conscious the individual's unconscious and the collective unconscious tendencies. It is both a goal and something to develop throughout the lifespan.
* **Journaling**
  + This technique allows the client to keep track of thoughts, feelings and behaviors so they can see their progress during therapy.
* **Sand Play**
  + This technique involves the use of a tray of sand for free expression, often used with a figures, symbols, avatars, or other miniature objects. This engages both children and adults in free expression and has been used successfully in a variety of trauma work.
* **Rituals**
  + This technique involves a series of actions involving the entire family in a sequence of steps, forming a play that is to be enacted under specific circumstances. An example of a ritual is a family sitting together daily, each getting equal time to speak well of the family, with no negative opinions allowed.
* **Shadow Work**
  + This technique addresses the qualities that do not fit our image of ourselves - anger, hatred, jealousy, greed, lust, and shame. It also addresses behaviors that are not culturally acceptable such as aggression, addiction and dependency. The goal is to integrate parts of ourselves that we try to hide from.

**Adlerian Therapy**

* **Analysis and Assessment**
  + This technique is about exploration of the family constellation (sociogram of the individuals at home during the client's formative years) and early recollections and is not about interpretations to the client.
* **Acting as If**
  + This is a form of encouraging and motivating clients to be the way they desire to be, "acting as if" the transition has already occurred.
* **Confrontation**
  + This is used by therapists to encourage client responsibility, looking at issues of taking responsibility for how others respond ("Why does my child yell at me?" "Because you allow him to. It is easier to give into a tantruming 8-year-old than to bet the parent."), presenting existing alternatives ("You don't have to work 3 jobs to bankroll your capable 28 - year - old. You can set limits and refuse to be taken advantage of. What do you want to do about it?"), taking responsibility for change ("Shall we continue to talk about this or do you want to take action?"), and considering time ("Knowing what you know now, how long to you plan to wait to take action? Five years?")
* **Encouragement**
  + Having the client be an active participant in treatment helps the individual begin to see themselves as capable.
* **Exploration of Social Dynamics**
  + At the core, the therapist believes the client's issues are primarily social in nature.
* **Exploration of Family Constellation**
  + In this theory, birth order, sibling interaction, parent interactions and the client's sense of their psychological position in the family are important to enhance insight about how the client has selected life-style. Family constellation is not limited to the immediate family, but rather to those present at home during the formative time of the client.
* **Push-Button Technique**
  + This is designed to help the client see they are responsible for how they feel, both good and bad feelings. The client is asked to visualize a happy event, re - experience the associated feelings, then an unhappy event and the associated feelings, and finally to return to the happy event, re - experiencing the happier feelings.
* **Reporting of Earliest Collections**
  + The therapist asks the client to describe their earliest recollections, which often provide insight into the patterns or interpretations the client has made in developing their life style.
* **Task Setting**
  + The client is given various tasks in their lives to assume responsibility for their own lives. Adler advised a client that he could be free of depression in 2 weeks if he followed the specific task plan of thinking daily of how to please another, with all of Adler's efforts aimed toward increasing the client's social interests.

**Reality Therapy**

* **Confrontation**
  + Because setting specific plans are a key element in this theory, when a client does not follow through on something, confrontation is not avoidable. The therapist cannot accept excuses but works to be positive and may attempt to engage humor to address the issue. A question the therapist might ask is, "What impact will not taking steps have on you?"
* **Humor**
  + Humor is spontaneous, idiosyncratic, and only occurs in the here-and-now, so it is a natural fit for Reality Therapy. Therapists can engage friendly involvement with the client by laughing at themselves, modeling clients to do the same.
* **Metaphors**
  + When a client speaks in metaphors, the therapist may choose to respond to the metaphor rather than the apparent content.
* **Paradox**
  + Cautioning the client to not follow through or encouraging the opposite behavior may be indicated to lower resistance. If a client does not elect to follow through on a goal or intervention, the therapist might say, "It seems we may have rushed that plan. You are not ready for that, but it is still a forward step because we know other issues need to be addressed first."
* **Plans of Action**
  + This technique involves assisting the client in making a specific, attainable, beneficial, time-limited plan of action. The client must be clear on what he/or she wants and what he/or she is taking responsibility for before success can be attained.

**Solution-Focused Therapy**

* **Coping Questions**
  + This is a question designed to underscore resources the client has not noticed. For example, the client may be overwhelmed by daily life and reporting significant depressive or anxious symptomology. In response, the therapist reflects, "I hear you say things are overwhelming, yet I am struck by how you get up each day and do all that is required to get the kids off to school and get to work. How do you do that?" with genuine curiosity, providing truth, validating the client's story (difficult feelings), and providing hope (drawing out coping skills).
* **Compliments**
  + An essential part of this therapeutic style is seeking to validate clients for what they are already doing well and to reinforce what the client is doing that is working. Compliments may come in the form of a question such as asking how the client did something, thereby inviting the client to provide the compliment by answering the question.
* **Exception Questions**
  + The therapist asks for a time when the problems were not problematic, discovering a time before the problem, a time the situation had less power, or perhaps a time of remission. This allows for discovery of strengths, skills, or tools the client may have deployed already to manage the situation or assists the client in seeing the problem is not all-powerful and has not existed for all time.
* **Invite the Client to do More of What is Working**
  + The therapist builds upon the client's strengths and invites the client to engage in more of what has previously worked or encourages the client to try something the client has raised as a consideration, sometimes referred to as "as experiment."
* **Looking for Exceptions**
  + In evaluating the problem, there may not be previous solutions that have worked, but there may be an event or moment in which the issue was less of an issue. This technique seeks to find strengths and alternative experiences to build upon.
* **Looking for Previous Solutions**
  + Clients often have solved similar issues or have ideas about the current issue. Questions such as, "Has this ever been less of a problem?" or "What have you done that helped?" elicit strengths and ideas on which to build.
* **Miracle Questions**
  + This is a means of questioning the client to assist in envisioning a future in which the problem is no longer present. Depending on the client and clinician, the question may be asked in a variety of formats, but in general the following elements are present: "If a miracle occurred tonight while you slept that solved this problem, only no one including yourself knew it was solved, what would be different, and how would you come to know the miracle occurred?"
* **Present and Future- Focus Questions vs. Past Orientation Focus**
  + Brief therapy maintains a future focus, always leading the client to the present moment and the future, remaining in the solution, and moving toward success, such as asking, "What will you do this week that will demonstrate you are making progress?"
* **Scaling Questions**
  + The client is asked to assign a number, typically on a scale of 0 to 10, to help measure abstract concepts like self-esteem, self-confidence, or willingness to change, as well as to help set goals, measure progress, and identify resources (i.e. "Raise mood to a 7 on the weekends", "Decrease anxiety by 3 points", "What would help raise the scale one point?")

**Brief Therapy**

* **Compliments**
  + An essential part of this therapeutic style is seeking to validate clients for what they are already doing well and to reinforce what the client is doing that is working. Compliments may come in the form of a question such as asking how the client did something, thereby inviting the client to provide the compliment by answering the question.
* **Coping Questions**
  + These are questions that serve as powerful reminders of how the client engages useful skills and tools, even when overwhelmed. Example: "How have you managed through this time?" This is an alternative means of accessing the client's resiliency and level of determination.
* **Invite the Client to do More of What is Working**
  + The therapist builds upon the client's strengths and invites the client to engage in more of what has previously worked or encourages the client to try something the client has raised as a consideration, sometimes referred to as "as experiment."
* **Looking for Exceptions**
  + In evaluating the problem, there may not be previous solutions that have worked, but there may be an event or moment in which the issue was less of an issue. This technique seeks to find strengths and alternative experiences to build upon.
* **Looking for Previous Solutions**
  + Clients often have solved similar issues or have ideas about the current issue. Questions such as, "Has this ever been less of a problem?" or "What have you done that helped?" elicit strengths and ideas on which to build.
* **Miracle Question**
  + This is a specific question designed to generate the initial steps of solutions - ones that can be acted upon in short order, perhaps the next day. The question proposes that a miracle occurs while the client sleeps, no one knows the miracle has occurred, the miracle is that the client's problem is solved, and the client is to consider the initial signs they would know the miracle occurred.
* **Present and Future- Focus Questions vs. Past Orientation Focus**
  + Brief therapy maintains a future focus, always leading the client to the present moment and the future, remaining in the solution, and moving toward success, such as asking, "What will you do this week that will demonstrate you are making progress?"
* **Scaling Questions**
  + A scaling question assists the client in assessing his/or her situation and tracks progress, asking how a client rates an item based on a scale (i.e. 1 to 10). It can also assist with clients who struggle with verbal skills. Any number of items can be measured, such as motivation, hopefulness, confidence, progress, anxiety, and depression.

**Narrative Therapy**

* **Deconstructing the Problem**
  + Using this technique, the therapist will assist the client in making the problem specific and manageable. For example, if the client reports, "My wife hen-pecks me, and I'm angry!" then there is no clear solution and the client's emotional needs are not certain. The therapist helps the client be more specific: "When my wife gives me a list of things that have to be done when I walk through the door, I feel unimportant as a husband, like I am only a handyman who hasn't just worked 10 hours to make our family bills meet," and the therapist could offer, "So you want your spouse to empathize with the stress you're bring home from working all day, recognizing you as a person, to give you a break?"
* **Deconstruction**
  + This technique helps others understand what the problem means to the client. For example, the therapist might say, "Tell us what you see when the problem is present and what we will see when it goes away."
* **Externalization Technique**
  + The client is asked to add a preposition to the behavior or characteristic he/or she desires to change. For example, instead of "I am anxious," the client is encouraged to say, "I am currently living with anxiety," which is followed by the therapist asking, "when did you discover anxiety first entering your life?"
* **Letters, Definitional Ceremonies, and Reflection**
  + Encouragement is needed by people in the larger community system to validate the new positive story line. Family members, the therapist, a support group, and trusted others can listen and speak openly (or write) to the client(s) about their perspective of how they view the new narrative coming and being alive in the client's life.
* **Narration of a New Story**
  + Once the problem is deconstructed and unique outcomes are realized, it is important that new solutions are identified and integrated as the individual or family moves forward. The client or client system needs a new positive story line in place that replaces the initial one presented when the client or client system entered treatment.
* **Unique Outcomes- Altering the Dominant Negative Story**
  + The therapist assists the client to focus on a life story that is divergent from the problem-saturated story narrative. For example, the client's dominant story is about marital issues, and the therapist says, "Tell me about a time when today's issues did not impact your marriage, like how did you fall in love?"

**Feminist Theory**

* **Bibliotherapy**
  + When using this technique, the counselor encourages reading on gender issues, gender role stereotypes, gender inequality, how sexism is promoted, topical issues (i.e. obsession with thinness, obsession with specific types of beauty markers), power differentials between the sexes, assertiveness, coping skills, and more. Reading empowers the client and allows the client to make informed choices.
* **Assertiveness Training**
  + This technique provides specific training and insight to raise women's awareness of their interpersonal rights, assist in transcending stereotyped sex roles, and alter negative belief systems to change daily patterns, actions, and interactions.
* **Gender Role Analysis and Intervention**
  + When using this technique, the counselor will explore with the client to assist the client in understanding the impact of gender role expectations in his/or her life and how social issues impact his/or her personal issues.
* **Power Analysis and Power Intervention**
  + This technique involves assisting the client in the discovery of the power differences between the sexes in society, understanding the power the client possesses, and understanding how all individuals exercise power.
* **Reframing**
  + The therapist will assist the client in altering the client's frame of reference for his/or her own behavior, shifting from intrapersonal to interpersonal focus to define his/or her issues.
* **Relabeling**
  + The client is to alter the evaluation or label given to a behavioral characteristic from a negative to a positive. For example: Jane begins to speak about herself as a strong, healthy woman with a great smile rather than inadequate in another way because she is not society's definition of "thin."
* **Self-Disclosure**
  + Disclosing to the client assists in equalizing the therapeutic relationship and provides modeling.

**Transactional Analysis Therapy**

* **Contract**
  + This is an essential element with all clients, individual and group, establishing the structure of the relationship, from the Child Ego state perspective of how the client will be different as a result of work done. The contract is concrete, specific, and measurable.
* **Empty Chair**
  + The Empty Chair is used to represent the various ego states, with the client playing out the various states (Parent, Adult, and Child).
* **Role Playing**
  + This technique is viewed as a "time out" from reality in which the client draws closer to the self, engaging in an intimacy and spontaneity of the "here-and-now" vs. the intellect of discussing what has occurred or consideration of what may happen. The focus is to engage the intellectual, physical, spiritual, and emotional self in an active way in session using psychodrama, allowing the individual to learn from the moment.
* **Script Analysis**
  + This is a checklist designed to explore early injunctions, decisions, games, and life positions. Script analysis is the process of uncovering the unconscious early decisions about how life shall be lived.
* **Structural Analysis**
  + This involves conducting first and second order analysis on the ego states expressed by the client (Parent, Adult, and Child), as well as the transactions between them as they act and interact with others in the client's life.

**Humanistic Therapy**

* **Check Feelings, Thoughts, and Bodily Sensations Behind the Story**
  + Ask the client to describe what he/or she is feeling as he/or she describes something, or conversely what the client is thinking as he/or she is feeling something. Having the client check for a sensation in his/or her body may be helpful to remain in the present, fully aware. For example, the client may say, he/or she is feeling tension in the shoulders as he/or she describes marital issues at this point, the therapist may say "allow yourself to breathe into the feeling in your shoulders and open up whatever associations come up and share what emerges."
* **Emphasis on Intention and/or Resistance**
  + With most client actions, you can focus attention on the intention or resistance toward wholeness, or both depending on the situation and current status of the therapeutic relationship. For example, if the client focuses on his anxiety, the therapist can focus on how that keeps him from engaging in more productive pursuits and in living a more inhibited life. On the contrary, the therapist could focus upon the client's tenaciously focusing on his health concern and explore what would happen if he used that same intensity and strength in more productive ways. The therapist could ask about how he would be and what his life would look like, if he experiences his own tenacity and strength and if he can describe his tenacity and strength.
* **Emphasis on Mutuality**
  + The therapist maintains a client-centered approach and forges a connection along a human journey together, empowering the client through mutuality. This is opposed to a hierarchical relationship in which the client is evaluated, has treatment prescribed, and is considered successful when the treatment is followed.
* **Emphasis on Transparency and Authenticity**
  + The therapist is real and exists as a person in session, is open, honest, direct, and clear, within the context of the therapeutic relationship and in line with the client's goals. For example, the therapist may share appreciation for the client's strength and courage to stay with difficult feelings or share the experience of feeling detached from the client, as though not making a strong contact or connecting on the issue at hand.
* **Engaged Curiosity**
  + The therapist engages genuine curiosity to draw the client out, encouraging the client to describe experiences of various life facets, such as employment, relationships, or hobbies. The therapist may wonder about what the client likes/does not like, how the client keeps moving forward, or what is held back in communications with a relationship.
* **Everything is Everything**
  + Assume coincidence does not exist, and what occurs in session is not an isolated, one-time event, but instead the client's way of being. For example, if the client confuses appointment times, the therapist can assume this is a behavior that occurs in other relationships and explore this at an appropriate time the therapist and client can explore thoughts and feelings about this way of being, the meaning made from it, or if change is desired, start a deeper discussion on how the client conducts life in general.

**Existential Therapy**

* **Relationship**
  + The role of the psychotherapist is primary in the therapy. Authentic integration of the interpersonal tensions is addressed through the primacy of experience, specifically by the therapist not manipulating the client by offering how to adjust, overcome culture, or otherwise adapt, which would deprive the client of genuine growth. Rather, the role is to guide through demonstration, to be a humble model of what is possible, and provide a sense of assurance that the quest the client seeks is worthwhile.
* **Using All Techniques**
  + These therapists "Borrow from Whatever". This technique is required to facilitate empowerment of the individual within the context of the individual's cultural reality. If there is a sense of disempowerment, techniques from Feminist Theory may be used (e.g. Power Analysis, Reframing), and if there is a strong extended family presence, elements of Bowen, Family System's Theory, or General System's Theory may be used (e.g. Genogram, Ecogram, "I" Position).

**Systemic Family Therapy**

* **Circular Questions**
  + This is a technique for interviewing and hypothesis validation in which each family member comments on the behavior and interactions of other family members.
* **Invariant Prescriptions**
  + This is an unchanging prescription given to all families that have symptomatic children, asking that parents spend time with each other, not with the children. The purpose is to create clearer generational boundaries and to break the pattern of destructive games.
* **Odd/Even Day Rituals**
  + This encourages irreverence or a more flexible view of the family as the family is given a directive that on odd days one set of rules or rituals holds true, and on even days another. For example, on odd days, the family is to act as if they need treatment, on even days as if they do not, or on odd days mom does the parenting and on even days dad does the parenting.
* **Rituals**
  + This technique involves a series of actions involving the entire family in a sequence of steps, forming a play that is to be enacted under specific circumstances. An example of a ritual is a family sitting together daily, each getting equal time to speak well of the family, with no negative opinions allowed.

**Family Systems Therapy**

* **De-triangulating**
  + The triangle is the smallest, stable relationship systems, but paradoxically is the most difficult for an individual to tolerate because there is always one person who is "on the outside." Bowen talked about "putting the other with the other," meaning linking individuals directly with one another rather than having the 3rd present to absorb the tension. It is imperative the therapist do the same with the therapist's presence, specifically not taking sides.
* **Genogram**
  + This involves drawing a complete genogram (sometimes called the Family Map), which looks like a family tree, but is comprised of additional information, such as emotional dynamics (marriages, divorces, significant events, over involved relationships, distance, conflict, and cutoffs). It is a snapshot representation of the family for the client, enabling hypotheses and insights, and the purpose and principles of the model are not withheld from the client.
* **I-Positions**
  + The therapist continuously uses "I" messages to differentiate himself or herself from the individual, couple, or family. The purpose is to demonstrate the responsible vs. irresponsible use of "I," the first of which differentiates by defining one's own beliefs and values, and the second of which makes demands (i.e. "I deserve" or "My right").

**General Systems Theory**

* **Advocacy**
  + The therapist will engage necessary supports or assist the client when stuck points cannot be overcome and present as a hindrance to the central work, including advocacy regarding unfair or outdated policies.
* **Ecomap**
  + The therapist will draw an Ecomap with the client to discover the social environment (conditions, circumstances, and interactions) surrounding the client, which will enable the therapist to see the interactions with multiple systems (friends, politics, religious, educational, vocational) that the client engages inputs and outputs. Draw the family household membership in the center circle. Then, engage the connecting systems with appropriate lines, which will indicate strength and direction of the relationship (i.e. strong, tenuous, conflicted, one way).
* **Reframing**
  + The issue or problem is removed from the identified client and assigned as a family issue and becomes the focal point of the intervention.
* **Tapping into all Systems**
  + This technique considers informal or naturally occurring systems (i.e. family, friends), formal systems (i.e. governmental agencies), and societal systems (i.e. schools, churches). Do they currently (or did they historically) exist within the system? Is the client engaging them appropriately? The therapist is temporary, but the client system is permanent.

**Emotionally Focused Therapy (EFT)**

* **Expand the Emotional Response**
  + When the client makes an emotional statement (i.e. "I feel out of control!"), the therapist will respond by asking the client to stay with the feeling, asking what it is like for them to be out of control, what it is like as they speak of it in the moment, how they feel as they speak, how they frame the experience, how they protect the self (if they did not, then what would occur), and finally validate the client's responses of his/or her experience (i.e. "It must be hard to feel scared") and then direct the partner/family members to engage as indicated (i.e. "And you feel she cannot protect you, tell her what that is like" "You cannot feel safe when he hits walls"), with the ultimate goal of pulling emotional expression that engages compassion and connection, and meeting unmet attachment needs.
* **Reframing the Problem**
  + The problem is reframed into a cycle, so the players are no longer victims of the situation, but rather they are on the same side looking into the cycle.
* **Restructuring the Bond**
  + When using this technique, the client and therapist will identify attachment needs and facilitate a change in interactions based on the identified needs to stop old patterns and engage in healthy ways.

