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Rehabilitation Counselor Competency When Working with SCI and Physical Disabilities

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Walden University

College of Social and Behavioral Health

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Denise M. Anderson

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Dr. Corinne Bridges, Committee Member, Counselor Education and Supervision Faculty
Dr. DeAnna Wilson, University Reviewer, Counselor Education and Supervision Faculty

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Sue Subocz, Ph.D.

Walden University
2022

Abstract

Rehabilitation Counselor Competency When Working with SCI and Physical Disabilities

by

Denise M. Anderson

MS, Springfield College, 2012

BS, Florida A& M University, 2008

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

Walden University

November 2022

Abstract

The purpose of this qualitative phenomenological study was to address the gap in knowledge of the perceived competency of rehabilitation counselors when working with patients with a spinal cord injury (SCI) and/or a physical disability. The factors that influence the mental health needs of person with SCI and the understanding of how rehabilitation counselors view their competency levels with supporting this population were explored. Selection criteria included licensed or certified rehabilitation counselors actively providing care for persons with SCI and/or a physical disability applying a theoretical framework. A qualitative descriptive phenomenological approach was used to address the central research question of rehabilitation counselors perceived competency when working with SCI and/or a physical disability. Semistructured interviews were conducted with six rehabilitation counselors. I applied the six steps described in the data analysis method, based on principles of phenomenological philosophy (see Broome, 2011; Giorgi, 2018). The following five major themes emerged: (a) clinical factors and certified rehabilitation counselors, (b) mental health and environmental concerns of clients, (c) necessary clinical skills and practice requirements for rehabilitation counselors, (d) supporting certified rehabilitation counselors in training, and (e) impacting social change for clients with disabilities. The implications of this study for positive social change include increasing the professional knowledge of how counselor educator programs can implement specific courses to prepare future rehabilitation counselors for working with SCI and persons living with a physical disability.

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Dedication

This work is dedicated to my beloved son, Jayden. Being your mother has been my greatest accomplishment. Having you developed me into a woman. You have made me stronger, and more resilient. I love you for your unconditional love and for never having a single complaint throughout this entire journey. You keep my heart smiling. Let this be proof that you can do all things through Christ who strengthens you. Never give up or allow anything or anyone to interfere with God's divine and purposeful plan for you. As my educational journey ends and yours continue, my prayer is that you move forward in a life of integrity and a strong sense of purpose.

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I want to acknowledge the never-ending support provided to me by my parents, Nathaniel and Patricia Primus. This could have never been possible if it had not been for your selflessness and unfailing support of my educational goals. Thank you for giving me the freedom to reach beyond what my mind could dream. To my husband, who did not always have the words but gave me the space and time I needed, thank you. For my friends who never left, who always understood and never questioned, thank you. I am eternally grateful to my dissertation committee, Dr. Ariel Harrison and Dr. Corinne Bridges. Your commitment to my study means so much. Thank you for replying "yes" to my invitation email. It has been an honor and a blessing to learn from both of you. Lastly, to the community of persons living with SCI and physical disabilities. I heard you; I see you, and now the community of counselor educators see you too. Thank you for your inspiration. Lastly to the participants of this study and all certified rehabilitation counselors; I thank you for your contributions and commitment to the community of disabled persons to include spinal cord injury.

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Chapter 1: Introduction to the Study

In today's global and diverse world, as the numbers for persons living with a disability increase, specifically a spinal cord injury (SCI), the need for rehabilitation counselors to possess competence of the person with SCI and/or a physical disability is preeminent. Previous studies have sought to explore counselor competence in relation to mental health professionals', licensed clinical social workers, school counselors, and licensed professional counselors. Areas of competence for these providers are explored in the context of a clinical individual encounter during psychotherapy; however, few if any studies have ever sought to explore competence in terms of providing rehabilitation counseling regarding the growing mental health implications of persons living with a disability and SCI. Furthermore, there are even fewer studies that specifically address how prepared or knowledgeable rehabilitation counselors are to render mental health counseling services to persons with SCI and/or a physical disability during the rehabilitation process.