**Strategic Therapy**

* **Paradoxical Intervention**
  + The therapist works to get the family to alter behavior by encouraging the problematic behavior, creating awareness of control over the behavior or defiance to it, leading to improvement.
* **Reframing**
  + This technique provides a positive rationale for treatment, whether the therapist believes it, so that it is logical to the individual or family to induce compliance for treatment. An example: Older brother Ben is not bossy, he is protective of his little sister Sally.
* **Restraining Technique/” One Down” Position**
  + When the client begins to explain that he/or she cannot engage a new skill or behavior due to anxiety or other excuse, encourage the client to not do too much too soon, that clearly, he/or she has only enough strength to show up for therapy.
* **Symptom Prescription**
  + The therapist prescribes the symptom, and what the individual or family may describe as "uncontrollable" is now encouraged by prescribing the problematic behavior as the only one allowed, encouraging the behavior by seeing how much it can be expanded (i.e. how many more tantrums the child can do and how the parents can provide a separate space for the child to do tantrums in a place where they will be safe), or giving the behavior a time and space (i.e. worry from three to four times daily). Power and control structures are discovered within families when this technique is applied.

**Contextual Theory**

* **Genogram**
  + Draw a genogram to determine the viewpoint of each family member - both those who are present and those who are not present - to discover legacies, loyalties, entitlement, and indebtedness issues.
* **Multi-Directed Partiality**
  + This technique involves sequentially turning toward each member, including those who are absent for whatever reason, and providing acknowledgment and examining the expectations of each person.

**Play Therapy**

* **Art**
  + Art is tied directly to the unconscious and brings out tangible symbols of emotions to the surface and allows the client to become more self-aware in a non-threatening medium. Traditional materials (crayons, paper, finger paint, markers, paints, clay, Play Doh, paste, glitter, clue, scissors, string, stickers) may be used, or electronic media may be incorporated. Art may be used alone or with other techniques.
* **Clay**
  + Clay can be used as art, or tied to other therapeutic goals, such as rolling it into a ball and smashing it, squeezing it through the fingers, or placing it in varying amounts to represent values of something, someone, or a decision.
* **Drama**
  + Have the client draw who he/or she would like to be, asking reflective questions about what is drawn, identifying behaviors that the person has that could assist in problems/goals, then invite the client to engage in the behaviors (i.e. young children may select superheroes and act as if they are the superhero). Variants may be having clients take on an unfamiliar role to change perspectives or practice a new behavior, or act as themselves in a situation or as a symbolic character or family member.
* **Music**
  + The client may be asked to bring in music that is meaningful, listen to it with the therapist, talk about the thoughts and feelings generated, and discuss how cognitions and emotions impact/and are impacted by the client's current circumstances. The client could also write a song.
* **Puppets**
  + These may be used by clients to reenact scenes, play out feelings, practice new behaviors, facilitate decision-making, develop communication skills, decrease isolation, play out fantasies, address thoughts, and express strong emotions.
* **Sand Play**
  + Sand trays may be used wet or dry, and children are offered miniatures in several categories to create a "world" or "scene." Categories include: Symbolic Objects (i.e. treasure chests, wishing wells), Natural Objects (i.e. shells, bones), Structures (i.e. bridges, gates), Vegetation (i.e. shrubs, trees), Animals (i.e. wild, domestic, prehistoric), Vehicles (land, space, war), People (i.e. fantasy, domestic, military), and Buildings (i.e. castles, schools, high rise). Sand play may or may not be directed.
* **Sculpting**
  + In a group, divide the members into two parts, one that will be the "artists" and one that will be the "clay," and have the "artists" sculpt the "clay" with ground rules of not touching the "clay." Once the sculptures are completed, the leader can tour the exhibit of sculptures, listening to the creator share about the creation process and how it is significant. Then have the members change roles. This can also be done in family therapy or with a sibling group to explore the impact of members on one another.
* **Story Telling**
  + Invite the client to record a make-believe show with the therapist as the guest of honor. Make an introduction of the client, noting important elements and content. Once complete, ask if there is a lesson or moral and whether any details are needed, and make positive comments (i.e. powerful, exciting, unusual, captivating). Turn off the recording device to gather any additional information needed (i.e. symbols, important actors, themes, emotional reactions), then tell the therapist's version of the story (i.e. same characters, situation, setting) only revised for improved resolution to conflicts or adding in coping or behavior changes.
* **Visualization**
  + Many uses are available to this technique, with the purpose being to engage the imagination where there are no barriers to reality, allowing the client to alter his/or her view of problems, consider strengths, or reconsider expectations about others. For example, a client may be invited to imagine that he/or she is camping in the woods in any structure he/or she likes (i.e. a sleeping bag in the open air, pup tent, large tent, cabin, cave) when a terrible storm begins the client is asked what happens to him/or her and to draw a picture of himself/or herself before, during, and after the storm is over.

3. Counseling Terms

(www.crcexam.com)

* **ABAB Experimental Design**
  + AKA "reversal design," behavior of single subject is measured at baseline, introduction of treatment, return to baseline conditions, reintroduction of treatment.
* **Affect**
  + Displayed emotions.
* **Agnosia**
  + A symptom of dementia in which an individual cannot name or recognize objects
* **Alogia**
  + Speech deficit
* **Anhedonia**
  + Inability to feel pleasure
* **Antisocial Personality Disorder**
  + Aggressiveness, deceitfulness, disregard for the rights of others, violation of the law and social norms, impulsivity, and lack of remorse.
* **Avoidant Personality Disorder**
  + Avoidant Personality Disorder involves pervasive feelings of inadequacy and fears of negative evaluation and avoiding abandonment.
* **Avolition**
  + Inability or unwillingness to begin and maintain activities
* **Borderline Personality Disorder**
  + Have a pervasive pattern of instability in relationships, self-image, affect or have impulsivity.
  + Unstable interpersonal relationships, unstable mood and self-image, and impulsivity
* **Classical Conditioning**
  + According to Pavlov, a behavior is learned when a stimulus is paired with an unconditioned stimulus to bring about a conditioned response.
* **Clinical Interview**
  + Used to gather information about the client.
* **Collective Unconscious**
  + Carl Jung theorized that humanity has an understanding of human history through this.
* **Control Group**
  + IV is not manipulated in this group
* **Correlation Coefficient**
  + Ranges from 0 to 1, has both direction and magnitude
* **Correlational Method**
  + Research that examines relationships among factors, does not determine cause and effect
* **Counter Conditioning**
  + Eliminating the present response to a stimulus by substituting another response.
* **Conditioned Response**
  + Conditioned response is a learned behavior (Example: Pavlov's dogs learned to salivate at the sound of a bell)
* **Conditioned Stimulus**
  + Conditioned stimulus is a neutral stimulus that is paired with an unconditioned stimulus (Example: Pavlov's bell)
* **Dependent Variable**
  + Variable measured in an experiment
* **Depersonalization**
  + Feelings of detachment from the self.
* **Derealization**
  + Feelings of unreality.
* **Displacement**
  + Unacceptable emotions are redirected from dangerous objects or safer ones with this defense mechanism
* **Dissociative Amnesia**
  + Inability to remember important personal information, reversible, may follow stressful events
* **Dissociative Identity Disorder**
  + Identities or personality states (alters) in an individual
* **Double-blind Study**
  + Experimenter and subjects do not know who is in control or experiment groups
* **Dream Analysis**
  + Psychoanalytic technique in which dreams are interpreted to unbury repressed desires
* **Dyspareunia**
  + Pain during intercourse; rare in men; medical reasons for pain must be ruled out
* **Electroconvulsive Therapy (ECT)**
  + Electroconvulsive therapy in which seizures are produced by sending electrical impulses through the brain
* **Ego**
  + Psychic structure that handles reality and operates on the reality principle.
* **Empathy**
  + Understanding the client’s perspective.
* **Encopresis**
  + Pattern of elimination of feces in inappropriate places.
* **Enuresis**
  + Voiding of urine in inappropriate places.
* **Epidemiology**
  + Prevalence and incidence of diseases
* **Eros**
  + Primarily sexual, the life instinct or life drive
* **Etiology**
  + Cause(s) of disorders.
* **Exhibitionistic Disorder**
  + Sexual arousal associated with exposure of genitals; element of risk important to the arousal
* **Experimental Group**
  + Receives manipulation of the IV.
* **External Validity**
  + Ability to generalize results to groups outside the research study.
* **Facial Agnosia**
  + Inability to recognize familiar people.
* **Female Orgasmic Disorder**
  + After normal sexual desire and arousal, delay or absence of orgasm.
* **Fetishistic Disorder**
  + Sexual attraction associated with objects; chronic and recurrent fantasies or urges or behaviors.
* **Fixation**
  + Freud: stuck at a stage of development.
* **Formal Civil Commitment**
  + By court order, can be requested by any citizen.
* **Free Association**
  + In psychoanalysis, the client talks about anything that comes to mind to release repressed memories
* **Generalized Anxiety Disorder**
  + Chronic anxiety and worry for at least six months
* **Genital Stage**
  + Freud: final stage of psychosexual development
* **Genuineness**
  + Therapist honestly communicates emotions and experiences.
* **Hallucinations**
  + Things are sensed (seen, heard, felt, smelled, tasted) that are not present; a psychotic symptom; auditory hallucinations are most common
* **Histrionic Personal Disorder**
  + Attention-seeking, excessive emotionality, easily influenced; may be inappropriately sexual and vague in speech.
  + Excessively emotional and actively engages attention seeking.
* **Hypothesis**
  + Proposal concerning a causal relationship.
* **Id**
  + Attention-seeking, excessive emotionality, easily influenced; may be inappropriately sexual and vague in speech
* **Incidence**
  + Number of new cases of a disorder during a certain period of time.
* **IV**
  + Variable that is manipulated in an experiment.
* **Informal or Emergency Civil Commitment**
  + Two doctors can sign a commitment order for a short length of time (24 hours to 20 days).
* **Insanity**
  + Cannot distinguish between right and wrong; or mentally ill.
* **Insomnia**
  + Problem with not getting enough sleep.
* **Internal Validity**
  + Manipulation of the IV caused the effects.
* **Kleine-Levin Syndrome**
  + Individuals may sleep 18-20 hours.
* **Latency Stage/Period**
  + Freud: emotionally calm stage of development, 6-12 years old
* **Latent Content of Dreams**
  + Unconscious desires that are masked by symbols in dreams.
* **Law of Effect**
  + Thorndike: when behaviors are followed by positive gratification, the behaviors are likely to occur
* **Magnitude**
  + Strength of correlation, expressed as a numerical value of "r"
* **Major Depressive Disorder**
  + At least 2 weeks and at least 4 symptoms; symptoms are feelings of worthlessness, inability to feel pleasure, impaired functioning; children may be irritable
* **Manic Episode**
  + At least 1 week; symptoms may include hyperactivity, flight of ideas, elevated mood, inflated self-esteem, decreased need for sleep
* **Manifest Content of Dreams**
  + The apparent content of the dream.
* **Mental Status Exam**
  + Evaluates a client's emotional state, cognition, time orientation, judgment, appearance, and sensing abilities.
* **Mood**
  + Predominant emotion.
* **Moral Anxiety**
  + Guilt and shame that results from immoral behavior
* **Multiple Baseline Design**
  + Improves generalizability by researching treatment that begins at different times in different groups in different settings.
* **Narcissistic Personality Disorder**
  + Grandiose, admiration-seeking, lacking in empathy, overvaluing accomplishments. May compare self with famous people and see self as unique and superior.
* **Narcolepsy**
  + Individuals are driven to fall asleep for short periods of time.
* **Negative “r”**
  + Inverse relationship between variables.
* **Negative Symptoms of Schizophrenia**
  + Behavior deficiencies, including speech deficits, flat affect, motivational deficits
* **Neuropsychological Tests**
  + Performance tests that measure brain functioning, given when brain damage is suspected.
* **Neurotic Anxiety**
  + Fear of consequences that could result from the expression of id impulses
* **Objective Anxiety**
  + Ego's reaction to real danger.
* **Obsessions**
  + Thoughts and urges that are irrational or intrusive
* **Obsessive-Compulsive Personality Disorder**
  + Perfectionistic, controlling, excessively orderly.
* **Oedipus Complex (boys) and Electra Complex (girls)**
  + Child is in the phallic stage sexually desires opposite-sex parent and fears same-sex parent; fear is ameliorated by identification with same-sex parent.
* **Operant Conditioning**
  + Skinner: Reinforcers and punishments will affect the learning of behaviors and their maintenance
* **Opiate Withdrawal Symptoms**
  + Nausea, diarrhea, muscle pain, insomnia; may last a week.
* **Oppositional Defiant Disorder**
  + Negative, hostile, antagonistic and defiant behavior pattern.
* **Oral Stage**
  + Freud: first stage of psychosexual development
* **Paranoid Personality Disorder**
  + Distrustful, suspicious, jealous and may want to harm others and be hostile.
* **Parasomnias**
  + Abnormal behaviors during sleep.
* **Paresthesias**
  + Tingling or numbness sometimes felt during panic attack.
* **Pedophilic Disorder**
  + Sexual arousal with regard to children.
* **Positive Effects of Amphetamines**
  + Treatment of narcolepsy and hypersomnia, improve mood, reduce fatigue, and weight loss.
* **Positive Effects of Cocaine**
  + Local anesthetic, stimulant
* **Positive Symptoms of Schizophrenia**
  + Behaviors such as hallucinations, delusions, disorganized speech
* **Posttraumatic Stress Disorder (PTSD)**
  + After a traumatic event, symptoms are intrusive memories, avoiding emotional triggers, emotional numbness, and arousal.
* **Prevalence**
  + Statistics involving the presence of a disorder among a certain population at a certain time.
* **Primary Process Thinking**
  + Id uses it to produce mental pictures.
* **Prognosis**
  + Most likely progress of a disorder
* **Projection**
  + Unacceptable desires are attributed to other people as a defense mechanism.
* **Projective Tests**
  + Person responds to ambiguous stimuli; given to reveal unconscious conflicts; harder to fake than objective tests
* **Psychoactive Drugs**
  + Alter thinking/emotions/behaviors; stimulants, depressants, opiates, hallucinogens.
* **Random Assignment**
  + Control group and experimental group should be as similar as possible.
* **Reaction Formation**
  + "Wrong" feelings are converted into their opposites with this defense mechanism.
* **Regression**
  + Individual returns to an earlier developmental stage as a defense mechanism.
* **Reliability**
  + Test gives consistent results over time
* **Repression**
  + Traumatic events and undesirable thoughts are buried in the unconscious.
* **Risk Factor**
  + Condition that increases the likelihood of getting a disorder.
* **Rorschach Inkblot Test**
  + Most widely used projective test
* **Schizoid Personality Disorder**
  + Prefer to be alone; low levels of emotion.
  + Pattern of detachment from social interactions and relationships and limited affect.
* **Schizophrenia**
  + Disturbances in behavior, speech, thinking, perception and emotions that involve psychosis; at least 2 symptoms of Schizophrenia for one month required for diagnosis.
* **Schizophreniform Disorder**
  + Same symptoms of Schizophrenia but duration is less than 6 months.
* **Schizotypal Personality Disorder**
  + Odd beliefs, perhaps of being psychic or having magic powers; unusual speech; problems with interpersonal relationships; sometimes psychotic episodes.
  + Interpersonal deficits and perceptual distortions and eccentric behavior.
  + Odd speech, unusual perceptual experiences or body illusions.
* **Scientific Statements**
  + Testable, based on observations, linked to measurable outcomes.
* **Secondary Process Thinking**
  + Ego uses it to plan and make decisions.
* **Sensitivity Training Groups**
  + Purpose is to improve empathy skills and promote personal growth.
* **Sensorium**
  + Awareness of the environment.
* **Sexual Response Cycle**
  + Desire, arousal, and orgasm… (Refractory period?)
* **Situational Type of Phobia**
  + Fear is related to situations.
* **Social Learning Approach**
  + Bandura: we learn through modeling and seeing models being rewarded and punished.
* **Social Phobia**
  + Fear of social situations.
* **Speech and Cognition**
  + Cognition judged by content, rate, and continuity of speech.
* **Standardization**
  + Similar procedures are used each time test is administered.
* **Statistical Significance**
  + Probability that a relationship happened by chance.
* **Substance Intoxication**
  + Getting drunk or getting high; impaired judgment, impaired motor coordination; symptoms depend on the drug, the quantity, and how it reacts in the individual.
* **Subtypes of Specific Phobias**
  + Animal, blood-injection-injury, situational, natural environment, other.
* **Suicidal Risk Factors**
  + Family history of suicide, mental disorder(s), low serotonin levels, alcohol use, stressful event that is seen as shameful, past history of suicide attempts.
* **Superego**
  + Psychic structure that internalizes morality.
* **Systematic Desensitization**
  + Form of counterconditioning developed by Wolpe.
* **Thanatos**
  + Death instinct.
* **The Pleasure Principle**
  + Immediate gratification of impulses (Id).
* **The Reality Principle**
  + Used by the ego to negotiate between the id and the environment.
* **Token Economy**
  + Positive behaviors are rewarded with tokens that are used to buy items/privileges of worth to the client.
* **Types of Disorganized Speech in Schizophrenia**
  + Illogical, incoherent, loose associations.
* **Unconditioned Response**
  + Unconditioned response that is naturally produced by a stimulus (Example: salivation of Pavlov's dogs in response to meat).
* **Unconditioned Stimulus**
  + Unconditioned stimulus naturally produces a response (Example: meat that Pavlov used with his dogs).
* **Unconditional Positive Regard**
  + Client is treated with dignity and respect.
* **Validity**
  + Test measures what it says it measures.
* **Waxy Flexibility**
  + When a person's position stays the same when someone else changes it.
* **Withdrawal**
  + Physically distressful symptoms when drug is not used.

4. Developmental Milestones

* Only during a baby's first month is its cry purely physiologically linked; from then on emotions are involved. Emotional contagion has been observed in children as early as two days after birth.
* **Milestones of Development:**
* **1-3 months:** Infant gains the ability to raise his/or her chin from the ground and can turn head from side to side and play with hands and fingers.
* **4-6 months:** Baby rolls over. At five months, the child reaches and grasps while sitting on someone's lap. At six months, the baby sits alone and may stand with support. First teeth appear between five and nine months.
* **7-9 months:** Coordination improves. Creeping and crawling usually begin between eight and nine months.
* **10-12 months:** Child pulls himself/or herself up to standing position with furniture and walks with help.
* **15 months:** Baby stands alone then gains ability to walk. He/or she throws things.
* **18 months:** Toddler can walk sideways and backwards.
* **2 years:** Child walks with a steady gait, jumps, runs in a controlled way, and can climb stairs with help.
* **3 years:** Typically, toilet trained, child dresses and undresses with simple clothing and can scribble.
* **4 years:** Child prints first name; he/or she has a stable preference for right or left hand.
* **5 years:** Youngster coordinates movement to music.
* **Middle childhood:** Gender differences appear. More physically mature than boys of the same age, girls are superior in skills requiring flexibility, agility, and balance. Boys are stronger and perform better in activities that require gross motor movement. For boys, early maturation improves popularity and adjustment. Late maturing boys lack confidence, perform more attention-seeking behaviors, and are considered childish. Early maturation works against girls resulting in lowered self-concept, dissatisfaction with physical development, sexual precociousness, and increased potential for drug and alcohol use. Late maturing girls also are likely to be dissatisfied with their physical appearance and resent being treated as younger than they are. Factors making for good development are high socioeconomic status, a two-parent family, little visible disfiguration, and healthy parental adjustment.

5. Services

(www.crcexam.com)

* **The Shelter Plus Care program** provides rental assistance for homeless individuals with disabilities, with a priority in serving individuals with serious mental illness, chronic alcohol and/or drugs problems, and acquired immunodeficiency syndrome (AIDS) and associated diseases.
* **The Street Outreach Program** provides educational and preventive services to run away, homeless and street youth who have been subject to, or are at risk of, sexual exploitation or abuse, and includes youth with disabilities.
  + The program establishes and builds relationships between street youth and program outreach staff to locate a safe, appropriate alternative living arrangement for youth through treatment, counseling, information and referral services, individual assessment, crisis intervention, and follow up support.
* **The Transitional Living Program for Older Homeless Youth (Administration for Children and Families)** program provides stable, safe living accommodations, basic life-skills, career counseling, educational training, and physical and mental health support services to homeless youths, ages 16 through 21, for up to 18 months.
* **The Basic Center Program (Administration for Children and Families**) establishes or strengthens locally-controlled, community, and faith-based programs that address the immediate needs of runaway and homeless youth and their families.
  + The Centers provide youth with temporary shelter, food, clothing, and referrals for health care.
  + The grants may also be used to provide counseling, outreach activities, and aftercare services for youth once they leave the shelter.
* **Disability benefits for military service members** are available through the Department of Veteran's Affairs and the Social Security Administration.
  + Expedited processing of disability claims, for military service members are available and expedited, and are different from the benefits provided by the Department of Veteran's Affairs.
  + Military service members who become disabled while on active military duty, regardless of where the disability occurs are eligible to apply for expedited benefits.
  + The benefits are paid to veterans based on injuries or diseases incurred during or exacerbated by active military duty.
  + Interestingly, these benefits may be paid to veterans disabled as a result from Veteran's Administration care, in certain instances.
* **Tricare** is military health care insurance.
* **The National Association for the Dually Diagnosed (NADD**) is a nonprofit membership association of professionals, care providers and families to improve the comprehension of, and service provision for individuals with developmental disabilities and mental health impairment.
* **The National Clearinghouse for Professions in Special Education (NCPSE)** was established to encourage national proficiency in the recruitment, preparation, and retention of proficient, educators and service personnel from diverse backgrounds, for children with disabilities.
* **The National Association of State Directors of Developmental Disabilities Services** is a nonprofit organization that improves and expands public service provision to individuals with intellectual and other developmental disabilities.
* **ARC** is the principal national community-based advocacy organization serving individuals of all ages with intellectual and developmental disabilities, Down syndrome, Fragile X, a variety of additional developmental disabilities and the comprehensive autism spectrum, and their family members.
* **The National Multiple Sclerosis Society** provides research on the prevention, treatment and cure of Multiple Sclerosis.
  + The organization provides education, programs and services to individuals living with Multiple Sclerosis, their families and the communities in which they live.
* **Small Business Innovation Research (SBIR) grants** help support the production of new assistive and rehabilitation technology. This two-phase program takes a product from development to market readiness.
* **Easter Seals** provides children's services, family services, adult and senior services, and caregiver support to individuals with autism and other disabilities and their families.
  + It provides child develop centers, physical/medical rehabilitation, employment and training, adult day services, in-home support, mobility options, wellness programs and camping and recreation programs.
  + The organization provides advocacy, outreach and community education to help individuals with disabilities achieve individual goals and overcome challenges encountered because of disabilities.
  + Services are individualized to meet the needs of individuals with disabilities and community through the provision of a network of centers in the United States and Australia.
* **The National Autism Association (NAA**) focuses on empowerment, advocacy and education for families, professionals and the community, affected by autism and other neurological disorders.
  + Their mission is to bring awareness that autism is treatable, and to the environmental toxins that may result in autism and other neurological diseases.
* **The Autism National Committee** work focuses on social justice, human rights and civil rights for citizens with Autism, Pervasive Developmental Disorder and associated behavioral disorders.
* **The Partnership and Communication component of the Division of One-Stop Operations** maintains communication and relationships with other federal agencies, stakeholders, groups representing state officials, business interests, workers, and the academic community.
* **The Policy and Planning component of the Division of One-Stop Operations** provides assistance and guidance on policy and recommendations on the One-Stop Career system including state Workforce Investment Act (WIA) strategic plans.
* **The Electronic Linkages component of the Division of One-Stop Operations** provides federal leadership in the operation and development of the "CareerOneStop E-Tools", consisting of a compilation of websites designed to provide workforce service and career information to job seekers, workers and employers.
* **The Career One-Stop Portal** provides a central point of entry to access all the Department of Labor's electronic operations.
* **Rehabilitation planning** includes disability management and may include life care planning.
* **Life care planners** identify the needs of individuals with disabilities that are expected to occur over the course of the lifetime of the individual.
  + They are hired to establish the need for services and identify appropriate financial, accounting and legal representatives to assist the individual with disabilities.
  + Life care planning is used to determine the lifetime loss of earning potential.
  + Life care planners calculate the expected cost of rehabilitation and disability care for the life of the individual with disabilities, whether the disability is classified as work related or as a congenital disability.
* **Disability management** refers taking steps to ensure an employee's expedited return to work and preventing work-related injuries through the identification and correction of potential hazards.
* **Disability case managers work** do encourage recovery, save money, ensure completion of appropriate forms on a timely basis, decrease the delay of benefits, assist continuance of work in the workplace, and examine the need for workplace modifications.
* **Forensic rehabilitation vocational experts** must be able to assess the extent of disability related to occupational environments in varying types of cases on multiple issues objectively, from the plaintiff's or defendant's side of a case.
* Eligibility for government benefits for individuals with disabilities may be based solely on disability or based on disability and income.
* **Eligibility for both SSI and SSDI** is based on a determination that an individual is disabled.
* **SSI and SSDI** are administered by the Social Security Administration (SSA).
* **When SSI and SSDI** are the sole source of income, individuals may also be eligible for Medicare and Medicaid health care and services.
* The Social Security Administration has determined that if an individual is able to participate in **AmeriCorps State/National programs,** they are considered as participants in substantial gainful activity, and are no longer considered as disabled.
* The living allowance received by SSI recipients who serve in AmeriCorps state/National programs may be considered as earned income. by the Social Security Administration.

6. VR Process

* **3 Criteria of Determining Eligibility in VR:**
  1. Individual has a disability.
  2. The disability impacts the ability to work (constitutes a substantial impediment to employment; aka a barrier to employment)
  3. If the individual can benefit from VR services and wants to work (and VR will help the person become employed). VR is assumed to lead to an employment outcome.
* **Presumptive eligibility:**

Presumed eligible for VR services if they are receiving SSI/SSDI funds (with proof) and can speed up the eligibility process.

* **Individualized Plan for Employment (IPE)**
* **VR Case Codes:**
  + **00**- Referral
  + **02**- Applicant
  + **06**- Extended evaluation
  + **08**- Closed after application or extended evaluation
  + **10**- Eligibility determined but no IPE developed yet
  + **12**- IPE written but not initiated
  + **16**- Physical or mental restoration services (Medical services are being provided)
  + **18**- Training (when consumer is in any form of training)
    - Can consist of Job seeking skills training
  + **20**- Job ready (Service-J)
  + **22**- In employment
  + **24**- Services interrupted (normally loss of contact with consumer)
  + **26**- Successful closure (maintained employment for at least 90 days)
  + **28**- Unsuccessful closure after services initiated
  + **30**- Unsuccessful closure before services begin
  + **32**- Postemployment services
  + **34**- Closed from postemployment services w/ employment maintained

7. Legislative History of the VR Program

* **1908: Federal Employees Worker’s Compensation Act**
  + Enacted to be an alternative to suing for work-related injuries.
* **1914: War-Risk Act**
  + Provided rehabilitation and vocational training as the start of everything. Gave US gov’t the authority to ensure at sea.
* **1917: Smith-Hughes Act**
  + Made fed monies available to states on a matching basis.
  + Established fed board for vocational education.
  + \*\*\*Easy to remember because we are talking about funding.
* **1918: Soldier’s Rehabilitation Act**
  + Created VR programs for disabled vets returning from WWI.
* **1920: Smith-Fess Act**
  + AKA civilian VR act and established a civilian VR program.
  + Opened VR up to civilians and not just disabled vets.
* **1935: Social Security Act**
  + As part of SS, VR became part of the fed program and is now a permanent program.
* **1936: Randolph-Sheppard Act**
  + Allowed blind individuals to operate vending stands in fed property.
* **1938: Wagner-O’Day Act**
  + Authorized fed gov’t to purchasing of certain items made from blind individuals in specific workshops to expand opportunities for blind to work in these workshops.
* **1943: Barden Lafollette Act**
  + Expanded eligibility for VR services to persons with ID and PsyD.
  + Expanded different types of physical restoration services.
  + Provided maintenance funds, usually a type of assistance where a person is in a training program and need assistance for things like transportation (something that is needed to continue with the training).

**Vocational Act Amendments**

* **1954**
  + Public Law 565 represented major expansion of fed gov’t to VR.
  + $3: $2 fed-state match and expanded funding in the millions by 1958.
  + Services in mental health greatly expanded.
  + Authorization of research grants.
* **1965**
  + Expanded state funding ratio 75:25 fed-state match.
  + Allowed 6 – 18 months extended evaluation for PWSD.
* **Rehabilitation Act 1973**
  + VR priority to support PWSD.
  + Consumer involvement emphasized further.
  + Development of the IWRP.
* **Title V of Rehab Act 1973**
  + **Section 501**:
    - Non-discrimination in hiring.
  + **Section 502**:
    - Architectural and transportation barriers and compliance board to oversee the compliance to the architectural barriers act in 1968.
  + **Section 503:** 
    - Prohibits discrimination of PWD in employment under any fed contractor or subcontractor receiving $2500 or more.
  + **Section 504:** 
    - Prohibits discrimination against PWD who are part of a federally supported program or activity that is receiving federal funds.
* **Rehab Act 1974, 1976, 1978**
  + Further strengthened services for PWSD.
* **Rehab Act 1986**
  + Authorized State VR agencies to provide SE services to PWSD.
  + Rehabilitation engineering services added.
* **Rehab Act 1992**
  + Emphasized consumer involvement in state VR procedures and policies.
  + IPE developed.
  + State rehabilitation councils established.
* **Workforce Investment Act 1998**
  + One-stop centers established for persons who needed immediate employment and to get employment resources.
* **Rehab Act Amendments 1998**
* **ADA**
  + **Title I**
    - Employment
    - Prohibits employment discrimination of qualified PWD in the public sector and government.
  + **Title II**
    - Public services
    - No PWD can be excluded by reason of disability by reason of participation in or denied benefit of services, activity, or program of a public program or entity.
  + **Title III**
    - Public accommodation
    - Prohibits discrimination of purchasing goods or services, facilities, advantages, in any public places of accommodation.
  + **Title IV**
    - Telecommunication
    - Telephone relay services operate 24 hours a day for PWD HH and Speech Impairments
  + **Title V**
    - Miscellaneous

8. Social and Cultural Foundations

* **Culture**
  + Defined as habits, customs, art, science, religion, and political behavior of a given group of people during a given period.
* **Dynamic**
  + Cultures are dynamic, each changing and evolving at their own rate.
* **Macro culture**
  + Major culture in a country.
* **Microculture**
  + Smaller culture in a country.
* **Acculturation**
  + Learning behaviors and expectations of a culture.
* **Emic vs Etic**
  + **Emic-** RC helps client understand his/her culture.
  + **Etic-** RC focuses on similarities in people, treating people as being the same.
* **Low context communication**
  + Long verbal explanation.
* **High context communication**
  + Nonverbal communication methods that are readily understood by others in the culture.
* **African Americans**
  + In 2010 it was 42 million at 13.6%
  + By 2050, 65.7 million comprising 15% of US
  + Five Identity Operations
    - Buffering
    - Code switching- speaking 1-way w/ a certain group of individuals and another way with others (speak differently w/ parents vs friends)
    - Bridging
    - Bonding
    - Individualism
  + Mental Health Issues
    - Can be over diagnosed in mental health
    - Under diagnosed in depression.
    - Suicide is prevalent
    - 40-44% of homeless have PsyR
    - 50% of federal inmates have PsyR
    - 45% of children in custody have PsyR
  + Use of spirituality, faith, and religion to cope with personal issues and challenges.
* **Asian Americans**
  + In 2000, there were 10 million individuals making up 3.6% of US.
  + By 2050, 37.6 million comprising 9.3% of US.
  + **Worldview**
    - Humility, interpersonal harmony, self-restraint, and obligation to family.
    - High context communication
  + **Experiences to psychological distress and coping mechanisms**
    - “Model minority”- people stereotype them as the ones who will be successful which causes a lot of stress.
    - Understanding racism and discrimination
    - Immigration experiences
  + Prefer crisis-oriented, brief and solution-focused oriented approaches rather than insight and growth-oriented approaches.
* **Hispanic/Latinos**
  + Largest ethnic minority group.
  + In 2011, 52 million comprising of 16.7% of US.
  + Least educated and successful minority group in US.
  + Low rates of HS completion hinder pursuit of college.
  + **Personalismo**- very intense sense of privacy and protectiveness, strong religious faith, powerful nation of pride and regionalism.
  + Strong sense of moral righteousness accompanied by a personal sense of guilt or shame.
  + High degree of emotional expressiveness.
* **Native Americans**
  + In 2000, 2.5 million comprising 1% of population.
  + 562 federally recognized tribes, unknown # of non-federally recognized tribes.
  + Each tribe has its own culture, beliefs, and practices.
  + Experience various degrees of individual and community trauma.
  + Historical trauma and unresolved grief are reactions to cultural loss and involuntary change.
* **Arab Americans**
  + 80% are US citizens. Most in US are from Southwest Asia and North Africa.
  + Islam emerged from Mecca and became the 3rd and most recent of world’s monotheistic religions.
  + Appreciate dreams and visions and consider them true reality.
  + Social system is collective and authoritarian.

9. Family Dynamics and Counseling

* **Circular Causality-** everyone’s behavior affects everyone else’s behavior.
* **Social Constructionism**
  + Meaning is constructed through a social interaction.
  + This is a narrative and solution-focused therapy.
  + Shaping how they understand and make meaning of the world and how these meanings are constructed.
* **Psychoanalytic Family Therapy**
  + **Founder:** Nathan Ackerman
  + Knowing where to look to discover basic wants and needs that keep people from acting maturely.
  + Free family members from unconscious restrictions so they can interact with each other as a whole.
  + Having Insight is necessary for behavioral changes.
  + **Techniques:** listening, empathy, interpretation, and analytic neutrality.
* **Conjoint Family Therapy**
  + **Key Figure:** Virginia Satir
  + Problem at hand was not the real issue; instead, she believed it was the way the person dealt with the issue(s) that created the underlying problem.
  + **Assumptions:**
    - 1. Virginia Satir's approach is based on congruence and openness in communication
    - 2. Families have many spoken and unspoken rules
    - 3. Relies on the validation process
    - 4. Emphasis is on family roles where the role played by each family member is based on one's behavior - the peace-keeper, the victim, the hard-working caregiver, and the disciplinarian
    - 5. Focus on emotional honesty, congruence, and systemic understanding
    - 6. Stuck families follow broken rules, and pathology is considered a deficit in growth (in a dysfunctional family, symptomatic behavior makes sense and is also covertly rewarded)
    - 7. People rely on a "nurturing triad" (or a primary triad, which consists of the two parents and child where the child is nurtured) as their source of identity
  + **5 styles of communication (4 dysfunctional & 1 functional)**
  + **Dysfunctional styles of communication:**
    - **1.** **Placater -** fearing rejection, they want to please, becoming dependent
    - **2. Blamer -** to cover their own inadequacies and emptiness, they attempt to control others by bullying and attacking their faults
    - **3. Super reasonable (coined "computers") -** keeping others at a 'safe distance', they depend upon detachment to protect their own feelings, skirting emotional issues with intellectual rationalization
    - **4. Irrelevant or Distractor -** often the youngest child falls into this category; rather than face the situation, they'll make the problem go away and pretend it doesn't even exist, hoping others involved will do the same
  + **Functional style of communication**
    - **1. Leveler or Congruent -** telling it like it is, they are honest and genuine.
  + **Why people do what they do**
    - 1. Strive for honesty and openness in family communication
    - 2. Family members are considered "functional" when they are given the opportunity to be individuals. This entails the family member having a life separate from the family, with freedom and flexibility in their skills to communicate with other family members.
    - 3. When family members allow their similarities to unite them and use their differences to help them grow.
  + **The Core of a Healthy "Self" Embodies Eight Levels:**
    - 1. Physical 2. Intellectual 3. Emotional 4. Sensual 5. Interactional 6. Contextual 7. Nutritional and 8. Spiritual
* **Bowen’s Family System Theory**
  + **Founder:** Murray Bowen 1978
  + AKA multigenerational or transgenerational family therapy.
  + Analyzing family from 3-generation perspective allows for better understanding.
  + ***Differentiation of Self:***
    - Social groups influence the way a person thinks.
    - The less differentiated and developed a person’s self is, the more they have an unhealthy dependence on and are controlled by others.
  + ***Triangulation:***
    - A triangle is the smallest stable relationship system.
    - A 2-person system is unstable forms into a 3-person system under stress and the 3rd person can serve a substitute for conversation or a messenger.
  + **2 goals:** decrease anxiety and increasing the level of differentiation from self.4
* \*KEY Figure most closely associated with Family Systems is Virginia Satir (family interacting with the counselor) and Murray Bowen.
* **Experiential Family Therapy**
  + Key figures: Carl Whitaker and Virginia Satir
  + Focus on mutually shared experience b/w therapist and the family.
  + Goal: increase family members’ capacity to experience their lives more fully by sharing their struggle with the “here and now.”
  + Therapist role: create turmoil and then coach family members through the experience.
  + Therapy is often conducted with 2 therapists.
  + Experiential family therapy was founded by Carl Whitaker and Virginia Satir. They believed techniques promote communication and interaction, while emotion organizes attachment responses and serves a communicative function in a relationship. They encouraged clients to relax defensive fears so genuine emotions can emerge, and in turn, elicit from partners or family a more compassionate and nurturing response.
  + Whitaker's model basically states that the cause and effect of family problems is emotional suppression. The tendency in family therapy is to confuse the instrumental and expressive functions of emotion by:
    - 1. Trying to regulate children's actions by controlling the child's feelings
    - 2. Dysfunctional families are less of the emotions that signal individuality
    - 3. Children grow up estranged from themselves
  + The concept was to help families to uncover their honest emotions and forge more genuine family ties from enhanced authenticity.
  + Whitaker and Satir had theoretical differences in their approaches: Whitaker believed self-fulfillment depends upon family cohesiveness, whereas Satir believed in the importance of good communication among family members.
  + Assumptions:
    - 1. Carl Whitaker's idea of experiential family therapy was based on a pragmatic stance with the belief that theory can hinder clinical work.
    - 2. Each family member has the right to be himself/or herself
    - 3. Based on the belief of the family being an integrated whole, not a collection of discrete individuals
    - 4. Familial togetherness and cohesion are associated with personal growth
    - 5. Emphasis is on the importance of involving extended family members in treatment (especially the expressive and lively spontaneity of children)
    - 6. Basis of this bold and inventive approach to family therapy was the result of Whitaker's spontaneous and creative thinking
    - 7. Whitaker stressed the importance of genuineness
    - 8. Techniques are secondary to the therapeutic relationship
    - 9. Whitaker believed in this atheoretical approach based on the assumption that many times, theory is a way for the therapist to create distance from clients; it also helps to control the anxiety of therapists by allowing them to hide behind their "theory".
* **Behavioral and CBT Family Therapy**
  + **Key figures:** Gerald Patterson and Neil Jacobson
  + **Focus:** discrete problem areas defined by clear behavior patterns.
  + **Goal:** modify specific behaviors or thought patterns to alleviate symptoms.
  + **Key concepts:** careful and detailed assessments and identify specific strategies designed to modify contingencies of reinforcement.
  + **Techniques:** behavioral contracts, training in communication skills, active suggestion, and homework.
  + CBT believe that symptomatic behaviors continue to occur in a family system when Members inadvertently reinforce these responses.
  + The social exchange theory utilized in Cognitive Behavioral family therapy states that most people strive to maximize rewards and minimize costs in their relationships.
  + Cognitive Behavioral family therapy is generally time-limited and symptom-focused.
  + Ex: A wife is experiencing some difficulty in stating her needs and becomes upset when her husband does things she does not agree with. Her husband becomes frustrated because nothing he does seems to please his wife and has a hard time trying to figure out what she wants. A Cognitive Behavioral family therapist might assist this couple by teaching them assertiveness and communication skills.
* **Structural Family Therapy**
  + **Founder**: Salvador Minuchin.
  + **Focus:** interactions of family members to understand structure of family.
  + **Key concepts:** 
    - Family Structure is an invisible set of rules that organize the way members relate to each other.
    - Family subsystems include spousal, parental, sibling, and extended family categories.
    - Boundaries are emotional barriers that protect and enhance integrity of families (disengagement – enmeshment)
    - Techniques: family mapping, enactments, and reframing.
* **Strategic Family Therapy**
  + **Key figure:** Jay Haley
  + **Focus:** solving present problems.
  + Resolve problems by focusing on behavioral sequences rather than insight.
  + Counselor acts a consultant and is responsible for planning strategies to resolve problems.
  + **Techniques:** using directives (advice, suggestion, and coaching), paradoxical techniques, and reframing.
* **Brief Family Therapy**
  + **Key figures:** Luigi Bscolo and Gianfranco Cecchia.
  + Popular due to economic limitations and introduction of managed care.
  + Solution-oriented approach: move from talking about problems to generating solutions.
  + Counselor/client discuss goals, resources, and exceptions to the problem.
  + Techniques: setting limited goals and an end point, reinforcing family strengths, and assigning HW, and use of the “miracle question.”
* **Family Counseling Strategies**
  + Key figures: Marshak and Seligman (1993)
  + Level 1: focus on the individual client.
  + Level 2: provide info for family.
  + Level 3: Provide emotional support for family.
  + Level 4: Provide Structure assessment and intervention.
  + Level 5: Provide family therapy.
  + Structural skills
    - Identify problems/needs, define outcomes and alternatives, and confront resistance.
  + Relationship skills
    - Building rapport and express empathic understanding to families.
* **Reality therapy**
  + Underlying theory is Choice Theory
  + We all choose what we do with our lives and that we are responsible for our choices.
  + Aimed at helping individuals gain more effective control over their own lives.
  + Behavior is central to our existence and is driven by 5 genetically driven needs such as: survival, belonging, power, freedom, and fun.
* **Resiliency model**
  + Rehabilitation model addressing how a family adjusts and adapts to a disability.
  + This model specifically addresses family adaptation.