Considering the factors that influence the mental health needs of persons with SCI and/or a physical disability, understanding how counselors view their competency levels with supporting this population is an important element of care and critical in the delivery of continuity of care for persons with SCI and/or a physical disability. To address this gap, I used a qualitative descriptive phenomenological approach. This chapter includes the background, purpose, problem statement, research questions, theoretical framework,

nature of the study, definitions, assumptions, scope and delimitations, limitations, significance and summary.

Background

Persons with SCI and/or a physical disability are easily overwhelmed at first onset of injury; therefore, the physical and emotionally stability of the person with SCI and/or a physical disability is dependent upon having a competent and experienced rehabilitation team (Michel et al., 2017). Rehabilitation counselors are encouraged to provide the emotional support and resources that can affect the persons' with SCI and/or a physical disability future health, independent living skills, and community reintegration. Often coping strategies need to be learned and adapted to support the collaboration of this process (Babamohamadi, et al., 2011). With the adaption of these strategies, persons with SCI and/or a physical disability feel a greater sense of empowerment and improved quality of life (Babamohamadi et al., 2018).

The psychosocial and physiological aspects of SCI and/or a physical disability gives rehabilitation counselors an in-depth perspective of what the client experiences daily (Fuseini et al., 2019). This could help increase competency in rehabilitation counselor's ability to get to know the persons with SCI and/or a physical disability mental and emotional needs while simultaneously observing how well the person with SCI and/or a physical disability is adapting to change and responding to various skills (Fuseini et al., 2019). Describing the psychological and social implications of SCI and/or a physical disability can be very complex. Individuals who have experienced various level of trauma from this injury can respond in different ways because of individual

personalities, available social support, cultural and diverse backgrounds, social economic status, age, education, and level of intelligence (National Spinal Cord Injury Statistical Center, 2016). Implications to SCI and/or a physical disability affects the whole person and contributes to how well the person responds to and cope with the injury (Batra & Chhabra, 2016). Earlier evidenced explored individuals living within the community with a traumatic spinal cord injury (SCI) and/or a physical disability regarding their chronic pain and to identify their preferred methods of coping with their pain (Norman et al., 2010).

The adjustment process of SCI and/or a physical disability can include relying on the rehabilitation treatment team or family to provide the most basic and personal care including bathing, feeding, and toileting (Gong De et al., 2021). This experience can be psychologically and emotionally stressful. As the rehabilitation counselor, it is important to be knowledgeable of physical changes of the injury as well as emotional deficits that impact the person daily. This process can be very difficult for women impacted by SCI and/or a physical disability during inpatient rehabilitation (Samuel et al., 2008). To help increase competency and awareness of the person with SCI and/or a physical disability experiences Leslie et al. (2017) conducted a delphi study to explore and identify attitudes, knowledge, and skills rehabilitation practitioners in the private sector need when working with persons with SCI and/or a physical disability.

In this study, the delphi methodology obtained consensus from a panel of experts on identifying the essential competencies (attitudes, knowledge, and skills) rehabilitation counselors in the private sector need while working with spinal cord injured workers.

This study employed a three round delphi study to obtain a consensus of eight rehabilitation practitioners who had experience working with SCI injured workers in the private sector about the essential competencies working with this population. Results from the study indicate that the development of multicultural and ethical competencies received particular attention from participants. This study is relevant to the identification of cultural competencies in rehabilitation counselors when working with minority populations.

The symptoms of anxiety and depression may interfere with rehabilitation possibilities while the patient is in the process of adjusting to the impairment and working towards the possibility of returning to what is familiar aspects of social life and employment (Johnson & Krause, 2019). Research has also consistently found that people with SCI who also have a depressive disorder or raised levels of depressive mood have increased risks of secondary complications such as pain and infections (Lim et al., 2017). Counselors who are involved in working with veteran clients describe the secondary complication such as pain and infections within the veteran population (Mamboleo et al., 2018). This study is a focused empirical investigation of clinical competency training for successful rehabilitation work with veterans with disabilities.