10. Assessments

**Intelligence Tests**

* **Seeks your ability to solve problems and look to learn and retain information.**
* **WAIS- III** (1997)
  + **Reports for full-scale**
  + Performance and verbal scales
  + Some changes in subtests and scores.
* **WAIS- R**
  + Most widely used construct and assessment of intelligence.
  + Strong construct validity.
  + Verbal performance and full-scale IQ scores are ratio scores.
    - Mean=100
    - SD=15
  + IQ scores reflect relative performance within one’s age group.
  + 11 subtests
    - Mean=10
    - SD= 3
  + IQ Score Values
    - 130 very superior
    - 120-129 superior
    - 110-119 high average
    - 90-109 average
    - 80-89 low average
    - 70-79 borderline
    - <70 ID

**Aptitude Tests**

* **General Aptitude Test Battery (GATB)**
  + Mean= 100
  + SD= 20
  + Developed by DOL and used by state employment offices and many rehabilitation sites.
* **CRC**

**Note: GRE** is an achievement test

**Personality Tests**

* **Minnesota Multiphasic Personality Inventory II (MMPI-II)**
  + Most widely used personality test for diagnosing psychopathology
    - 4 basic validity scales
    - 10 basic clinical scales
      * Hypochondriasis
      * Depression
      * Conversion
      * Hysteria
      * Psychopathic deviate
      * Masculinity-femininity
      * Paranoia
      * Schizophrenia
  + Mean=50
  + SD= 10
  + 567 T/F items
  + Can be hand-scored or through computer.
  + Basic use is to diagnose psychopathology.
  + Basic clinical scales
    - Hypochondriasis
* **Rorschach personality tests-** inkblot used to diagnose psychopathology and are impressionistic.
* **16 Personality-Factors (16 PF)**
* **California Psychological Inventory (CPI)**
* **Meyers-Briggs Type Indicator**

**Interest Inventories**

* **Self-Directed Search**
  + John Holland environment and personality model.
  + Can be self-administered, scored, and interpreted.
  + RIASEC personality types used in this assessment.
  + Individual working environments compatible with personality styles= satisfaction with work.
* **Wide-Range Interest Opinion Inventory**
* **Kuder Interest Inventory**

**Dictionary of Occupational Titles (DOT)**

* Published by DOL and classified by digit codes. Covers 12,000 occupations.
* Occupational Information Network (O\*Net) replaced it.
* 9-digit codes used in VR to look up vocations that would fit well w/ client in developing the IPE.
* **DOT Digits**
  + First 3: occupational category
    - 1- category
    - 2- division
    - 3- group
  + **4-6:** specify job’s relationship to the data
  + **7-9:** gives each job a unique code.
  + **First 6 are most important to the counselor** and each group falls alphabetically.
  + Helpful for determining transferable skills.
* **Related information:**
  + **Physical demands**
    - **1-** lifting, carrying, pulling
    - **2-** climbing, balancing
    - **3-** stooping, bending, kneeling, crouching, and crawling
    - **5-** reaching, handing, fingering, grasping
    - **6-** speaking and hearing
    - **7-** vision
  + **Work conditions**
    - Environmental conditions (inside/outside, heat/cold, warm/humid/dry, noise levels)
  + **Specific Vocational Preparation (SVP)**
    - Training and experience required to do the job.
    - **1:** short demonstration only (unskilled)
    - **2:** up to 30 days of training (unskilled)
    - **3:** 30 days - 3 months (semi-skilled)
    - **4**: 3-6 months (semi-skilled)
    - **5:** 6 mos.- 1 yr. (semi-skilled)
    - **6:** 1 yr.- 2 yr. (semi-skilled)
    - **7:** 2 yr. -4 yr. (skilled)
    - **8:** 4 yr. – 10 yr. (skilled)
    - **9:** > 10 yr. (skilled)
    - Levels 5-9 require vocational training and/or college.
  + **Skill levels**
    - **1-2** unskilled
    - **3-6** semi-skilled
    - **7-9** skilled
  + Helps with job analysis and identifying transferable skills.
* **Psychological Evaluations** provide information regarding intelligence, aptitudes, achievement, personality, interests, and adjustment related to vocational Functioning.
  + Establishes presence of cognitive or psychiatric Diagnoses.
* **Apticom**- a computerized aptitude test designed to replace the GATB. Yields immediate results.
* **WAIS-IV**:
  + Generates 2 broad scores:
    - Full scale IQ (FSIQ) based on the total combined performance of four indexes.
    - General Ability Index (GAI) based on the 6 subtests that comprise the Verbal Comprehension Index (VCI) and the Perceptual Reasoning Index (PRI).
      * GAI can be used as a measure of cognitive abilities which are less vulnerable to impairment.
  + Consists of 10 subtests and 5 supplemental subtests and generates 4 indices:
    - VCI includes 4 subtests:
      * Similarities
      * Vocabulary
      * Information
      * Comprehension
    - PRI includes 5 subtests:
      * Block design
      * Matrix reasoning
      * Visual puzzles
      * Picture completion
      * Figure weights
    - Working Memory Index (WMI) obtained from 3 subtests:
      * Digit span
      * Arithmetic
      * Letter-number sequencing
    - Processing Speed Index (PSI) includes 3 subtests:
      * Symbol search
      * Coding
      * Cancellation
* **Stanford-Binet 5 (SB-5):**
  + Consists of 10 subtests (5 verbal and 5 nonverbal)
    - Nonverbal subtests can be used for people w/ hearing impairments, communication disorders, and limited English-language background.
  + Yields FSIQ, verbal IQ and nonverbal IQ scores, and 5 factor indexes (fluid reasoning, knowledge, quantitative reasoning, visual-spatial reasoning, and working memory)
* **Peabody Picture Vocabulary Test-3 (PPVT-III)**
  + Untimed, easily administered (10-12 mins), oral test of intelligence.
  + Reading is not required, and responses are indicated by pointing.
  + Applicable for people with ID.
* **Slosson Intelligence Test- Revised (SIT-3)**
  + Easily administered oral test of verbal intelligence.
  + Quick screening test of intelligence.
  + Can be used for people w/ visual impairments, reading difficulty, and physical disabilities

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* **General Aptitude Test Battery (GATB**):
  + measures 8 different aptitudes via 12 timed tests.
  + 9 aptitude factor scores are based on the 12 subtests:
    - **G:** General learning ability
    - **V:** Verbal aptitude
    - **N:** Numeric aptitude
    - **S:** Spatial aptitude
    - **P:** Form perception
    - **Q:** Clerical perception
    - **K:** Motor coordination
    - **F:** Finger dexterity
    - **M:** Manual dexterity
  + Yields 3 composite scores:
    - Cognitive
    - Perceptual
    - Psychomotor
  + M= 100 and SD=20
  + Lengthy time which takes about 2 hours to administer.
* **Differential Aptitude Tests (DAT)**
  + Used for vocational plus educational counseling guidance.
  + 2 levels:
    - Level 1: Grades 7-9
    - Level 2: Grades 10-12
  + Can also be used with adults.
  + Takes about 156 minutes to administer.
  + Consists of 8 subtests:
    - Verbal reasoning
    - Numerical reasoning
    - Abstract reasoning
    - Perceptual speed and accuracy
    - Mechanical reasoning
    - Space relations
    - Spelling
    - Language usage
* **Self-Directed Search (SDS):** 
  + Self-administered, self-scoring, and self-interpreted vocational interest assessment.\
  + Based on Holland’s Theory.
* **Strong Interest Inventory (SII)**
  + Based on Holland’s theory and yields 6 personality scores (RIASEC)
  + Four major sections:
    - Six general occupational themes
    - 30 basic interest scales
    - 244 occupational scales
    - 5 personal style scales
* **Reading Free Vocational Interest Inventory- 2(R-FVII-2)**
  + Identify vocational preferences for CD/LD through illustrations of individuals engaged in various occupational tasks.
  + Used w/ people w/ ID age 13 and older.
  + Provides scores for 11 interest areas for men and women.
* **McCarron-Dial Evaluation System (MDS)**
  + Work sample assessment used to predict ability for community-based employment.
  + Test battery containing 8 instruments that assess 5 factors:
    - Verbal-cognitive
    - Sensory
    - Motor
    - Emotional
    - Integration
  + Basic battery=3 hours to administer
  + Comprehensive battery= 5 days to administer
* **VALPAR**
  + Analyzes work samples through Methods-Time-Measurement standards (MTM):
    - Analyze tasks to determine how long it would take an experienced employee to repeatedly perform the exercise over an 8-hour workday.
* **Situational Assessments:**
  + Consumer’s job performance and work behaviors observed in a realistic and controlled work environment such as a rehab facility or sheltered workshop.
  + AKA community-based situation assessment, job tryouts, on-the-job evaluation (OJE), and SE evaluation.
  + Focuses on work potential regarding the ability to:
    - Accept supervision
    - Get along with coworkers
    - Stay on task
    - Sustain productivity for 8 hours
    - Tolerate frustration.
* **Ecological Assessments**
  + Occur in a natural setting such as the worksite where the person can potentially become a long-term employee.
  + Evaluate the person’s capacity to meet the productivity demands of that setting at present or in the near future through the provision of training or on-the-job supports.
  + Ex: SE placements and OJE’s.
* **OJE’s**
  + Can occur within work stations in institutions, rehab facilities, business and industries focusing on a variety of variables including personality, attitudes, aptitudes, work traits, work skills, and physical capacities.
  + Can range from 1-day to 1 month or longer.
* **Bender-Gestalt:** The Bender Visual Motor Gestalt Test (abbreviated as Bender-Gestalt test) is a psychological test used by mental health practitioners that assesses visual-motor functioning, developmental disorders, and neurological impairments in children ages 3 and older and adults.
* **WRAT-4:** Good test for RC’s who want to determine a client’s basic reading and arithmetic capabilities for future training.
  + Brief measure of overall academic achievement when consumer has not had recent educational experience.
  + Measures:
    - Sentence comprehension, word reading, spelling, and math computation.
  + 35-45 minutes to administer.
* **Haptic:** intelligence test for the blind.
* **Peabody Individual Achievement Test-R (PIAT-R)-** wide range screening measure in math, reading, spelling, and general info.
  + Has 6 sub categories (math, reading recognition, reading comprehension, spelling, general info, and a total score).
* **Adult Basic Learning Exam (ABLE):** used to determine the general education level of adults who have not completed a formal 8th grade education.
* **Minnesota Multiphasic Personality Inventory-2 (MMPI-2)**: most widely used personality inventory.
  + Designed for adults age 16 and older.
  + 567 statements
  + 10 clinical scales used:
    - Hypochondriasis (Hs)
    - Depression (D)
    - Conversion Hysteria (Hy)
    - Psychopathic deviate (Pd)
    - Masculinity-Femininity (MF)
    - Paranoia (Pa)
    - Psychasthenia (Pt)
    - Schizophrenia (Sc)
    - Hypomania (Ma)
    - Social introversion (O or Si)
* **Myers-Briggs Type Indicator (MBTI):** based on Jung’s concepts of perceptions and judgment. Score is summarized in 4 letters.
  + There are 8 scales yielding 4 bi-polar dimensions:
    - Extroversion (E) vs Introversion (I)
    - Sensing (S) vs Intuition (N)
    - Thinking (T) vs Feeling (F)
    - Judgment (J) vs Perception
  + Yields 16 different personality types.
* **Sixteen Personality Factors (16-PF):** measures personality among 16 primary factors.
  + Has 128 questions
  + Requires a 3rd-6th grade reading level.
  + 16 factors:
    - Warmth, reasoning emotional stability, dominance, liveliness, rule-consciousness, social boldness, sensitivity, privateness, apprehension, openness to change, self-reliance, perfectionism, and tension.
* **Scales of Measurement**
  + **Nominal:** any categorical variable (assigns numerals but doesn’t distinguish size or amount).
  + **Ordinal:** Indication of rank/ordering (placing 1st, 2nd, and 3rd).
  + **Interval:** equal intervals on the scale (e.g., Celsius temperature scale).
  + **Ratio:** Possesses a nonarbitrary zero point (e.g., measures of weight).
* **Forms of Reliability**
  + **Test-retest:** a measure of consistency overtime. Relationships b/w scores on 2 administrations of the same test.
  + **Split-half:** measures internal consistency. Indicate consistency of scores on two different parts of the test (e.g., odd vs. even items).
  + **Parallel forms:** correlation indicates the consistency of scores on two alternate, but equivalent forms of the same test taken at the same time.
  + **Cronbach’s Alpha:** internal consistency statistic calculated from the pairwise correlation b/w items.
* **Forms of validity**
  + **Face validity:** Looking at the test’s content and making a basic appraisal based on the “face of the test”
  + **Content validity:** evaluation by SME’s of the test items’ representativeness of the construct being measured.
  + **Criterion or predictive validity:** comparison of the test with a related outcome measure.
  + **Construct validity:** extent to which the measure actually measures the theoretical construct.
* **Raw score:** performance on a test (percent of items correct).
* **Z scores:**
  + M= 0
  + SD= 1
* **T-scores:**
  + M=50
  + SD= 10
  + Measure differences b/w groups.
* **IQ scores:**
  + M=100
  + SD= 15
* **VDARE-** **Vocational Diagnosis and Assessment of Residual Employability (transferable skills)**
  + Level of education, aptitude, and vocational functioning a person has following an injury is abbreviated on the VDARE as the RFC (Residual Functioning Capacity).
  + The vocational assessment and evaluation of an individual’s earning power following the onset of injury and/or illness is generally considered a multi-dimensional process of reviewing pertinent medical information, gathering relevant data through interviewing, and determining an individual’s worker traits and job skills that have the potential for transferability to the examinee’s so-called residual functional capacity (RFC).

11. Program Evaluation

* **5 phases:**
  + **Needs assessment**
    - Study whether there are problems that need to be addressed in program operations or participants.
  + **Assessment of Program Theory**
    - To solve problems according to a theoretical assumption.
  + **Formative/Process Evaluation**
    - Monitors a program.
  + **Summative/Outcome Evaluation**
    - Assess program’s impact on outcomes
  + **Efficacy Assessment**
    - To examine whether a program is worthy.
* **1979 Belmont Report:**
  + Established 3 basic principles for ethical research on human subjects:
    - Beneficence
      * + Research should do no harm and should be constructed to maximize the benefits of research.
      * Autonomy
        + Subjects provided w/ opportunity to make conscious and informed decisions about participating in research.
        + Informed consent.
      * Justice
        + Requires that researchers consider the issue of fairness and equity when selecting individuals for research.

12. Medical & Psychosocial Aspects of Disability

* **13 body systems:**
  + **Circulatory:** pumps and channels blood
    - Cardiovascular disease
  + **Digestive:** digests and processes food
    - GI hemorrhaging and liver disease
  + **Endocannabinoid:** appetite, pain perception, mood, memory, and motor learning.
    - MS
  + **Endocrine:** regulates body function
    - Diabetes mellitus
  + **Integumentary:** protects the body
    - Burns
  + **Immune system:** protects against disease
    - HIV and inflammatory arthritis
  + **Lymphatic:** circulates lymph
    - Lymphoma
  + **Musculoskeletal:** provides support and movement
    - Amputation
  + **Nervous:** processes information
    - TBI
  + **Reproductive:** for generation
    - STD’s
  + **Respiratory:** for breathing
    - Asthma
  + **Urinary:** balances body fluid
    - UTI
  + **Vestibular:** controls balance and special orientation
    - Vestibular balance disorders
* **Chronic obstructive pulmonary disease (COPD)**
  + 3rd leading cause of death in US
  + Most common pulmonary disorder that can cause disability.
  + Progressive disease that makes it hard to breathe (gets worst over time).
  + Leading cause is smoking followed by air pollution, chemical fumes, or dust.
  + **2 types:**
    - **Chronic obstructive bronchitis** (Disease of the airways).
    - **Emphysema** (affects airways and the alveoli).
  + **Treatment:**
    - Inhaled meds, antibiotics to treat infections, and corticosteroid drugs for inflammation.
  + **Cystic fibrosis (CF)**
    - Genetic disease in which thick, dehydrated mucus secretions lead to infection and destruction of obstructed lung passageways leading to progressive respiratory insufficiency.
  + **Accommodations:**
    - Take into consideration the energy demands involved w/ travel to and from work.
    - Allow access to supplemental oxygen and avoid placing patients w/ chronic cough near others.
    - Persons w/ asthma should avoid work environments containing pollutants to which they are sensitive (e.g., tobacco smoke, pollen, animal dander, and chemicals).
    - May need time for airway clearance techniques or antibiotic therapy during the work day.

**Cardiovascular Diseases**

* **Coronary Artery Disease (CAD)**
  + Leading cause of death in US.
  + Plaque accumulates in the blood vessels and produces stenosis (hardening and narrowing of the blood vessels), ischemia (restriction of blood supply), and blood clots (thrombus).
  + Medications purpose to increase blood flow.
  + **Accommodations:**
    - Focus on fatigue/weakness (e.g., reducing amount of physical exertion)
    - Respiratory difficulties (e.g., avoiding temperature extremes), and stress (e.g., providing counseling).
* **Arrhythmias:** abnormal heart rate or rhythm.
* **Congestive Heart Failure (CHF)**
  + Severity leads to experiencing severe fatigue, physical weakness, anorexia, nausea, vomiting, & possible cognitive changes.
  + **2 common types:**
    - **Dyspnea:** difficulty breathing
    - **Edema:** swelling of extremities

**SCI**

* Almost ½ result from car accidents.
* More than 80% occur in men w/ average age of injury at 40 y/o.
* Complete and incomplete injuries.
* **Cervical level damage** will lead to impaired function in both upper and lower extremities (tetra and quadriplegia).
  + **Quad/Tetraplegia** affects all 4 limbs (damage from C1-C7)
* **Thoracic (or below) level damage** will lead to paraplegia (function maintained in upper extremities, but some degree of impairments in lower extremities).
  + **Paraplegia** affects lower extremities.
* **Damage at C3 or above** typically requires a ventilator.
* **Complete C4 injury** requires assistance w/ nearly all ADL’s.
* **Injuries occur below T12** may be able to walk w/ crutches & braces.
* **Sacral lesions** may result in loss of voluntary control of bowel & bladder functions.
* **T6 injuries** may result in autonomic hyperreflexia (an episode of severe hypertension that can produce a severe headache, dizziness, sweating, and risk of stroke).
* **Complications include:**
  + Spasticity (hypertonia), permanent joint contractures, pressure sores (decubitus ulcers), osteoporosis, bone fractures, repeated lung infections, sexual dysfunction, repeated UTI’s, and kidney/bladder damage.
* **Accommodations:**
  + **Focus on ADL** (e.g., personal assistant @ work to help w/ grooming, toileting, & eating).
  + **Workstation access** (e.g., alt access for comps such as speech recognition).
  + **Worksite access** (e.g., accessible restrooms, lunchrooms, and breakrooms).
  + **Work travel** (e.g., accessible transportation).

**MS**

* Chronic & unpredictable disease that attacks the CNS.
* Typically experience 1 of 4 disease courses.
* **Relapsing-remitting MS**
  + About 85% initially diagnosed w/ this.
  + Experience attacks of worsening neurologic function (relapses) followed by partial or complete recovery periods (remissions).
* **Secondary-progressive MS**
  + Disease worsens more steadily.
  + Exacerbation, relapses, &/or plateaus may not occur.
* **Primary-progressive MS**
  + Slowly worsening neurological functioning w/ no periods of remission.
* **Progressive-relapsing MS**
  + Steadily worsening disease along w/ periods of exacerbations which may or may not be followed by periods of remission.
* **Typical symptoms:**
  + Fatigue, numbness, walking/balance/coordination problems, bladder dysfunction, bowel dysfunction, vision problems, dizziness and vertigo, sexual dysfunction, pain, cognitive dysfunction, emotional changes, depression, & spasticity.
* **Treatment:**
  + Immunomodulatory drugs alter course by slowing progression & reducing relapse rate.
  + Steroidal meds reduce severity & duration of exacerbations.
* **Accommodations:**
  + **Weakness/fatigue** (e.g., modified work schedule).
  + **Motor dysfunction** (e.g., automatic door openers).
  + **Cognitive problems** (e.g., written memos).
  + **Sensory problems** (e.g., use of large print).
  + **Heat insensitivity** (e.g., air-conditioned work environment).

**Diabetes**

* **Type 1**
  + AKA juvenile or insulin dependent.
  + Typically, 1st diagnosed in children, teens, or young adults.
  + Beta cells in pancreas stop producing insulin because body’s immune system has destroyed them.
  + Acute onset
  + **Symptoms:**
    - Frequent urination, drinking, eating, and weight loss.
  + Severe attack can cause coma/death.
* **Type 2**
  + AKA adult-onset
  + Most prevalent form of diabetes.
  + Insulin resistance: fat, muscle, and liver cells fail to use insulin properly & over time the pancreas loses the ability to secrete sufficient insulin in response to increased blood sugar levels.
  + Overweight & inactive 🡪 Type 2.
  + Slower & insidious onset.
  + **Symptoms:**
    - Fatigue, nighttime urination (nocturia), and vision difficulties.
  + **Long term complications:**
    - Damage to eye (retinopathy).
    - Kidney (end-stage renal disease).
    - Nerve function.
    - Cardiovascular & peripheral vascular disease (e.g., foot ulcerations, gangrene, & amputations).
  + **Treatment**
    - Medication, nutrition, exercise, and self-monitoring blood glucose.
* **Gestational**
  + Occurs in some women during late stages of pregnancy & typically resolves after baby is born.
  + However, now at higher risk of developing Type 2.
* People taking insulin or oral hypoglycemic agents need a work schedule and level of physical activity that remains as consistent as possible.
* Diabetic retinopathy leads to more visual disability than any other eye disease.
  + Almost all people with Type 1 and nearly 60% of people w/ Type 2 will develop this disease.
* **Accommodations:**
  + **Hypo/hyperglycemia** (e.g., allow for storage of meds such as insulin).
  + **Neuropathy** (e.g., modifying job tasks that require fine finger dexterity).
  + **Fatigue/weakness** (e.g., providing a rest area with a cot).
  + **Kidney disease** (e.g., time off for dialysis).

**Hepatitis**

* Associated w/ liver inflammation and swelling.
* **Causes:**
  + Immune cells attacking the liver.
  + Infection from virus (e.g., hepatitis A, B, and C).
  + Liver damage from alcohol
  + Overdose of medication.
* May start and recovery rapidly (e.g., acute hepatitis, hepatitis A) or long-term disease (chronic hepatitis, liver damage, liver failure, and liver cancer).
* **Symptoms:**
  + Abdominal pain or distention.
  + Breast development in men.
  + Dark urine and pale or clay-colored stools.
  + Fatigue.
  + Fever (usually low grade).
  + General itching.
  + Jaundice (yellowing of eyes/skin).
  + Loss of appetite.
  + Nausea and vomiting.
  + Weight loss.
* Persons w/ **hep B or C** do not have symptoms when they are first infected but may develop liver failure later.
* **Major Accommodation:**
  + For fatigue/weakness (e.g., flexible leave).

**Chronic Pain**

* Persists longer than 6 months.
* Low back pain effects 60-80% of all people in US at some point in their lives.
* **Complex Regional Pain Syndrome (CRPS):**
  + AKA reflex sympathetic dystrophy
  + Neuropathic pain syndrome that develops when the PNS & CNS becomes over-reactive after initial localized injury.
  + **Usually experience** 
    - Electrical shooting and burning pain
    - Allodynia (pain from stimuli that isn’t usually painful).
    - Dysesthesia (unpleasant sensations).
    - Hyperalgesia (increased sensitivity to pain)
    - Tremors.
    - Swelling.
    - Hyperhidrosis (excessive sweating).
    - Edema
    - Color and temperature changes of skin.
    - Muscle atrophy that occurs when range of motion is limited by pain, contractures, and inability to use muscles due to pain.
* **Migraines**
* **Myofascial pain syndrome**
  + Connects jaw muscles to temporal bones).
* **Fibromyalgia**
  + Generalized aching.
  + Wide spread muscle tenderness.
  + Muscle stiffness.
  + Fatigue.
  + Poor sleep.
  + More common in women.
* **Treatment requires a multidisciplinary approach.**
* **Accommodations:**
  + **Focus on activities of ADL** (e.g., use personal attendant at work).
  + **Depression and anxiety** (e.g., developing strategies to deal w/ work problems before they arise).
  + **Fatigue and weakness** (e.g., reducing or eliminating physical exertion and workplace stress).
  + **Muscle pain and stiffness** (e.g., implementing ergonomic workstation design).
* **Causalgia**- condition causing intense pain that cannot be cured.

**Cancer**

* 2nd leading cause of death in US.
* Disorderly and uncontrollable growth and spread of abnormal cells.
* **Eastern Cooperative Oncology Group Scale**
  + Most often used scale to categorize a patient’s functional capacity.
  + Range from 0-4:
    - 0 (normal activity w/o physical limitation).
    - 4 (in bed 100% of the time).
* Lasting fatigue has biggest impact on work.
* **Accommodations:**
  + Focus on fatigue (e.g., reducing physical exertion, scheduling rest breaks, and allowing time off for medical treatment).

**Hematological Disorders**

* **Lymphoma**
  + Lymphocyte undergoes a malignant change & begins to divide uncontrollably.
  + May present w/ nodal disease (swollen, growing lymph glands) or extra nodal disease (tumors in other organs).
  + **Symptoms:**
    - Fever.
    - Drenching night sweats.
    - Itching.
    - Loss of more than 10% of body weight.
  + **Accommodations:**
    - Fatigue (e.g., reducing physical exertion).
    - Allow time off for medical treatment.
* **Leukemia** 
  + Abnormal proliferation of leukocytes in bone marrow, resulting in lack of normal bone marrow cells.
  + Acute leukemia leads to critical illness w/ symptoms of low blood count.
    - Weakness.
    - Shortness of breath.
    - Infection.
    - Fever.
    - Bleeding.
  + **Residual long-term problems:**
    - Fatigue
    - Decreased energy levels.
    - Depression.
    - Employment problems.
    - Marital problems.
    - Negative body image.
  + **Accommodations:**
    - Fatigue (e.g., reducing physical exertion).
    - Allow time off for medical treatment.
* **Hemophilia**
  + Congenital illness in which there is a defect in number or function of platelets.
  + Bleeding can occur anywhere, such as bleeding in joints (hemarthrosis), soft tissue, urine (hematuria), and the brain.
  + Chronic bleeding into joints can lead to inflammation, scar tissue formation, and restriction of movement.
  + Bleeding into brain and spinal canal can lead to nerve damage w/ resulting functional and psychological disability.
  + Hemophiliac patients who were treated with concentrates before 1984 were at risk for HBV and HIV
  + **Accommodations:**
    - Jobs w/ direct threat of physical injury should be avoided.
* **Sickle cell disease**
  + Problem w/ hemoglobin solubility cause red blood cells to assume a nonpliable sickle shape.
  + Experience anemia and may experience an aplastic crisis (abrupt decrease in cell production), which is extremely painful event requiring hospitalization.
  + **Accommodations:**
    - Strenuous work or work environments w/ extreme temperature changes and low oxygen levels should be avoided.

**HIV**

* Gradually destroys immune system.
* AIDS is the final stage of HIV and 6th leading cause of death among 25-44 y/o in US.
* **Symptoms:**
  + Diarrhea.
  + Fatigue.
  + Fever.
  + Headache.
  + Frequent vaginal yeast infection.
  + Mouth sores.
  + Rash.
  + Sore throat.
* **Accommodations:**
  + **Fatigue/weakness** (e.g., an accessible ramp)
  + **Chronic diarrhea** (e.g., worksite near a restroom).

**Schizophrenia**

* **Positive symptoms:**
  + **Delusions**
    - Erroneous beliefs involving misinterpretation of perceptions or experiences.
  + **Hallucinations**
    - Perceptual distortions that can occur in any sensory modality such as gustatory (taste), visual, olfactory (smell), and touch (tactile).
    - Auditory are most common.
  + **Disorganized speech** 
    - Loose associations and use of neologisms (use of newly coined terms/words).
  + **Grossly disorganized or catatonic behavior**
    - Unpredictable agitation and difficulties performing ADLs.
* **Negative symptoms:**
  + Flat affect (lacking emotional expression).
  + Poverty of speech (Alogia).
  + Lack of motivation (Avolition).
* **May experience impairments in:**
  + Verbal and nonverbal memory
  + Working memory
  + Attention
  + Executive functioning
  + Processing speed
* **Schizoaffective disorder:**
  + When person experiences symptoms of schizophrenia and a co-occurring affective disorder such as depression and/or mania.
* **Schizophreniform**
  + Experiences sufficient symptoms of schizophrenia but the symptoms have not been present for at least 6 months.
* **Pharmacological Treatments:**
  + Antipsychotic meds have significant side effects:
    - Tardive dyskinesia (involuntary stereotyped movements of the mouth and face).
    - Hypotension.
    - Tremors of the arms.
    - Rigidity in extremities.
    - Internal listlessness (akathisia): agitation, distress, restlessness.
    - Dry mouth
    - Blurred vision
    - Sexual dysfunction
    - Weight gain

**Depression**

* 10-25% women and 5-12% of men.
* Dysthymic disorder has many features like depression but less vegetative symptoms (e.g., sleep problems, appetite problems, weight changes, and psychomotor symptoms).
* Symptoms:
  + Negative and pessimistic beliefs.
  + Negative self-image.
  + Suicidal thoughts
  + Difficulty concentrating
  + Physical symptoms (e.g., lethargy, insomnia, hypersomnia, loss of appetite, overeating, and loss of sexual interest).
* **Pharmacological Treatments:**
  + Antidepressant meds
  + Tricyclics and monoamine oxidase inhibitors, and SSRI’s.
  + Reuptake inhibitors and dopamine and norepinephrine uptake inhibitors.

**Bipolar disorder**

* **Bipolar I**
  + More severe form experiencing phases of depression and episodes of severe mania (elevated, expansive, or irritable mood lasting from several days to several months).
* **Bipolar II**
  + Less severe form experiencing periods of depression along w/ periods of hypomania.
* **Pharmacological Treatments:**
  + Mood stabilizers
  + Anticonvulsants, lithium, valproic acid, and anticonvulsant lamotrigine.

**Anxiety Disorders**

* Most prevalent of all PsyR disorders affecting approximately 29% of individuals in a lifetime.
* **Panic disorder**
  + Sudden and unanticipated attacks involving a sense of imminent doom accompanied w/ symptoms such as increased heart rate, difficulty breathing, dizziness, and terror.
* **Generalized Anxiety Disorder**
  + Constant worrying across many situations.
* **PTSD**
  + Symptoms:
    - Re-experiencing the event through nightmares, intrusive memories, physiological reactivity when exposed to internal or external cues surrounding the event.
    - Illusions
    - Hallucinations
    - Dissociative flashbacks.
  + May avoid stimuli associated w/ the traumatic event that was experienced or witnessed.
* **OCD**
* **Phobic disorder**
* **Pharmacological Treatments:**
  + Anxiolytics (antianxiety drugs such as benzodiazepine and valium.
  + Benzos have potential to lead to dependence.
  + BuSpar (buspirone) is used to treat anxiety and seems to avoid issues of dependence.
  + SSRI’s can be particularly helpful in treating panic disorder, social phobia, and OCD.

**Personality Disorders**

* **Cluster A**
  + Paranoid, schizoid, and schizotypal personality disorders.
  + Often appear to be odd or eccentric
* **Cluster B**
  + Antisocial, borderline, histrionic, and narcissistic personality disorders.
  + Often appear to be dramatic, emotional, or erratic.
* **Cluster C**
  + Avoidant, dependent, and obsessive-compulsive personality disorders.
  + Appear to be anxious or fearful.

**Persons w/ PsyR disabilities** often have difficulty relating to others, may be socially isolated, and have limited social support. Limited tolerance to stress of any kind and tend to function poorly in emotionally charged or socially critical situations.

**Substance Abuse** is a common **Co-occurring disorder** and is associated w/ increased relapses and hospitalizations, homelessness, violence, problems w/ physical health, treatment nonadherence, problems w/ legal system, and occupational probs.

**Accommodations of PsyR disabilities** include later staring time because of morning drowsiness because of meds and flexible leave for therapy.

**TBI**

* Leading cause in young children and elderly is falls.
* Leading cause in adolescents/young adults is car accidents, followed by violence, assault, and suicide attempts.
* Described as open, closed, blunt, sharp, penetrating, or nonpenetrating.
* Brain contusions (bruises to the brain) caused by Coup (injury to initial impact of brain against the skull) and contrecoup (injuries that occur as the side of the brain opposite the initial impact rebounds against the skull).
* **Glasgow Coma Scale** 
  + Used to determine level of responsiveness.
  + Scores from 3 (more severe injury) to 15 (least severe injury).
* **Physical problems:**
  + Balance problems, fatigue, pain, weakness on one side of body (hemiparesis), uneven gait, movement coordination/gait problems (ataxia), motor planning problems (apraxia), decreased motor speed, seizure disorders, and sensory deficits.
* **Cognitive problems:**
  + Impairments in attention/concentration, memory, visual or auditory processing, verbal reasoning, critical thinking, language, and awareness.
* **Psychosocial problems:**
  + Personality changes, emotional lability, depression, flat affect, substance abuse, low frustration tolerance, impulsivity, disinhibition, and lack of initiative.
* **Accommodations:**
  + Provide written instructions.
  + Assign 1 task at a time.
  + Allow additional time to perform tasks.

**CP**

* Non-progressive, noncontagious motor conditions that appear in infancy or early childhood.
* **Caused by** abnormalities in parts of the brain that control muscle movement and that affect muscle tone, movement, and motor skills.
* **Types of CP:**
  + **Spastic** (muscle and joints are tight, abnormal walk).
  + **Dyskinetic, ataxic, hypotonic, and mixed.**
* **Symptoms:**
  + Abnormal movements (twisting, jerking, or writhing) of the hands, feet, arms, or legs while awake, which get worst during periods of stress.
  + Tremors
  + Unsteady gait
  + Loss of coordination
  + Floppy muscles
  + Some have decreased IQ, speech problems, hearing/vision diseases, or seizures.
* **Accommodations:**
  + ADLs (accessible restrooms)
  + Fine motor control (writing aids)
  + Gross motor control (unobstructed hallways).

**Epilepsy**

* **Partial seizures**
  + Initial activation of system of neurons limited to 1 part of a single cerebral hemisphere.
  + Classified according to whether consciousness is impaired.
  + **Complex partial seizure**
    - Consciousness is impaired.
    - Symptoms: repetitive motor movements, fumbling with hands, lip smacking, or aimless wandering.
    - Usually experience a brief aura or warning before an oncoming seizure.
  + **Simple partial seizure**
    - Consciousness is not impaired.
    - These may evolve into complex partial seizures or generalized seizures (involving both hemispheres).
    - May involve motor, sensory, autonomic, or a combo of symptoms w/o impaired consciousness.
    - Usually last less than 30 seconds and not always related to problems in job performance.
* **Generalized seizures**
  + Seizures appear to begin simultaneously in both hemispheres.
  + Consciousness is usually impaired.
  + **Generalized Tonic-Clonic**
    - Most common generalized seizure.
    - Body becomes rigid (tonic) for a period of seconds and then the individual begins to experience a series of rhythmic jerking (clonic) movements.
    - Lasts about 1-3 minutes.
    - **Status epilepticus** is a true medical emergency where a tonic-clonic seizure lasts more than 10 minutes or if the individual has had several seizures within this time and has not regained consciousness.
  + **Absence seizure (Petit Mal)**
    - Brief disruption of consciousness (usually less than 20 seconds)
    - Autonomic symptoms such as dilated pupils and mild rhythmic moves of the eyelids, but sometimes involve blank stares.
* **Treatments**
  + Antiepileptic meds.
  + Neuropsychological evaluation is essential when developing a rehab plan.
* **Accommodations**
  + Focus on workplace safety (e.g., keep aisles clear of clutter)
  + Memory (e.g., provide written or pictorial instructions).

**Burns**

* Described by depth of damage.
* **First-degree (partial thickness)**
  + Involve damage to upper layer of skin (epidermis).
* **Second-degree (deep partial thickness)**
  + Burns extend to the upper layers of the dermis, but sufficient dermal tissue remains.
  + Spontaneous local healing can occur generally and heal over 2-3 weeks if treated appropriately.
  + Can result in severe scaring.
* **Third-degree (full thickness)**
  + Complete damage to all layers of the skin and involve loss of vascular and neural structures.
  + Rehab focuses on scar management, therapeutic exercise, pain management, psychological problems, and surgery.
  + May require extensive reconstructive surgery and hospitalization over a 1-2-year period.
  + Cosmetic issues that may limit occupations involving contact w/ the public.
* **Accommodations:**
  + Individuals w/ skin grafts may not be appropriate for work environments w/ extremes of temperatures or outside work w/ sun exposure.
  + Individuals w/ reduced lung function may need to avoid work environments filled w/ dust, smoke, or other air pollutants.

**Visual Impairment**

* **Samuel Howe** was an educator for the Blind and developed a specific alphabet for them.
  + Personal adapted mobility aid for the elderly blind.
* **Legal blindness** 
  + Visual acuity of less than 20/100 or if central visual field is restricted to 20 degrees or less in the widest meridian of the better eye.
* **Glaucoma or retinitis pigmentosa** creates a peripheral field defect leaving only a small central field of vision intact.
* **Cataract** is a clouding that can occur in any or all parts of the lens resulting in decreased visual acuity, loss of contrast, and glare.
* **Macular degeneration** is one of the leading causes of visual impairments in older adults.
  + **Symptoms:** object distortion, decreased visual acuity and color recognition, loss of contrast, or scotoma.

**Hearing Impairment**

* **4 types of hearing loss**
* **Conductive**
  + outer or middle ear damage.
* **Sensorineural**
  + Inner ear and/or auditory nerve.
  + Presbycusis is progressive sensorineural hearing loss because of aging.
  + Most sensorineural loss does not respond to medical or surgical intervention.
* **Mixed**
  + Both conductive and sensorineural component.
* **Central**
  + Damage along the auditory pathway or in the brain itself.

**Assessment Concepts of Human Daily Function**

**Personal Care Activity assessments**

* Ex: The Barthel Index
* Involves person’s ability to take care of him or herself, including hygiene, dressing, eating, toileting, caring for physical well-being, diet, and fitness. Also, ability to transport oneself to required places to perform self-care and transfer one’s body from one location to another as needed.

**Body Function Assessments**

* Evaluations of neuromuscular and movement-related functions, such as mobility of joints and bones, muscle tone, reflexes, and gait patterns.

**Assessments of ADL**

* Ex: Katz ADL scale
* Commonly based on clinical observation of clients when engaging in self-care activities in the environment in which they are usually performed.
* Interviews of clients and caregivers are often used as well.