Jeon (2014) conducted a qualitative study to investigate how well rehabilitation counselor trainees in CORE accredited rehabilitation counseling programs are prepared to advocate with and on behalf of clients. Jeon (2014) explored how competent rehabilitation counselor trainees are in advocacy as well as how accurately rehabilitation counselor educators perceive their trainees' preparedness to act as advocates for their

clients. The instrument contained 30 questions with five questions in each of the following six domains: client/student empowerment, client/student advocacy, community collaboration, system advocacy, public information, and social/political advocacy. A total of 45 students made attempts to access the survey and 39 students from 20 programs across the United States submitted a completed survey. A total of 51 faculty attempted to make access to the survey and 49 faculty from 26 programs across the United States submitted a completed survey. The results indicated that rehabilitation counseling students developed advocacy competencies in some areas. It was also found that rehabilitation counseling students have lower advocacy competencies in the community and public level domains than in the individual level. Rehabilitation counseling students reported that rehabilitation counseling course work and their prior experiences with persons with disabilities are most substantial factors in the process of developing advocacy competencies. This qualitative study is applicable for the purpose of sharing how counselor programs implement trainings and counselor readiness post-masters to work with disability clients and how students perceive competency of trainings experience (Jeon, 2014).

As a rehabilitation professional, understanding the factors that influence support mechanisms to assist the transition to home and community during the counseling process can facilitate social integration of the individual with SCI (World Health Organization [WHO], 2018). WHO suggests the healthcare professional's perspective is necessary when depicting a thorough picture of the barriers to meet the needs of individuals with SCI. According to the provider's perspective, competent care for persons

with SCI and dysfunction in acute inpatient rehabilitation largely depends on the clinical guidelines and standards of care that reflect evidence-based best practices (Bracken et al., 2012). For the individual to have an opportunity for optimum quality of life, the rehabilitation treatment team must be able to implement an individualized care plan that outlines interventions for the individual and care givers; this can also include peer counseling in the earlier stages of inpatient rehabilitation (Roth et al., 2019). Evidence provided by the presented articles could impact prevention and treatment of the persons with SCI as it relates to their mental, social, and environmental implications. Rehabilitation counselors could use the data within these articles to increase knowledge about the needs of SCI individuals and improve areas of competency and clinical practice.

Problem Statement

The American Psychological Association's Guidelines for Assessment of and Intervention with Persons with Disabilities (2012) described the lack of training psychotherapists receive as it pertains to working with clients diagnosed with a disability. Persons with disabilities (PWD) are frequently overlooked and underappreciated on a global realm. These persons form the largest minority in the country (United States Department of Labor, 2017). In the United States alone, the Centers for Disease Control and Prevention (CDC, 2019) reported that there are more than 61 million adults with a registered disability. Disability is defined as a physical and or mental limitation that impacts one or more major life activities. This definition equates to 26% of the U.S. adult population, which is one of four adults (CDC, 2019). According to the Americans with

Disabilities Association (ADA), a person living with a SCI is identified as a person with a disability. SCI is a debilitating neurological condition (Alizadeh et al., 2019).

This type of disability is brought on by a significant impact to one of two levels of the spine identified as complete or incomplete (Alizadeh et al., 2019). SCI commonly results from a sudden, traumatic impact on the spine that fractures or dislocates the vertebra (Leden et al., 2017). The initial force delivered to the spinal cord is known as the primary injury resulting in displaced bone fragments, discs, or ligaments. These forces cause bruises or tears in the spinal tissue. This injury to the spine can be caused by traffic accidents, gunshot injuries, falls, sports injuries, or disease of the spine. Spinal cord injury occurs when there is any damage to the spinal cord that blocks communication between the brain and the body (National Spinal Cord Injury Statistical Center [NSCIS], 2016). The International Journal of Physical Medicine & Rehabilitation (2014) defined SCI as a "catastrophic physical injury resenting substantial obstacles to adjustment in the long-term, often being associated with additional challenges" (p. 226). The additional challenges caused by SCI could create community obstacles such as integration and long-term quality of life. Findings included in the NSCIS (2016) suggests the need for additional exploration and comprehension of what it means to live with SCI and/or a physical disability.

Additionally, anxiety and depression have been viewed by many clinicians as an inevitable consequence of SCI. Craig et al. (2015) performed a systematic review and revealed that SCI patients in the rehabilitation phase still have a risk of depression and that almost 30% of those may develop a risk of depression. In addition, Craig et al. found

that the potential depressive risk may be approximately 27% when SCI patients return to their normal life. In examining SCI during the first 5 years post-SCI, Arrango-Lasprilla et al. (2014) found possible factors that influenced depression development included demographic characteristics, injury causes, and rehabilitation discharge factors. Additionally, Kennedy and Roger (2015) found a significant correlation between anxiety and depression in individuals with SCI. Essentially when patients are not adequately prepared to cope with life after a spinal cord injury, symptoms of depression and difficulties with acceptance can occur (Dorstyn & Kraft, 2015).