13. Vocational Rehabilitation

**Rehab Act of 1973**

* Mandated that states begin serving PWD w/ most significant disabilities before those w/ less severe disabilities.
* Client-Counselor joint involvement in development of IWRP.
* Implemented pilot project CAP programs to rec assistance w/ application and advocacy services.
  + CAP was mandated in 1984.
* Demonstration projects for ILS.
* Mandated program evaluation and accurate data tracking.
* Established the Nat’l Institute of Handicapped Research 🡪 NIDRR; increased funding for disability and rehab research.
* Advanced civil rights of people through Title V
* **Rehab Act 1973 Title V**
  + **Section 501**
    - Mandated nondiscrimination and affirmative action in federal hiring.
  + **Section 502**
    - Est Architectural & Transportation Barriers Compliance Board to oversee compliance to the Architectural Barriers Act of 1968.
  + **Section 503**
    - Prohibited discrimination in employment on basis of disability and required affirmative action plans among recipients of federal contracts and their sub- contractors of amounts more than $10k; and employers or contractors w/ >50 employees $50k.
  + **Section 504**
    - Prohibits disability-based exclusion of otherwise qualified PWD from participation in any federal program/activity or one that receives federal funding (including school districts, colleges, universities, hospitals, day care programs, public welfare agencies, or nursing homes).

**Rehab Act Amendments of 1992**

* Increased client involvement and participation in development, implementation, and evaluation of the IWRP.
* Rehab Advisory Councils to guide state VR policies and procedures (most members should be PWD).
* Increase access to VR services by presumption of benefit.
* 60-day eligibility determination.
* Prepare more minority backgrounds to become rehab counselors.
* Increased state-fed match to 78.7%.

**Workforce Investment Act (WIA) of 1998**

* Linked VR program to the state’s Workforce Development System.
* Purpose: to streamline services by integrating multiple employment and training programs in one agencies, where clients can easily access employment info and services they required through a “One-stop” system.
* VR is a mandated partner and must provide services to some extent via the one-stop center.

**Rehab Act Amendments of 1998**

* Streamline and increase access to services by establishing eligibility for people receiving SSI/SSDI.
* IPE replaces IWRP (emphasize employment focus of VR program).
* Clients can develop their own plans or in conjunction w/ an RC.
* Expand outreach to minorities as they experience higher rates of disabilities.
* Improved due process by establishing policies and procedures related to mediation of disputes and provide hearings before impartial hearing officers.
* Increased acceptable employment outcomes: telecommuting, self-employment, and small business operation.

**Case and Caseload Management**

**Case Management**

* Process of coordinating and integrating case services.
* **Involves:**
  + Intake interviewing
  + Assessment and evaluation
  + Planning, coordinating, and evaluating services
  + Recording/reporting of case information.
* **5 Knowledge Domains:**
  + **Medical Treatments and Services**
    - Pharmaceutical and pharmacological mgmt.
    - Assessing clinical info used for developing Treatment plans.
    - Est Treatment goals that meet client’s healthcare and safety needs.
  + **Community Resources and Services**
    - Community-based funding resources
    - Eligibility for community-based care
    - Crisis intervention
  + **Professional Judgment and Problem-solving**
    - Ethical and legal issues related to confidentiality, planning and goal development techniques, & applying problem-solving techniques.
  + **Cost Containment**
    - Cost analysis and determine cost-effectiveness.
  + **Psychosocial Aspects of Disability** 
    - Personality theories
    - Interaction of psychological and social factors as pertain to wellness and independence.

**Caseload Management**

* Systematic synthesis of client info from diverse sources to enhance RC decision-making and ensure the effective and efficient delivery of appropriate services to accomplish successful client outcomes w/in agency & ethical guidelines.
* Refers to mgmt. of total caseload as opposed to a single client.
* Counseling & managerial skills to ensure efficient and effective decision making and coordination of services.

**Independent Living**

* Client-driven movement to achieve ctrl over one’s life, choosing one’s own goals, activities, and support system, including the strategies, people and animal supports necessary to accomplish objectives.
* First ILC established in 1970s in Berkeley, CA
* **Philosophy**
  + Barriers and stigma, not the disability, prevent community inclusion of PWD.
  + People have right to self-determination.
  + PWD are experts in their own self-care.
* **Rehab Act Amendments 1978**
  + Funds were authorized for provision of ILS.
* **Statewide Independent Living Councils (SILC)**
  + Client-controlled council to establish state IL plans.
* **Centers for Independent Living (CIL)**
  + Cross-disability, nonresidential, community-based nonprofit programs that provide info and referral, IL skills training, peer counseling, & individual & systems advocacy.
* **Title VII of 1998 Rehab Act Amendments**
  + Mandate services and administrative systems through which ILS are provided:
    - Est SILCs and CILs

**School-to-Work Transition Services**

**Education for All Handicapped Children Act (PL-94-142) of 1975**

* Concerning the public education of children and YWD, mandated:
  + Free & appropriate education for all SWD through age 21 or graduation.
  + Required states to identify, locate, and evaluate children who required SERS.
  + Required that education be provided in the LRE and to max intent possible to integrate w/ students’ w/o disabilities.
  + Nondiscrimination in testing and evaluation services for children w/ disabilities.

**Individuals with Disabilities Education Act (IDEA) 1990**

* Mandates that children w/ disabilities have a free appropriate public education available that includes SERS to meet their needs and prepare them for employment and IL.
* Increased focus on post-school transition and mandates transition planning in the IEP.
* Has been reauthorized several times, most recently in 2004.
* 2004 Amendments focused on transition and broadened the definition.

**Individualized Education Plan (IEP)**

* Written plan that specifies special education goals and services to meet unique education needs of a SWD.
* Beginning age 16 (or younger) a statement of needed transition services and interagency responsibilities or linkages before the student leaves school.
* Some students don’t have an IEP but still require reasonable accommodations and may have a **504 plan.**

**Rehab Act Amendments of 1998**

* Describes VR role in transition.
* Coordinate services, polices, and procedures w/ education officials responsible for provision of public education of SWD.
* Plan is designed to facilitate transition of students from receiving services in school 🡪 VR services and includes formal interagency agreement b/w state education agency and state VR agency.

**Disability Management**

* Prevention and remediation strategies to prevent disability from occurring in the workplace, and early intervention following the onset of disability.
* Development and implementation of integrated services that promote the recovery and RTW of an injured worker, prevent injury or exacerbation of injury or disability, and ctrl costs associated w/ the injury.
* **Proactive techniques:**
  + Used to reduce occupational disabilities:
    - Wellness programs.
    - Safety awareness.
    - Illness/injury prevention.
* **Reactive techniques:**
  + EAPs
  + Transitional work programs.
  + Outplacement
  + Work hardening programs.
* **Certification of Disability Management Specialists Commission (CDMSC)**
  + Independent body that protects the public by monitoring the competency of DM specialists.
* **Work Interruption Case Management**
  + Knowledge domain of DM that includes comprehensive individual case analysis/disability case mgmt., etc.
* **Disability Prevention and Workplace Intervention Plan**
  + Knowledge domain of DM involving risk mitigation, ergonomic evaluation and recommendations, health and wellness initiation, development of worksite modifications, and job accommodations.

**Forensic Rehabilitation**

* Variety of RC services provided in legal or quasi-legal settings or pertaining to legal proceedings.
* Testifying as a vocational expert in WC or SSA hearings, civil court proceedings, personal injury litigation, life care planning, marriage dissolution or family court hearings, employment discrimination, or medical malpractice cases.
* Need a graduate degree and several years of practice in RC, and knowledge in med aspects of disabilities, functional limitations, rehab and vocational potential, transferable skills analysis, marketability, and employability.

**Worker’s Compensation (WC)**

* Insurance-based program providing monetary compensation for workers who are injured OTJ.
* Prior to the establishment of WC, injured worker was forced to sue the employer to obtain payment for medical services and recover wages.
  + **3 defenses made success in these lawsuits doubtful:**
    - **Assumption of risk-** injury was a normal and accepted danger associated w/ employment.
    - **Fellow servant doctrine-** prevented recovery if the injury was caused by a fellow worker’s negligence.
    - **Contributory negligence-** prevented recovery if worker’s own negligence contributed to the accident or injury.
* WC essentially guarantees compensation benefits for workers who forego their rights to sue their employer in the event in injury.
* WC is described as a “no-fault” system, whereby benefits are paid regardless of who is at fault for the injury, if the injury or disease happened at work or was caused by work.
* Persons injured OTJ receive money to replace lost wages at a fixed amount, medical expenses, and typically VR.
* **Second Injury Fund:**
  + A fund established by the state for compensating a partially disabled employee who sustains another injury. The fund may pay the entire amount or a portion of the total amt. These funds exist to aid employers who hire handicapped or disabled workers.
* WC is an employer-funded program, achieved either through the purchase of commercial insurance or by setting up a self-insurance acct.
  + Most states have exclusion criteria for small companies and for domestic and agricultural workers.
* **Claims are typically handled by state-based compensation boards and statues** regulating eligibility, compliance, and administrations of benefits and services are **legislated at the state level.**
* Certain basic standards for provision of WC are set by fed govt.
* Fed employees, interstate railroad workers, seamen, persons loading and unloading vessels, and some construction workers working around navigable waters are covered by federal laws.
* **Fed WC programs include:**
  + Federal Employer’s Compensation Act (FECA).
  + Longshoreman and Harbor Workers’ Compensation Act.
  + Railroad Retirement and Unemployment Acts.

**WC Laws**

* Wage loss benefits are calculated using an impairment rating, a wage loss system, or loss-of-earning capacity.
* **5 Categories of Impairment Rating System:**
  + **Temporary Total Disability (TTD)**
    - Wages usually paid to claimant while s/he is off work due to a WC claim.
    - This is the worker’s status following an industrial injury or illness and a brief qualifying period of generally days or weeks.
    - Usually involves the period where a worker receives reimbursed medical services directed toward maximum medical improvement (MMI) or medical stability.
    - During this period, the worker receives wage loss benefits based on preinjury earnings while regarded by the attending physician as unable to work.
    - Wage loss benefits are 2/3 of the injured worker’s average weekly wage at the time of injury.
  + **Temporary Partial Disability (TPD)**
    - Injured worker can return to former employer in some modified capacity but at reduced function or earnings compared to the preinjury status.
    - Worker receives income maintenance at a percentage of the difference b/w preinjury and post injury earnings.
    - Usually covers the medical bills and a wage differential if the claimant can work, but not in the same capacity while recovering from a work-related injury.
  + **Permanent Partial Disability**
    - Injured person can work but has a permanent, residual deficit.
  + **Permanent Total Disability**
    - Worker is unable to work in any capacity.
  + **Survivor Death Benefits**
  + **\*\*Question:**
    - Marie is a sewing machine operator who lost the use of one eye when a needle flew into it. What is her level of disability?
      * Marie is regarded to have **permanent partial disability.** The disability is a permanent loss of the use of one eye, and she retains use of her remaining eye, making the disability partial, as the claimant still retains vision in her other eye.

**Scheduled and Unscheduled Injuries**

* In cases of permanent total disability or permanent partial disability, at the point of MMI, the attending physician determines the degree of loss, disability, or impairment, if any.
* The “Impairment Rating” is determined by medical guidelines as well as individual state statues that classify the injury as either **scheduled** or **unscheduled.**
* **Scheduled Injuries**
  + Involve the extremities, eyes, or ears.
  + Schedules of impairment list the disability and the corresponding compensable payment for the loss.
* **Unscheduled Injuries**
  + Industrial injuries not found in the statutorily defined schedule (e.g., SCI and double amputation).
  + Benefits of unscheduled injuries are calculated differently than for scheduled injuries.
  + At the date of MMI and release of RTW by the physician, the injured worker is entitled to compensation based on the diff b/w preinjury and post injury earnings.
  + The benefit is paid over the life of the worker and periodic adjustments can be made if the earnings capacity of the individual worker changes.

**Earning Capacity**

* At the time permanent partial disability or permanent total disability is determined, the individual state WC’s regulatory body receives a petition from the insurer w/ evidence of the degree of loss and offering a specific compensation settlement or award.
* At this time, litigation becomes appropriate or to be seriously considered.
* The worker has the right to protest the award and hire an attorney.
* This is an area where VR interventions may be effective.
* Vocational expert may play a vital role in the hearing process by presenting evidence on behalf of either the plaintiff (injured worker) or the defendant (insurer and employer).

**Purpose of VR in WC**

* VR has been an important benefit included in WC since 1970’s.
* The primary goal of VR services in WC is the early RTW and minimized loss of earnings capacity by the injured worker to help mitigate insurer and employer losses.

**RTW Hierarchy**

* **In WC VR, this describes the preferred order** **of service goals** and seeks to capitalize on existing capacities and relationships w/ the injured worker’s employer.
* RTW in the same job w/ the same employer.
* RTW in the same but modified job, w/ the same employer.
* RTW in a different job (capitalizing on transferable skills), w/ the same employer.
* RTW in the same job, w/ a diff employer.
* RTW in the same but modified job, w/ a diff employer.
* RTW in a different job (capitalizing on transferable skills), w/ a diff employer.
* RTW in a diff job w/ re-training, w/ the same or diff employer.
* RTW in self-employment.

**Miscellaneous Worker’s Comp**

* In a workers' compensation case the vocational expert is MOST likely to testify before a worker’s compensation board.
* **Consolidated Omnibus Budget Reconciliation Act 1986 (COBRA)** is a mandated act passed by Congress passed, allowing employees temporary continuation of health care coverage at employer's group rates (known as COBRA). The rates are only available under certain circumstances such as loss of employment either voluntary or involuntary to exclude "gross misconduct" or a reduction in the number of hours where insurance benefits are not available.
  + The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. Qualified individuals may be required to pay the entire premium for coverage up to 102 percent of the cost to the plan.
  + COBRA generally requires that group health plans sponsored by employers with 20 or more employees in the prior year offer employees and their families the opportunity for a temporary extension of health coverage (called continuation coverage) in certain instances where coverage under the plan would otherwise end.
  + COBRA outlines how employees and family members may elect continuation coverage. It also requires employers and plans to provide notice.

**Life Care Planning**

* LCP services are a form of medical and catastrophic case mgmt. involving the design of a plan of comprehensive and long-term rehab and related services for an individual who has experienced a catastrophic injury or has significant chronic healthcare needs.
* Identify and communicate the details of care that will be necessary from the point of evaluation through the projected end of the individual’s life.
* **Areas to be addressed:**
  + Projected needs for evaluations and therapies
  + Diagnostic testing
  + Edu assessments
  + Vocational and educational planning
  + Equipment needs and aids for independent functioning
  + Meds and medical supply needs
  + Care setting considerations and need for architectural renovation
  + Transportation
  + Health maintenance and services
  + Leisure and rec services
* **Interdisciplinary team involved:**
  + Physicians and medical specialists
  + OTs
  + PTs
  + Rehab professionals
  + Lawyers
  + Economists
  + Family and friends
  + The individual him/herself

**Substance Use Treatment and Rehabilitation**

* **SA**
  + Maladaptive pattern of substance use that leads to clinically significant impairment or distress as manifested in **one** **of the following areas w/in a 12-month period:**
    - Recurrent substance use that results in failure to fulfill major role obligations at work, school, or home.
    - Recurrent use in situations in which it is physically hazardous.
    - Experience substance use-related legal problems.
    - Continued use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
* **Substance Dependence**
  + Maladaptive pattern of substance use resulting in clinically significant impairment or distress but is **manifested in 3 (or more)** **of the following areas w/in a 12-month period:**
    - **Tolerance:** need for markedly increased amounts of the substance to achieve intoxication or the desired effect.
    - Withdrawal: use to avoid or relieve withdrawal symptoms.
    - Taking the substance in larger amounts or over a longer period than intended.
    - Persistent desire or unsuccessful attempts at cutting down or controlling the use.
    - Spending a great deal of time in activities necessary to obtain or use the substance or recover from the substance’s effects.
    - Giving up important social, occupational, or recreational activities because of substance use.
    - Continuing to use the substance despite knowledge of having a persistent or recurrent physical or psychological problem likely to have been caused or exacerbated by the substance.

**SA, Disability, and Rehab**

* **Prevalence** of SA disorders are nearly 2x higher among PWD (adults) compared to general population.
* More than 20% of persons eligible for VR Services experience substance use/dependence.
* PWD as well as SA disorders have lowest successful closure rates in VR agencies.
* Presence of disability significantly increases risk for SA, alcohol and illicit drug use, and prescription abuse.
* Among PWD, younger adults are more likely to use illicit drugs and older adults are more likely to abuse prescription meds.
* SA disorders are most frequently occurring comorbid disability in persons w/ mental health diagnosis.

**Models of SA Addiction**

* **Moral Model**
  + Based on beliefs about right and wrong or acceptable and unacceptable behavior.
  + SA seen as a personal choice, and individuals as capable of making alternate choices, and this model is still prevalent in public policies and attitudes.
* **Disease Model**
  + Addiction seen in terms of a medical orientation resulting from genetic predisposition, pathological metabolism, or as an acquired disease resulting from repeated exposure.
  + SA seen as a primary disease w/ progressive and irreversible stages and as chronic and incurable, thus the term “recovering” rather than “recovered” addicts is used by proponents of this perspective.
  + Abstinence, rather than cure is seen as the goal of Treatment.
* **Genetic and Biological Models**
  + Biological and genetic constitution can predispose the individual to substance dependency.
    - Difficult to separate environmental and social factors likely to contribute to the development of addiction or dependence.
* **Neurobiological Model** 
  + Actions of neurotransmitters (chemical messengers) cause chemical changes in the limbic system of the brain that may lead to addiction.
* **Psychological Models**
  + **Cognitive-Behavioral Models**
    - People perceive or derive certain satisfactions and reinforcement from substance use.
    - Addiction results from an inability to regulate or ctrl the reward system.
  + **Learning Models**
    - Substance use is a result of faulty learning, and that use is reinforcing and leads to repeating the behavior, which may lead to addiction, and that social or environmental conditions may be associated w/ or trigger the behavior.
    - The aversive effects and tension associated w/ withdrawal may motivate the continued SA.
  + **Psychodynamic Models**
    - SA is a symptom of other psychopathology, and problems with regulation or affect and link SA to inadequate parenting, ego deficiencies, attachment disorders, masturbation, homosexuality, and other issues.
  + **Personality Theory Models**
    - Certain personality traits (e.g., dependency, immaturity, and inability to express anger) lead to addiction.

**Wellness and Illness Prevention Concepts**

* **Health** 
  + **WHO and ICF:**
    - Multidimensional approach to health includes:
      * Environmental factors
      * Personal factors
      * Body structure and function
      * Activities/tasks engaged in
      * Participation/involvement and ability to participate in activities.
* **Wellness**
  + A way of living/process, rather than an end state.
  + Striving for or achieving and maintaining the optimal level of well-being and health of which one is capable.
* **Self-Management**
  + Learning and practicing skills necessary to carry on an active and emotionally satisfying life in the face of a chronic condition.
* **Models of Health Promotion and Health Behavior**
  + **Health Beliefs Model**
    - Behavior depends on 2 variables:
      * Value placed by an individual on a particular goal.
      * The individual’s estimate of the likelihood that a given action will result in achievement of that goal.
  + **Theory of Reasoned Action**
    - Intention to perform a behavior is the primary determinant of behavior.
    - Intention influenced by attitude, including:
      * Belief that action will lead to certain outcomes.
      * Value attached to the outcome.
      * Subjective norms: extent to which person believes that other individuals or groups think that s/he should engage in the behavior, weighed by individuals desire to comply with their wishes.
  + **Theory of Planned Behavior (Ajzen, 1991)**
    - Behavioral intentions are a function of:
      * Attitude toward the behavior
      * Subjective norms surrounding the performance on the behavior
      * Behavioral ctrl (individual’s perception of ease w/ which behavior can be performed).
  + **Social Cognitive Theory (Bandura, 1989)**
    - Behavior change and maintenance area function of expectations about whether the behavior will achieve certain outcomes and efficacy beliefs.
  + **Transtheoretical Model**
    - Health decision making and stages of change.
    - Stages represented as categories along a continuum of readiness to change a behavior:
      * Precontemplation, contemplation, preparation, action, and maintenance.
    - Transitions b/w stages are modified by factors such as self-efficacy, psychological, environmental, cultural, socioeconomic, and other variables or behaviors specific to context of change.