Rehabilitation counseling has been described as a process where the counselor works collaboratively with the client to understand existing problems, barriers, and potentials to facilitate the client's effective use of personal and environmental resources for career, personal, social and community adjustment following disability (Hawley et al., 2014). Rehabilitation counselors are expected to be prepared to assist individuals in adapting to the environment, assist in accommodating the needs of the individual, and work toward the full participation of individuals in all aspects of society, with a particular focus on independent living and work.

The primary goal of rehabilitation counseling is to assist individuals with disabilities gain or regain their independence through employment or some form of meaningful activity (Hawley et al., 2014). Developers of this goal assumed that meaningful activity provides individuals with disabilities social networks, interpersonal relations, and ultimately experience a good quality of life. While the goals of rehabilitation counseling are relatively unequivocal, the process by which rehabilitation

counselor's work with clients to achieve these goals has become increasingly diverse and complex due to the broadening scope of disability groups served, and the various settings in which rehabilitation counseling services are provided.

For the counseling profession, it is important to provide culturally responsive services to which clients are entitled (Mental Health Services Administration, 2016). This includes persons who have been impacted by a SCI. Given the mental health challenges experienced by individuals with SCI, Bauman and Milligan (2016) argued that when all factors of rehabilitation are not included in counselor training programs it creates an additional responsibility on counselors to help patients of SCI cope with this difficult life event. Limited mental health training available in serving clients with disabilities further hinders the profession's ability to advance and this may equate to the provision of inadequate care (Stuntzner et al., 2014). The American Rehabilitation Counselors Association (2018) recommended that counselors and counselor training programs support the attainment of these competencies among all counselors, in recognition of disability as a part of personal identity and cultural diversity and in affirmation of their professional commitment to social justice.

According to the National Spinal Cord Injury Statistical Center (2016), there are 12,500 new cases of SCI each year in North America. More than 90% of SCI cases are traumatic and caused by incidences such as traffic accidents, violence, sports or falls (WHO, 2013). There is a reported male-to-female ratio of 2:1 for SCI, which happens more frequently in adults compared to children (WHO, 2013). With the increase of this

population, there is an urgent need to understand the ways in which individuals are supported in coping with their condition as it is likely that counselors of all backgrounds and specializations may work with persons with SCI. Addressing the mental health needs through counseling can help manage the personal wellbeing and self-concept of SCI individuals (NSCSIC, 2016). Therefore, when considering the factors that influence the mental health needs of persons with SCI, understanding how counselors view their competency levels with supporting this population is an important element of care and critical in the delivery of continuity of care for persons with SCI.

Purpose of the Study

The purpose of this qualitative descriptive phenomenological study was to understand rehabilitation counselors perceived competency in addressing the mental health needs of a person with SCI and/or a physical disability. Considering the factors that influence the mental health needs of persons with SCI and/or a physical disability and understanding how counselors view their competency levels with supporting this population is an important element of care and critical in the delivery of continuity of care for persons with SCI and/or a physical disability. I addressed this gap by using a qualitative descriptive phenomenological approach. This approach is a widely cited research method and has been identified as important and appropriate for research questions focused on describing the who, what, and where of events or experiences and gaining insights from participants regarding a phenomenon that lacks understanding by society (Matua, 2015). I employed six semistructured interviews to explore and understand the counseling process relationship, working with persons with SCI as a

disability, and/or physical disability, perceived competency, and experience trainings in school, decision making, and clinical settings for formulating problem statements.

Research Questions

RQ: What are the lived experiences of rehabilitation counselor's ability to support the mental health needs of SCI and/or physical disability clients?

SQ: How does the preparation of rehabilitation counselors support the person with SCI's and/or physical disability mental health needs?

Theoretical Framework

When choosing a research design, the researcher is actively trying to create a link between the problem, purpose, and research question(s) and conceptualizing how to best answer the questions (Bloomberg & Volpe, 2016). The selected framework for this qualitative inquiry was Giorgi's phenomenological descriptive method, adapted from Husserl (see Giorgi et al., 2017). The research study used Giorgi's (2018) framework to help guide the development of the research and design the practices used for this study. Giorgi's (2018) descriptive phenomenological approach, influenced by Husserl's (1974, 1977) framework of phenomenology, allows the researcher to gather rich, thick descriptions in its original existence. With descriptive phenomenology I used the technique of bracketing off personal biases and influences around the SCI population to get to the essences (see Smith et al., 2009) of the rehabilitation counselors' perspectives. The focus of descriptive phenomenology was on the correlation of the noema of

experience which is the competency of the rehabilitation counselor's and the noesis of how this influences care for the SCI and/or a physical disability patient.

Using the view of Husserl (1974, 1977), I used intentionality as the counselor's knowledge, experience, and perceptions of their SCI and/or a physical disability experience as a comprehensive intentional response. It is here that the distinction of noesis and noema was made. I did not change the natural attitudes of the rehabilitation counselor and applied phenomenological reduction to be open to the full range of the conscious experience and therefore in bracketing I did not change the counselor's experiences with the SCI and/or a physical disability patient. A qualitative phenomenological design rooted in Husserl's descriptive transcendental approach from which Giorgi (1970a) closely follows, allowed for an open dialogue where participants could share their experiences and provide these sensitive details that are instrumental to the growth and advancement of the SCI and/or a physical disability population. Further, this approach kept the fullness of the rehabilitation counselor's expressions and fruitfulness of the participant's contributions in the research without removing their viewpoint within the process of analysis. A more detailed explanation of the theoretical framework is provided in Chapter 2.

Nature of the Study

The nature of this study was qualitative, based on Husserl, who is the founder of phenomenology of which Giorgi (1970a) closely followed. Giorgi built upon this

philosophical foundation and designed a research approach using Husserl's phenomenological framework that phenomenon is perceived or understood in the human consciousness. In this study, I described the perceived competency of rehabilitation counselors when working with SCI and/or a physical disability client, which suggest that the research should be qualitative in nature. The focus of my study was to explore how the perspectives on counselor competency, rehabilitation care, self-concept, and overall perceptions of mental health care needs for SCI and/or a physical disability to understand the lived experiences and preparations of rehabilitation counselors in a qualitative way. Using Giorgi's descriptive phenomenology, I described the experiences and their perceived psychological perspective, which allowed the participants to provide and articulate meanings that were based on their personal individual experiences.

Theoretical Foundation

Descriptive Phenomenology

Giorgi's descriptive psychological design aligned with the purpose of the study because the intent was to produce results that are based entirely upon what the participant said. Phenomenological researchers are interested in the activities of consciousness and the objects that present themselves to consciousness (Giorgi, 2012). The operative word for Giorgi in phenomenological research is 'describe'. In this study, I applied the six steps of data analysis using semistructured 60-minute interviews with a proposed sample size of 6 rehabilitation counselors in order to describe the lived experiences and understand how preparation and competency with the SCI and/or a physical disability client influences the counselor's ability to support long term rehabilitation and mental

health needs. Description is the goal of the method and is embedded in interpretation from which Husserl (1911, 1965) said it must manifest itself in knowledge and in consciousness. Using descriptive phenomenology, I described the participant experiences exactly as they were presented. This design allowed me to produce a semistructured description of the lived experiences of rehabilitation counselors as it was communicated by the participants with preconceptions and biases bracketed in epoche (Giorgi, 2012).

Definitions

Competency: Competency is described as providing respectful and timely communication, taking appropriate action when cultural diversity issues occur, and being accountable for the outcomes as they affect people of all races, ethnicities, genders, national origins, religions, sexual orientations, or other cultural group identities (RC Code of Ethics, 2017).

Mental Health: Mental health is defined as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (WHO, 2018).

Physical Disability: Physical disability is defined as a physical and or mental limitation that impacts one or more major life activities (CDC, 2019).

Rehabilitation Therapy: Rehabilitation therapy is a process where the counselor works collaboratively with the client to understand existing problems, barriers and potentials to facilitate the client's effective use of personal and environmental resources for career, personal, social and community adjustment following disability (Commission in Rehabilitation Counselor Certification, 2017).