14. Insurance Programs and Social Security

* **SSA definition of disability:**
  + Inability to engage in any SGA by reason of any medically determinable physical or mental impairment that can be expected to result in death or hast lasted or can be expected to last for a continuous period of not less than 12 months.
* **Social Security Disability Insurance (SSDI)**
  + Est in 1954
  + Receive monthly income benefits and Medicare insurance.
  + SSDI is an eligibility program: person must have worked and paid social security taxes, be permanently disabled, and earn less than SGA.
  + Eligibility is based on contributions the worker (in some cases the spouse or parents) made to FICA while employed.
* **Supplemental Security Income (SSI)**
  + Monthly benefits and Medicaid to adult’s w/ children w/ disabilities and has limited income and resources, people w/ low income age 65 or older, or the blind.
  + Amt of benefit rec’d is based on sources of income and living situation.
  + Fed govt determines that base SSI benefit rate annually.
* **Medicaid**
  + Federal-state matching program available to certain low-income and eligible individuals and families.
  + Guidelines are administered and set by each state.
  + Provides payments directly to the health-care provider (not the individual).
  + Covers hospital and doctor visits, medication, and sometimes personal assistant services.
* **Medicare**
  + Federal health insurance program for people age 65 or older and SSDI recipients.
  + Financed by payroll taxes and monthly premiums deducted from social security checks.
  + Part A:
    - Covers up to 80% of inpatient hospital care, skilled nursing homes, home health care, and hospice care.
  + Part B:
    - Medical insurance for doctors’ services and other medical services and supplies not covered by hospital insurance and it requires an insurance premium.
* **Trial Work Period (TWP)**
  + Allows SSDI recipients to engage in a work trial for at least 9 months and still receive full SS benefits regardless of earnings.
  + Medicare is also continued for at least 93 months beyond the 9-month TWP beginning the month after the last month of the TWP.
  + Some people purchase Medicare coverage after benefits run out.
* **Extended Period of Eligibility (EPE)**
  + SSDI recipients who complete a TWP can, for a 36-month period, still receive benefits for any month in which earnings are below SGA.
* **Plan for Achieving Self Support (PASS)**
  + Allows SSI recipients to set aside income or resources which will not be considered when calculating initial and continuing eligibility for SSI payments.
  + This helps to establish and maintain SSI eligibility and increase SSI payment amts.
* **Impairment-Related Work Expenses (IRWE)**
  + When determining SGA, cost of certain impairment-related items and services related to work are deducted from individual’s earnings.
  + Item/service must be necessary for individual to work, be related to the disability, be paid for by the individual, and be paid by the individual in a month during which s/he worked.
* **Ticket to Work (TTW)**
  + SSDI/SSI recipients receive a ticket (voucher) to obtain employment services, or other support services that enable self-support, from a state VR agency or other approved employment services provider.
  + Program is voluntary, and services are paid directly to providers through the TTW program.

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* **Labor Market Access (LMA**) matches a client's worker traits to occupational titles.
  + **Labor market access** considers the injured worker's medical limitations as determined by the treating and evaluating physicians as well as available employment that the injured worker can perform.
  + The evaluation takes into consideration such things as medical restrictions, pain, and side effects of medication the injured individual is taking.
  + In addition, this evaluation considers the injured worker's work history, outward effects of the disability, and adjustments that would need to be made for the injured worker to complete the essential functions of the position.
* **Veteran's Administration** programs help Active Duty service members and Veterans who have service-connected disabilities become in Achieving independence in daily living, maintaining employment, and becoming suitably employed.
  + They do not necessarily help individuals enroll in a degree seeking program leading to employment.
* **Guide for Occupational Exploration (GOE)**
  + The Guide for Occupational Exploration was designed by the US Employment Service to provide career counselors and other DOT users with additional information about the interests, aptitudes, entry level preparation and other traits required for successful performance in various occupations.
  + Job titles are arranged by Interest Factors
* **The basic function of career-development programs in an organization** is to help workers improve and upgrade their job qualifications.
* **OVR** was established in 1943.
* **TEFRA (Tax Equity and Fiscal Responsibility Act of 1982)** requires employers to offer equal health insurance benefits to all their employers - including those over the age of 65 who are eligible for Medicare
  + **TEFRA (Tax Equity and Fiscal Responsibility Act of 1982**) requires employers to offer equal health insurance benefits to all their employers - including those over the age of 65 who are eligible for Medicare.
  + **Additionally, TEFRA mandates that**, in the case of such an employee, the private insurance plan will serve as primary payor and Medicare as secondary payor. Similarly, OBRA (Omnibus Budget Reconciliation Act of 1987), established private employer-sponsored as primary payor and Medicare as secondary payer for individuals covered under both SSDI and a spouse's health plan, and those who returned to work.

15. Miscellaneous CRC Concepts and Terminology

* Rehabilitation counselors store the records of clients following termination of services and should ensure reasonable future access and maintain records in accordance with national or local statues that govern records.
* **SAGE** is an effective vocational evaluation tool used with junior high school students.
* **Functional limitation:** negative effect on the performance of tasks and activities due to a medically defined condition.
* **SSI/SSDI:** primary factor that determines what benefits a PWD will receive is the individual’s financial status. In addition, the disability must last for at least 12 months.
* Group leaders are not expected to set objectives and goals for members of the group.
* **ADC-** AIDS Dementia Complex.
* How are normative and ipsative measures different?
  + **Ipsative -** compares each test item with other test items on the same exam
  + **Normative-** every test item is scrutinized independently
* **Job Club:** the idea was born out of the theory of behaviorism.
  + Use of a buddy-system and support network makes it unique.
  + Dr. Nathan Azrin pioneered the idea of job club in 1970’s.
* Legal violations may suggest an ethical violation
* A common communication style of newly formed groups in the first stage of group therapy is when Group members focus on the group leader and ignore other group members
* Anal retentive personality relates to stinginess
* A Type II error occurs when the researcher fails to reject a false null hypothesis, also known as a false negative.
* The Social Security Administration considers this age range to be "Person Approaching Advanced Age": age 50-54
* Disclosure of disability when working with individuals with disability is allowed only as it directly pertains to access to employment and training services, and prior to discussing information about the individual with a disability, with the permission of the individual with a disability. Information about an individual with disabilities is provided only as needed, in discussing the individual with other staff members or agencies. One-Stop Centers must provide private office space (including ensuring telephone conversations are kept private) in which to discuss disability related issues with the individual with a disability and other individuals. Disclosure of information concerning individuals with disabilities to other individuals accessing the One-Stop system is prohibited. The option of meeting with One-Stop Center staff in private offices is offered to individuals with and without disabilities.
* **Amusia**: The inability to recognize musical tones or to reproduce them.
  + **Amusia** can be congenital (present at birth) or be acquired sometime later in life (as from brain damage).
  + **Amusia** is composed of a- + -musia and literally means the lack of music. Also, commonly called tone deafness.
* Professionals working in corporations of disability management are likely to collaborate with case managers, healthcare professionals, and mental health community professionals. They are least likely to collaborate with workfare specialists.
* **Psychoeducational** involves treatment modalities that “family stress” is responsible for creating schizophrenic children, but that families per se do not create schizophrenia.
* **Expressing feelings** is not a goal of REBT
* **The Gouldings** combined TA with Gestalt
* A warm environment would be least likely to affect a person with Lupus.
* **Luepnitz** has indicated that most of the beginning theories regarding family therapy were riddled with sexism
* **The magic shop** refers to exchanging qualities the clients possess for qualities a client desires.
* **According to Brain and Conlon, work-related injuries result in much more time out of work than non-work-related injuries.** The reasons for this may include: Inadequacies of the injured worker's medical provider system, the injured worker's lack of motivation, the injured worker's blaming the employer, psychological factors of disability (depression, low self-esteem, resentment), finances and the amount of paperwork involved.
* **Key element in effectively evaluating a program** is to first write precise goals and objectives.
* After consulting with a professional who continues to violate his/her code of ethics, your next step would be to Report to the professional organization's ethics committee.
* **Parsons** is the father of career counseling.
* Validity is a valid measure that is measuring what it is supposed to measure. It must be reliable, but a reliable measure need not be valid. Reliability measures something consistently, but not necessarily what it is supposed to be measuring. Validity is the most important factor.
* The Personnel Test Form I is also known as the Wonderlic.
  + The Wonderlic Cognitive Ability Test is a popular group intelligence test used to assess the aptitude of prospective employees for learning and problem-solving
  + It offers pre-employment tests and student selection assessments.
* **Cross-sectional study** (also known as across-sectional analysis, transversal study, prevalence study) is a type of observational study that analyzes data collected from a population, or a representative subset, at a specific point in time—that is, cross-sectional data.
* **Disabled American Veterans (DAV)** mission is to empower veteran to optimal lives with dignity and respect by assisting veterans and their families (and widowed spouses and their orphans) in accessing comprehensive benefits and services available to them through the DAV and other government agencies. DAV contends for the civil rights of disabled veterans and their families and provides public education outreach on the needs of veterans in their attempts to transition back into civilian life. The DAV provides a network of state level departments, volunteer programs, and local chapters to extend support to disabled veterans and their families in communities.
* **The 16 major initiatives of U.S. Department of Veterans Affairs (VA) are:** 1) Eliminate veteran homelessness, 2) Enable current (21st century) service delivery and benefits, 3) Automate GI Bill benefits, 4) Create virtual electronic records over a lifetime, 5) Improve the mental health of veterans, 6) Build convenient, seamless relationship management capability interactions, 7) Design a veteran centered health care delivery, coordinated care system model, 8) Enhance veteran s access to healthcare and V.A. experience, 9) Ensure national emergency need preparedness, 10) Develop capabilities and empower systems to drive both performance and outcomes, 11) Establish a strong VA infrastructure using an integrated model of operations, 12) Renovate human capital management, 13) Implement research and development to enhance the long-term health and well-being of veterans and their families, 14) Optimize the implementation and execution of the Strategic Capital Investment Planning (SCIP) process of the VA s capital portfolio, 15) Improve veteran healthcare using cost reduction strategies, and 16) Use health informatics to transform health care delivery.
* **Office of Disability Employment Policy (ODEP)** provides access to education, training, and increased employment opportunities through several programs including programs targeting minority owned and operated businesses, women, individuals with disabilities, and lesbian, gay, bisexual and transgender individuals. ODEP funds a collaborative effort with several leading disability and business organizations focused on inspiring flexible and inclusive workplace practices to promote employment outcomes for individuals with disabilities.
* **The Specially Adapted Housing Grants program** provides grants to construct or adapt an existing home for veterans or service members with 100 percent permanent total service-connected disabilities to provide a barrier free living environment.
* **Rehabilitation counselors are committed to all areas of supporting their clients or evaluees; there are six primary values that serve as the foundation for the Code.** 
  + Respecting human rights and dignity
  + Ensuring the integrity of all professional relationships;
  + Acting to alleviate personal distress and suffering;
  + Enhancing the quality of professional knowledge and its application to increase professional and personal effectiveness;
  + Appreciating the diversity of human experience and culture; and,
  + Advocating for the fair and adequate provision of services.
* **The key purpose in program evaluation** is to determine organizational accountability.
* Research studies to determine the effectiveness of therapy show that: Client attributes are better forecasters of successful results of therapy than therapist attributes
* **The correlation coefficient value, r,** is always between -1 and 1.
* Introvert and Extrovert are Jungian concepts that fit his classification as polarities.
* **Propinquity** is related to the decline in racial prejudice when individuals live next door to minority persons
* When a patient becomes incapable of making medical decisions and has not completed any advance directive, a surrogate must be assigned (who may be a parent, spouse, adult son or daughter, domestic partner, adult brother or sister, close friend, or two physicians who may choose to consult a medical ethics committee) to make medical decisions.
* If a patient chooses, due to mental or physical incapability, a court may appoint a conservator to handle the patient's financial affairs, who must annually report the allocation of the patient's finances.
* If a court, after outside petition, determines a person incapable of making financial decisions (an inability to provide for food, clothing, and shelter, or inability to protect against loss of property) a patient may be assigned a conservator involuntarily.
* The conservator is still required to report annually to the court.
* With the assignment of a conservator, the patient may no longer sign checks, use credit cards, buy or mortgage property, sign a lease or any contract involving finances which may be performed by the conservator.
* Availability of core services to everyone through partnership and service delivery organization One-Stop Career Centers and Vocational Rehabilitation, Employment Networks and the Social Security Administration preventing Employment Networks from the opportunity to serve individuals with significant disabilities and other underserved groups are some factors that inhibit participation in One Stop Career Centers and Workforce Investment Boards.
* Typical characteristics of people with learning disabilities do not include compliant.
* **Private sector rehab differs from public sector rehab in that** services tend to be more specific.
* **Disability organizations may be characterized as** service provision and advocacy organizations. Service provision organizations provide services to individuals with disabilities. Disability advocacy organizations are administered and staffed by individuals with disabilities and focus on changing disability systems. They seek to increase accessibility for individuals with disabilities, and to increase service provision to individuals with disabilities. As an example, Independent living Centers are generally administered and staffed by individuals with disabilities.
* Of the minority groups, in the next few years the workforce will see the largest growth of women entering.
* In the event a rehabilitation counselor is unavailable, it is necessary they maintain a way the client can reach them or another rehabilitation counselor within the clients own local area.
* **The MMPI** is the most widely used psychological assessment tool with a strong research base, and it provides profiles and multidimensional psychological characteristics, making it the most legally defensible test.
* **Criminal deviancy** is not a sufficient criterion to determine mental illness.
* **Pica disorder** is eating disorder typically defined as the persistent ingestion of nonnutritive substances for at least 1 month at an age for which this behavior is developmentally inappropriate. It may be benign or may have life-threatening consequences.
* **Community service organizations that work with individuals with disabilities of all age ranges include** National Mental Health Association affiliates, Lighthouses (visually impaired), Self-advocacy groups, Parent resource centers, Independent living centers, United Cerebral Palsy affiliates, Arc affiliates, Brain Injury Association affiliates, National Association of the Deaf groups, Self Help for Hard of Hearing chapters, and Easter Seals affiliates.
* One's training as a CRC may be considered complete when one has retired from the profession.
* If you wanted to evaluate whether a person seems satisfied with his or her area of work, then one thing you might want to look at would be how long he or she has been doing this type of work.
* Having individuals in a family deal with their unhealthy patterns of relating and communicating is accomplished by family group therapy through techniques that target the **process** of family interactions.
* Vocational experts will be most likely used in cases where the disability is emotional.
  + A CRC may be called upon to evaluate a client's emotional status. Both the pre-disability psychological status and acute emotional reaction to disability will affect rehabilitation. The client's ability to learn adaptive coping skills should be understood by the CRC.
  + Medical disability information is provided by the appropriate physicians and other medical experts.
  + Psychologists provide information on mental health and cognitive disabilities.
* **Crystallization** is the stage in which an individual makes his or her final career decisions.
* **Physical disability** is defined as anatomical loss affecting one or more body systems.
* **An emotional disability** is not a physical disability; however, it may be the result of a physical disability.
* **Delusion** refers to a fixed false belief and is a mental health condition.
* **Family loss** is a loss of part of a client's family system and is not an anatomical loss.
* **HBV-** Hepatitis B Virus
* **Correlation coefficient** is a measure of the magnitude of the relationship between two variables
* A client takes the same test on three occasions, spaced a month apart. The test-retest correlation between the first and second test should be **greater than** the correlation between the first and fourth test.
* **Coefficient alpha** is a reliability coefficient that should be used if internal consistency is a consideration.
* A suicide hotline is a good example of a secondary prevention program.
* A CRC wishes to avoid **unnecessary procedures** in insurance rehabilitation.
* **The function of Rehabilitation Research and Training Centers (RRTCs) is to** Conduct coordinated and integrated advanced programs of research targeted toward the production of new knowledge, to improve rehabilitation methodology and service delivery systems, alleviate or stabilize disabling conditions, or promote maximum social and economic independence for persons with disabilities.
  + **National Institute on Disability and Rehabilitation Research (NIDRR)'s Rehabilitation Research and Training Centers (RRTCs)** conduct coordinated and integrated advanced research programs targeted toward the production of new knowledge, which may improve rehabilitation methodology and service delivery systems, alleviate or stabilize disabling conditions, or promote maximum social and economic independence for persons with disabilities.
  + RRTCs are operated in collaboration with institutions of higher education, rehabilitation providers or other appropriate services.
  + RRTCs provide national or regional resources for research information for individuals with disabilities and the parents, family members, guardians, advocates, or authorized representatives of the individuals.
  + These centers conduct related training programs, including graduate, pre-service and in-service training. The centers also disseminate and promote the utilization of research findings.
* **Privilege** is the right of clients to keep information disclosed in therapy out of court.
* **Two advantages of reality therapy** are that it deals with conscious behavioral problems and it is short term
* When seeking consultation with colleagues; the rehabilitation counselor should maintain the identity of the clients to avoid undue invasion of privacy. Disclosure of information should only include the information necessary to achieve the purpose of the consultation.
* **The Civil Rights Act of 1964 (Title VI) and Rehabilitation Act of 1973 (Section 504)** set federal standards for implementing regulations for non-discrimination in the treatment of individuals based on disability, including specialty populations.
  + These standards include actions that in effect discriminate based on disability, program accessibility, and provision of necessary auxiliary aids and services to afford equal opportunity; unless this would result in undue burden or fundamental program alteration.
  + These regulations provide for modification of necessary policies, procedures, and practices to avoid discrimination, unless the modifications would require fundamental program alteration.
  + These regulations and standards mandate the administration of service provision in the most appropriate integrated setting.
  + Standards under these Acts mandate non-discrimination based on race, color, or national origin as well as disability and include provision of meaningful access to program participation and communication for Limited English Proficient (LEP) individuals.
  + Federal standards to implement non-discrimination related to these statutes include coordination with community and faith-based organizations.
* **Internal validity** determines whether any observed changes are caused by the treatment itself. If there are alternative explanations for the change, i.e., sitting through a 6-hour-long post-test while hungry, tired and bored, the treatment has low internal validity.
* **The board of directors** has the authority to make the final approval of the operating budget in an organization.
* In a Worker's Compensation job placement case, the highest priority is returning the individual with a disability to the same job with the same employer.
  + A job analysis is performed to make this assessment.
  + If it is determined that it is not possible for the employee to return to the same position with the same employer, the job is assessed for adjustments that may be made in the workplace to allow the individual to return to work.
  + The most desirable outcome is to return to a previous job in a WC case.
* Low weight is not necessarily a characteristic behavior of someone with bulimia.
* When evaluating and appraising the performance of a supervisee the rehabilitation counselor supervisor must assure the supervisees ability to **achieve, improve or maintain** the counseling competencies to be utilized; to ensure the supervisees effectiveness in their role.
* **Description of stereotypic movement disorder** would include repetitive driven motor behavior.
* **The interval scale** measures by using equal intervals.
  + Ex: The interval between 22 and 25 is equal to the interval between 13 and 16 because they are both 3 units apart from each other.
* **MMI** refers to maximum medical improvement regarding Worker’s compensation cases.
  + MMI refers to the point at which it is no longer likely that there will be improvement in the organ system or body part which was impaired in a work-related injury.
  + **Temporary partial disability** **benefits** may continue until the doctor determines that the patient has "reached the stage of ultimate improvement" or MMI, at which point the establishment and extent of any permanent disability resulting from a work-related injury may be determined by the physician.
* Most insurance rehabilitation involves Worker’s Compensation.
* The DOL Employment and Training Administration focus for the four sequences of Work Incentive Grants (WIGs) to enhance access to One-Stop Centers by individuals with disabilities has shifted from Purchase, installation, and training of frontline staff in use of assistive technology resources to providing a specialized "disability navigator" position.
* **Rehabilitation Services Administration (RSA) is responsible for administering** Protection and Advocacy for Assistive Technology, Recreation Programs and Migrant and Seasonal Farmworkers.
* **Wide Range Employability Sample Test** is not recommended for individuals with competitive work potential.
* **Autism** occurs during childhood or adolescence and typically persists for life.
* Structural family therapy seems to be most effective when dealing with heroin addicts and individuals with anorexia nervosa.
* Coordination of services is the essential aspect of case management.
* Low back injury is an example of an unscheduled injury in Worker’s Compensation cases.
* **Borderline personality disorder is most likely to be treated with** lithium carbonate.
* **The concept of the emotional system** is central to The Bowen Theory.
* According to research, **boys** tend to reach the highest level of deleterious behavior within the first year after a divorce.
* **Emotional as well as economic dependency** is the main reason why women stay in abusive relationships.
* **The Hiskey-Nebraska Test of Learning Aptitude** is a non-linguistic test developed for children with language problems to determine their intelligence. Due to its non-verbal nature, it is often used with deaf children.
* If the results of a test show scores that plot out to be positively skewed, you would find More low scores than high scores.
* **Forced Choice Memory Test** appears to have strong validity for determining brain damage.
* **Rural Appalachians** tend to marry early in life.
  + It is a cultural region in the Eastern United States that stretches from the Southern Tier of New York to northern Alabama, Mississippi and Georgia.
* To fully assist a client the rehabilitation counselor should maintain a level of support by working with them to educate them on their rights; this enables the client to make fully informed decisions on their own behalf while remaining safe within the rehabilitation plan.
* With clients who have facial disfigurement, it is important for counselors to model **image improvement techniques.**
* **1936 Randolph-Sheppard Act** provided funds to determine the type of work that visually impaired adults could perform.
* The word "constantly" in a job description means 2/3rds to all the time.
* Rehabilitation Counselors should perform and document a risk assessment when providing forensic evaluations.
  + To effectively provide a forensic evaluation; the rehabilitation counselor should consider all areas that may present a risk; such as a personal relationship with the evaluees, therefore compromising the ethical decision-making process.
* **Permutations-** a way, especially one of several possible variations, in which a set or number of things can be ordered or arranged.
* If a family therapist decided that he or she wanted to augment an interpersonal perspective with the addition of an intrapsychic orientation, the therapist could use object relations.
* **Second Injury Funds:** the employer will be protected from excessive claims if the employee is injured again.
* **Paradoxical techniques** place the client in a double-bind, so that therapeutic change occurs regardless of what the client does.
  + Paradoxical techniques are used as strategies in [psychotherapy](http://psychology.wikia.com/wiki/Psychotherapy) and [behavior therapy](http://psychology.wikia.com/wiki/Behavior_therapy) to help client [reframe](http://psychology.wikia.com/wiki/Reframing) their difficulties.
  + Broadly with this approach, therapists encourage clients to continue with their symptoms and the supporting behaviors.
  + The paradox is then that the person they have asked to help them reduce their difficulties is telling them to continue with their problems.
* Leadership functioning in a group does not include Director.
* **Statistical regression example:**
  + You decide to retest a group of students, and when you do, you find that their scores seemed to have crept towards the mean.
* **A delusional disorder is characterized by** at least one month of non-bizarre delusions and does not exhibit active phase symptoms of schizophrenia.
* **The General Aptitude Test Battery** is often used in state employment services offices.
* According to the ADA, no covered entity will discriminate against a qualified individual with a disability regarding **hiring.**
* Agriculture is exempt from Workers' Compensation coverage.
* Longshoremen, federal employees and mine workers are all covered by Workers' Compensation.
* Workers Compensation incorporates coverage for workers, injuries, occupational diseases, and second injuries.
* State laws cover most workers with some exceptions, including farm workers, domestic employees, professional athletes, self-employed individuals, individuals working for very small businesses, and casual or incidental workers.
* Injuries are covered irrespective of fault, unless the injuries are due to intoxication or are self-inflicted.
* Occupational diseases or conditions such as black lung, mesothelioma, and radiation poisoning are fully covered under workers' compensation.
* Second injuries are covered by states' second injury funds to protect individuals against subsequent injuries, compounding disability resulting from an earlier injury.
  + If, for example, a worker with one arm lost his other arm, the impact of the loss would be far greater because of the preexisting condition
  + Second injury funds cover additional expenses from the compound effect of injuries and facilitate vocational rehabilitation.
* According to Super, career choice is an extension of the individual’s self-concept.
* **The Research and Training Center on Disability in Rural Communities (RTC-Rural**) at the University of Montana works to improve health, employment and community interaction outcomes for individuals with disabilities through scientific research in rural disability and rehabilitation.
  + Using evidence-based contextually appropriate research and training programs, the project provides solutions and information on resources available in most rural communities. Within the scope of this project is the development and evaluation of telecommunications protocol and improvement of rural transportation for rural VR service provision.
  + RTC-Rural evaluates premature VR service termination and identifies evidence-based strategies for retention of rural consumers with disabilities using health care and VR services to improve employment outcomes.
  + RTC-Rural evaluates a mental health peer support model for individuals with mobility or sensory impairments and who reside in a rural location.
  + Three overarching goals of RTC-Rural are 1) to promote economic development, 2) link Small Business Development Centers and VR, and 3) provide an innovative, online state-of-the-science rural disability and rehabilitation conference.
* Z-score Subtract the mean from the raw score and divide by the standard deviation.
* "Covered entity" refers to an employer who must comply with the ADA.
* When someone needs drugs to maintain emotional well-being, he or she is exhibiting psychological dependence.
* The term "substantially limits" is not affected by short-term impact of the impairment.
* **Experimental research models** best describe cause-and-effect relationships.
* **The Hearing Loss Association of America (HLAA**) provides individuals who experience some degree of hearing loss with resources to help them adjust to hearing loss.
  + They advocate and educate the public on prevention, screening, and treatment for hearing loss. T
  + he organization works to have an impact on research, access and legislation on hearing loss and assistive technology such as cochlear implants, hearing aids, and communications devices.
  + They work toward advancing Medicare initiatives to cover the cost of newborn hearing screening and cochlear implant reimbursement through insurance.
  + The organization formerly known as Self Help for Hard of Hearing People, Inc. changed the name of the organization to Hearing Loss Association of America (HLAA).
* **The National Center for Hearing Assistive Technology** provides training in assistive technology.
* **Hearing Loss Support Specialists Training** is a distance learning program provided online that educates individuals about hearing loss, legislation, and resources.
* Under the One-Stop Center system, eligibility criteria for individuals with disabilities needing core, intensive, and training services must not discriminate intentionally or unintentionally against individuals with disabilities.
  + Individuals with disabilities must have full access to core, intensive and training services that are available to all One-Stop Center consumers.
  + Individuals with disabilities, under the One-Stop Center system are not served solely by Vocational Rehabilitation services.
* **Cases involving injured railroad workers are most often like personal injury cases.**
* CRCs working with individuals who have incurred an injury will assess vocational strengths and weaknesses and work to develop an individual plan for employment (IPE). The IPE describes vocational rehabilitation services needed for the client to return to employment. The IPE includes vocational rehabilitation services necessary to eliminate identified barriers to employment. The IPE is developed with, not for the client. The IPE must be agreed upon by the client and the CRC counselor. The IPE includes: an employment goal, description of vocational rehabilitation services required for the client to return to work, time lines for the onset of services and for the projected date of employment. IPEs identify who will provide each service, and who will pay the costs involved in completing the plan. In addition, the IPE includes information on outcome measures (the manner in which progress toward employment is evaluated), the responsibility of Vocational rehabilitation and the responsibilities of the client. Injured clients must also apply for and secure additional financial benefits that may assist in paying for the client's IPE.
* **Title I of the Rehab Act of 1973 Amendment** states the VR is funded by federal grants to states.
  + Under Title I of the Rehabilitation Act of 1973, as amended (Act), states receive federal grants to operate a comprehensive VR program. These funds are awarded to designated state VR agencies within each state.
* **Title V of the Rehabilitation Act of 1973** that advanced civil rights for individuals with disabilities.
  + **Section 501** mandated nondiscrimination in hiring individuals with disabilities in the federal government.
* In any group, the most popular child (in terms of birth order) is most likely to be the **youngest child.**
* **Culturally different:** Therapist and client belong to two different cultural groups.
* Behavioral therapies discount the significance of family resistance.
* An EEG is not a test needed for patients taking lithium.
* **The purpose of the Rehabilitation Cultural Diversity Initiative (RCDI)** was to enhance cultural competence in the delivery of rehabilitation services, to intensify outreach to individuals with disabilities, and to develop recruitment strategies to engage individuals with diverse backgrounds in rehabilitation work.
  + **RCDI** was designed as part of a national strategic plan to implement priority cultural diversity training for all Rehabilitation Act funded programs.
* **The Consortia of Administrators for Native American Rehabilitation (CANAR)** was formed to advocate for effective rehabilitation and vocational rehabilitation program service delivery to American Indian and Alaska Native individuals with disabilities.
* RCDI and Region VIII Rehabilitation Continuing Education Program (RCEP) coordinated meetings to address Section 121 funded American Indian Vocational Rehabilitation Services Projects to improve tribally appropriate Vocational Rehabilitation (VR) nation-wide Native American reservation service delivery.
* CANAR launched efforts to advocate for Native American rehabilitation programs that provided VR services to American Indians and Alaska Natives with disabilities who reside on or in proximity to Federal or State reservations, Alaska Native villages, rancheros, and pueblos.
* Most private sector CRCs work with insurance companies.
* Private sector claimants are likely to have prior work experience.
* **The Geist Picture Interest Inventory** can be used with culturally different or low-educated individuals to determine vocational and avocational interests by circling the one picture in a series of three that they most prefer.
* During assessment and problem definition, the rehabilitation engineer must consider chronological, mental, behavioral and functional age of the individual with disabilities in the determination of interventions to be utilized in helping individuals with disabilities.
  + Rehabilitation engineers cannot make presumptions that the mental and behavioral age of the individual with disabilities matches the individual's chronological age.
  + Individuals with congenital disabilities may also have a more restrictive range of life experiences and quality of life resulting in behavioral tendencies and reactions more closely corresponding to individuals of a much younger chronological age.
  + Rehabilitation engineers will need to collect biographical and behavioral information from direct clinical observation, information from the individual with disabilities, family members, social workers, medical practitioners, teachers and others in the natural ecosystem of the individual with disabilities.
  + Rehabilitation engineers need to consider the needs of very young children with disabilities and the elderly when designing rehabilitation engineering adaptations for these individuals.
  + These individuals may have lower levels of physical strength and diminished ability to process and retain information.
  + Considerations may include ability of an individual with written and/or verbal receptive and/or expressive difficulties, the ability to process differing levels of complexity or length of information provided to the individual, and response time needed for the individual.
  + Other considerations may include the ability of an individual with disabilities to see, hear, read, and comprehend information.
* **Using a checklist** is the best way to guarantee that you have covered all the necessary subjects in your initial life care planning interview.
* **The major advantage of factor analysis** is that the number of factors it results in is small.
* **Mary Switzer** is one of the most influential women leaders in the field of rehabilitation. Very influential in shaping the Rehabilitation Act of 1954.
* **Employment handicap:** an impairment of an individual’s ability to prepare for, obtain, or retain employment consistent with such person’s abilities, aptitudes, and interests.
* **Placement handicap:** have not acquired the JSS to be able to obtain employment.
* **Industrial Designation Code**
  + Jobs are arranged according to products
* **Donald Super**
  + Donald Super’s (1953) life span developmen­tal theory includes five major stages.
    - **Growth stage (birth to 14)** is characterized by the development of attitudes, interests, needs, and aptitudes associated with self-concept.
    - **Ex­ploratory stage (ages 15-24)** occupational choices are narrowed.
    - **Establishment stage (ages 25-44)** is characterized by work experience.
    - **Maintenance stage (ages 45-65)** the person experiences a con­tinual adjustment process to improve the working sit­uation.
    - **Decline stage (ages 65 and over)** there is reduced work output and eventual retire­ment. Super’s theory has been expanded and reined over the years.
    - Super’s (1996) theory has increasingly been viewed as the most comprehensive of the devel­opmental approaches.
* **Anne Roe**
  + Roe’s (1956) theory focuses on early relations within the family and their subsequent influence on career choice. Roe classifies occupations into two major categories: person oriented and non-person oriented.
  + Roe’s major con­tribution appears to be her emphasis of the impact of childhood experiences on career development and her job classification system.
  + She would agree that an individual’s vocational choice and path are important in meeting unconscious needs.
* **Eli Ginzberg**
  + In contrast to the static approach of the trait-and-factor theory, Ginzberg, Ginsburg, Axelrod, and Herma (1951) were the first to view career devel­opment as a lifelong process, with an emphasis on very early development.
  + Ginzberg and associates outline three distinct stages or periods in the career-choice pro­cess, each of which is divided into substages.
  + During the fantasy stage (childhood before age it), play grad­ually becomes work oriented and reflects initial prefer­ences for certain types of activities. The second period, called tentative, is divided into four substages (interest, capacity, values, and transition) and lasts from ages 11 to 17. During the tentative period, the individual be­comes more aware of work requirements and of his or her own abilities and values and makes decisions re­garding vocational likes and dislikes. At the realistic stage (ages 17 to young adult), there is further integra­tion of perceived abilities and occupational interests. As the person first narrows his or her choices to a few possibilities and then makes a commitment by selecting a job or entering specialized training. Ginzberg (1984) reemphasized that career development is lifelong pro­cess for those who seek to attain major job satisfaction. As changing work goals occur, a person will reassess how to improve it with the work environment.
  + Viewed that occupational choice is progressively irreversible.
* **Minnesota Theory of Work Adjustment:** satisfaction (employee’s satisfaction with the job) and satisfactoriness (employer’s satisfaction w/ employee’s ability to perform the job) lead to job tenure, the main criterion of work adjustment (job tenure).
  + Work-Adjustment theory centers on the premise that work adjustment is the basic process by which an individual worker adapts and interacts with his/her work environment over the course of his/her entire lifespan. Also called the Minnesota Theory, the Theory of Work Adjustment (TWA), is based on three main elements: the individual, the work environment, and correspondence.