Spinal Cord Injury (SCI): SCI is a debilitating neurological condition that blocks communication from the brain to the body (Alizadeh et al. 2019).

Assumptions

As the researcher, I assumed that participants provided an honest description of their lived experiences as applicable to the research questions. In addition, assumptions included that rehabilitation counselors have experience working with SCI and/or a physical disability client, and that rehabilitation counselors know what SCI is and what a physical disability is. This is important because individuals without disabilities tend to concentrate on what they perceive to be adverse aspects of having a disability (Smart, 2009). If not appropriately evaluated, these biases or attitudes can influence clinicians' work with clients and their families (Hartley, 2012). Therefore, it was important to explore the rehabilitation therapists' perceptions and competency of SCI and/or a physical disability when working with the disability community.

Scope and Delimitations

In this study, the scope was limited to certified rehabilitation counselors who are providing services in a therapeutic rehabilitation setting for persons who have been impacted by a SCI and or physical disability. Therapeutic rehabilitation was defined as providing help for disabled persons, the removal or reduction of disabilities, physical rehabilitation, or physical restoration (WHO, 2021). Rehabilitation is defined as the restoration of someone to a useful place in society (WHO, 2018). The research was delimited by licensed clinical social workers and licensed school counselors who do not work with spinal cord injured or physically disabled clients in an outpatient or inpatient

setting, or who have no knowledge of what a SCI is. Rehabilitation counselors were chosen for this study due to their specific attention to helping clients with disabilities cope with their feelings of anxiety and depression and reintegrate into the community (Stuntzner & Hartley, 2014). Transferability in qualitative research provides the participants with evidence that the research findings could be applied in other contexts, situations, or populations (Korstjens & Moser, 2018). The scope of this study limit transferability of the findings from rehabilitation counselors to other specialized groups of counselors working in school, education, or community outpatient settings by implementing the experiences of the research findings to developed programs. Although the scope of this study limited transferability, the research identified a need to describe the competency of rehabilitation counselors while working with persons with physical disabilities, and SCI (see Burns et al., 2017; Marini et al., 2018). The goal of qualitative research was aimed at gaining a deep understanding of a specific phenomenon rather than a surface description of a population (Hameed, 2020). A quantitative method would not allow the researcher to provide a deep understanding in specific details as described by the rehabilitation counselors' personal experiences working with SCI and/or a physical disability or perceived competency.

Limitations

Defining qualitative research has its challenges as it relates to defining the term clearly (Ritchie et al., 2013) since it does not have its theory or paradigm nor an obvious set of methods or practices that are merely of its own (Denzin & Lincoln, 2011). Silverman (2010) argued that qualitative research approaches sometimes leave out

contextual sensitivities and focus more on meanings and experiences. The qualitative descriptive phenomenological approach, as identified in this study, attempts to uncover, interpret, and understand the participants' experience (Wilson, 2014; Tuohy et al., 2013) as described by the rehabilitation counselor.

As a qualitative study, limitations of data analysis rely on the self-report of rehabilitation therapists and cannot be independently verified. Qualitative research is open-ended, and participants have more control over the content of the data collected. The techniques used during data collection to include structured interviews, focus groups, and observations can alter the information in subtle ways. This could increase the possibility of bias depending on the research findings. This could fail to provide accurate information about a rehabilitation counselor's true ability to identify with the SCI and/or a physical disability client's area of competency.

Oppong (2013) analyzed the sampling issues in qualitative research to ensure that the sample size of a given study is adequate or representative. Alshenqeeti (2014) assessed the value and limitations of interviewing as a research instrument. He looks at the practical issues of adopting interviews and he discusses the validity and reliability of interviews in research studies. Jamshed (2014) advocated the use of interviewing and observation as two main methods to have an in depth and extensive understanding of a complex reality. With this method in mind, the process of qualitative research can be time consuming. Depending on how soon entry is gained and the amount of participation, the results can take weeks or several months to interpret.

Qualitative research requires thoughtful planning to ensure the obtained results are accurate. There is no way to analyze qualitative data mathematically. This type of research is based more on aspects of reality and lived experiences rather than statistical results. Maxwell (2013) advocates that qualitative research works with the universe of meanings, motives, aspirations, beliefs, values, and attitudes, which corresponds to a deeper phenomenon that cannot be reduced by variables. As a person living with SCI and/or a physical disability, awareness of biases is factored in to make sure the personal experience with SCI and/or a physical disability does not interfere or add to the experiences of the rehabilitation counselors' experiences or their approach to counseling SCI and/or a physical disability, and perspectives of the person with SCI and/or a physical disability mental health need. During the process of data collection, I applied epoche by bracketing my own experience and knowledge concerning challenges or benefits associated with the phenomena to understand the counselors' experiences entirely by staying away from confirmation biased results.

Significance

The profession of rehabilitation counseling has been shaped significantly by graduate training programs that have, for many years, been grounded in providing students with the knowledge and skills necessary for working with persons with physical and mental disabilities. As the research shows, the image of disability is changing and well defined as disability groups broaden and grows globally. Today, rehabilitation counselors work in various settings including hospitals, private clinics, outpatient clinics, and schools. While the primary role of rehabilitation counselors has not changed

substantially, the specific functions of counselors do vary according to their practice settings (public, private for profit, community-based rehabilitation organizations, etc.) and the disability group being served. The diversity of rehabilitation counseling function is apparent. The diversity of disabled clients specifically SCI and/or a physical disability is also apparent. To provide effective services to the SCI and/or a physical disability population, rehabilitation counselors must apply competence in their roles, functions, knowledge, and skills for the needs of the person with SCI and/or a physical disabilities emotional, social, and environmental factor.

This phenomenological study filled the gap in counseling literature by providing an understanding of the experiences concerning preparation and practice that rehabilitation counselors who work with clients with physical disabilities, including, SCI possess. The relationship between rehabilitation counselors and therapeutic outcomes for persons with SCI and/or a physical disability may not include services for support of mental health care needs. Bauman et al. (2015) argued there is limited information available to guide individuals with SCI and/or a physical disability in choosing the best options post-SCI and/or a physical disability rehabilitation to include maximizing recovery and future planning for health and wellness. Findings from this study support the literature in understanding training opportunities for counselors who work with persons with SCI and/or a physical disability. Additionally, findings support clients with SCI and/or a physical disability to get the mental health care they need as rehabilitation counselors may learn ways to integrate mental health services into long-term rehabilitation care (WHO, 2016).

The findings of this study contribute to social change by providing information that counselor education programs may be able to use when training rehabilitation counselors for serving clients with disabilities, to include the SCI community. Data from this study support counseling programs on examining areas of competency and increase educational regimes to specifically identify SCI and/or a physical disability as a part of a minority group of disabilities. Counselor education training programs could describe the global psychosocial effects of this type of injury with use of understanding, empathy, and appropriate use of referrals to balance physical and mental well-being. The findings from this study can contribute to social change by supporting trained and competent certified rehabilitation counselors who could increase the opportunities to provide a greater impact on the SCI and/or a physical disability community and the long-term emotional stability for persons with SCI and/or a physical disability.

Summary

This chapter described the perceived competencies of rehabilitation counselors while working with spinal cord injured persons using a qualitative descriptive phenomenological research method. The interviews described the counselor experiences as it relates to counseling, knowledge of SCI and/or a physical disability, biases, and attitudes of disabled persons. Interviews provided counselors the opportunity to include their lived experiences within the current body of inclusion counselor education research. Chapter 1 was designed to introduce this qualitative descriptive phenomenological study of rehabilitation counselors and their lived experiences involving counseling persons with SCI and/or a physical disability. This chapter included the background of the problem,

purpose of this research, research questions, theoretical framework, significance of the study, and implications for social change. Chapter 2 includes a literature review involving research that examines who rehabilitation counselors are, roles of rehabilitation counselors, understanding SCI as a disability, and physical disability with a focus on current practices, biases, and recommended competencies.

Chapter 2: Literature Review

The purpose of this qualitative phenomenological study was to describe the perceived competency of rehabilitation counselors when working with SCI and/or a physical disability. Considering the factors that influence the mental health needs of persons with SCI and/or a physical disability, understanding how counselors view their competency levels with supporting this population is an important element of care and critical in the delivery of continuity of care for persons with SCI and/or a physical disability.