**Cases from crcexam.com**

* The organizational chart of a very large organization would most likely resemble top-down management pyramid showing lines of authority.
* Which type of information would be LEAST important for you to review before a hearing?
  + Rehabilitation Law
* Which is the LEAST helpful source for medical equipment costs?
  + Claimant
* The element that is LEAST effective in providing for emotional reinforcement as a modality to increasing CRC morale and effectiveness is Automatic yearly cost of living increase
* George is a CRC employed at an agency out in the sticks. If he ever chooses to take off to the big city from his current job, what should he do with his clients' records?
  + give the records to another CRC in the clinic
* If you are dissatisfied with medical information related to a life care plan and question its accuracy, since it is medical, you would request an additional medical evaluation. An attorney is not qualified to render a medical opinion. In some instances, representatives of an insurance provider or other individual or organization may resort to videotaping a claimant with a hidden camera to determine malingering by the claimant.
* Disability management will be MOST effective when it is Regularly assessed
* Which career option would be least viable for a CRC?
  + In home healthcare.
* The most prevalent form of injury in workers' compensation cases is lower back injury.
* The Individualized Written Rehabilitation Plan (IWRP) is now called the Individualized Plan for Employment (IPE).
* You are involved in case consultation. This means that: you meet with the CRC to discuss the case but do not actually meet with the client
* Sheltered employment is the LEAST likely objective for rehabilitation
* The trend concerning public and private rehabilitation is that private rehabilitation is increasing, and public rehabilitation is decreasing. Private rehabilitation is increasing in the areas of vocational/career services, forensic services, and transitional services provided through private practice in corporations, schools, and social service agencies.
* A physician is the best qualified to determine life expectancy of an injured worker. Insurance companies formulate actuarial tables of individual life expectancy based on statistical analysis of groups of individuals and individual characteristics; however, the disabled individual's physician is the most qualified to determine the life expectancy from a medical perspective for an individual. Rehabilitation counselors are trained on aspects of disability, not life expectancy.
* Client and payor agree to plan after confirmation of diagnosis is a sequence that is typical in life care planning.

**Bowen’s Theory from crcexam.com**

* When analyzing a genogram to explore the family system's emotional boundaries and level of fusion, a Bowenian therapist would pay close attention to the location and geographical proximity between the family members. Members who live very close to each other might experience high levels of fusion and members who live very far away might be experiencing emotional cutoffs.
* Bowenian therapists use coaching to avoid becoming overly involved or triangulated with clients and to assist clients in becoming aware of the family system's emotional processes.
* In a genogram, the symbol used to represent an excessively close or fused relationship between members consists of 3 parallel lines.
* A dotted line is used on a genogram to represent emotional distance in a relationship between family members.
* The term genogram is used in Bowenian theory to describe a diagram that lists family members and their relationships. It is like the concept of a family tree.
* The decision to expand the genogram assessment outside the nuclear family system depends on the extent of the crisis the family is presenting with and the level of anxiety of the nuclear family. If the therapist does not gather the family's history carefully, they might miss something big that could have tied in things together or assist the members in gaining perspective.
* When discussing relationship problems during a session, Bowenian therapists usually ask about the family of origin relationships to determine if the same patterns are being repeated and increase the current family members' awareness of this repetition and how it related to their previous attachments with their family of origin.
* Bowen's idea of "coaching" refers to the ability to work with a client around fulfilling goals outside of the therapy session.
  + Bowen often pointed out that the therapy sessions were only as valuable as lessons that the client took with him. Therefore, it was especially important to work on accomplishing goals outside the therapy session.
* One danger of triangulation is that it can freeze conflict in place.
* While some triangles can seem harmless, the danger in engaging in triangulation is that it can become a habit to bring in a third party who helps ease the anxiety into the relationship and while this may in fact reduce the anxiety between the two individuals engaged in the relationship, it can also freeze conflict in place, since it diverts attention from the conflict and the relationship itself, which inhibits the ability to face the conflict and actively work on seeking a resolution to it, which in turn causes the conflict to stay under wraps, but never go away.
* Increasing the ability to distinguish between thinking and feeling is one of the guiding principles of Bowenian therapy. This ability can be used in resolving relationship conflicts.
* When working with families who had a member with Schizophrenia, Bowen observed anxious attachment.
* Bowen worked for the National Institute of Mental Health in the 1950s. During this time, he worked on a project in which families who had a member with schizophrenia were hospitalized for research. Through observation, he discovered a pathologically intense emotional bond between these mothers and their children. This unhealthy need for closeness was mainly driven by anxiety and is known as anxious attachment.
* A husband and wife are experiencing difficulty in their marriage. The husband decides to increase his involvement with his son and spends a lot of time with him. This in turn, takes pressure off the wife who now has more freedom, since her husband is not on her back anymore. What Bowenian term can be used to describe the process by which the husband and wife in this scenario decreased the anxiety in their relationship?
  + The husband and wife in this scenario utilized triangulation to decrease the anxiety in their relationship by bringing in a third party, their son, to deflect the attention from the couple's conflict and avoid further confrontation.
* During the midlife crisis stage, the parents must learn to understand and deal with the changes they are experiencing in their life as they become older, understand and deal with the changes the children are experiencing as they become older and more autonomous, and understand and deal with the changes in their relationships with their own parents as their parents age and may need more support to continue to have a good quality of life.
* Projection, emotional reactivity, and differentiation all relate to Bowen’s Theory.
* After creating the new therapeutic triangle, the Bowenian therapist works with the partners to increase their ability to manage anxiety and to fortify their emotional functioning.
* In families with intense conflict, members can become emotionally dependent on the way others interact or behave with them.
* **According to Bowen therapy,** dyads are inherently unstable. Dyads are known to seek stability by involving themselves in triads.
* When tension builds between two people, there is no easier way to diffuse the tension or high-stakes moment than with a third person who is presumably more neutral and can take stress off of each individual involved.
* **Monica McGoldrick and Betty Carter are feminist Bowenian therapists** who added gender and ethnicity to the list of concerns and societal processes that affect family systems.
  + They emphasized how gender inequality kept men and women in family systems trapped in gender roles that favored males and how ethnicity and cultural norms play an important role in a family system's patterns and processes.
  + They also raised awareness about how cultural differences in family processes are not necessarily signs of dysfunction in the system and how therapists should be careful and not impose their own beliefs about families to the clients.
* **One of the primary tasks of the “having young children” stage of the family life cycle** is to adjust and make space for the new addition to the family.
  + During the stage of the family life cycle in which the family has young children, the primary tasks for both partners are to adjust and make space for the new addition to the family, to cooperate in the tasks of child rearing, to keep the marriage from being second to parenting, and to reassess the relationships with the extended family members.
* **Bowenian theorists** believe that the ability to handle stress is a function of the level of differentiation. They believe that the more differentiated a person is, the more resilient and capable of dealing with stress that person will be. A person who is well differentiated will also experience more flexible and nourished relationships. The less differentiated the person is, the less amount of stress it will take to break the person down and cause symptoms.

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