Therapeutic rehabilitation was defined as providing help for disabled persons, the removal or reduction of disabilities, physical rehabilitation, or physical restoration (WHO, 2021). Rehabilitation is defined as the restoration of someone to a useful place in society (WHO, 2018). It was important to define the difference between therapeutic rehabilitation and rehabilitation as one relates to treatment therapy received by patients who go through an amputation, suffer a brain injury or stroke, or experience an orthopedic or spinal cord injury. Rehabilitation is for persons who need substance use services related to alcohol and drug use. The rehabilitation counselor's code of ethics (Commission on Rehabilitation Counselor Certification [CRCC], 2017) stated rehabilitation counselors does not misrepresent their competency to clients or others. In this study, I explored the perceived competency of rehabilitation counselors when working with persons with SCI and/or a physical disability.

Determining how rehabilitation counselors perceive their competency in helping persons with SCI and/or a physical disability regain, physical, mental, and or cognitive

abilities that have been lost or impaired because of SCI and/or a physical disability could provide counselor education training programs the global psychosocial effects of this type of injury with use of understanding, empathy, and appropriate use of referrals to balance physical and mental well-being. Findings from this study, could positively impact social change in the field of rehabilitation counseling. First, understanding relationships among these factors could lead to information that could contribute directly or indirectly to increasing competency of rehabilitation counselors as it relates to the mental health and emotional needs of persons with SCI and/or a physical disability. Second, findings could contribute to increasing the community awareness within the public rehabilitation counseling sector and could lead to improvement in the quality of services for persons with SCI and/or a physical disability. In the following sections of this chapter, the literature search strategy, theoretical framework, literature review, and conclusion are provided.

Literature Search Strategy

Multidisciplinary databases were used in the development and exploration of the literature. The results included journal articles, books, and dissertations. Sources used include Google Scholar, World Journal of Orthopedics, and Journal for Spinal Cord Injured Persons, SAGE Journals, VISTAS Online, and Walden University library. The key words searched were *rehabilitation counselors, counselor competency, spinal cord injury, rehabilitation therapy,* and *mental health.* The searches covered the following years: 2015-2020.

Theoretical Framework

In this qualitative study, I used a descriptive phenomenological approach to guide the research process to understand the perceived competency of rehabilitation counselors when working with spinal cord injured clients based on Husserl. According to Husserl, human conscious experiences are experiences of the world, and it is the world that gives meaning to these experiences (Teherani et al., 2015). This was a qualitative study where descriptive phenomenology was explained from its historical underpinnings.

Phenomenology as a methodological framework has evolved into a process that seeks reality in individuals' narratives of their lived experiences of phenomena (Cilesiz, 2009; Husserl, 1970; Moustakas, 1994). Phenomenology includes different philosophies consisting of transcendental, existential, and hermeneutic theories (Cilesiz, 2010). While transcendental philosophy is often connected with being able to go outside of the experience, as if standing outside of oneself to view the world from above, existential philosophy reflects a need to focus on our lived experience (Ihde, 1986; Langdridge, 2007). Hermeneutic phenomenology emphasizes interpretation as opposed to just description. In this study, I used the descriptive phenomenological framework developed by Husserl, who provided the basis for phenomenology (Moustakas, 1994).

Descriptive phenomenology is widely used in social science research as a method to explore and describe the lived experience of individuals. Descriptive phenomenology is a philosophy and a scientific method and has undertaken many variations as it has moved from the original European movement to include the American movement (Westcott, 1994). The philosophical underpinnings of Husserlian phenomenology are that

of the lived, human experience and as such Husserl sought to reinstate the human world as a foundation of science that brought justice to the everyday lived experience; going to the things themselves (Dahlberg et al., 2001). Below, I described the principles of intentionality, noema, noesis, epoche, and phenomenological reduction to illustrate how each of these principles are applied within the context of this framework.

Intentionality

Husserl (1970) argued that there is a positive relationship between perception and objects. The object of the experiences is actively created by human consciousness. Therefore, for Husserl (1931), intentionality is one of the fundamental characteristics of the phenomenology that is directly related to the consciousness. Intentionality refers to doing something deliberate (Peoples, 2021), such as going to the library for some purpose. It does not refer to doing something without thinking, such as reading or seeking directions. For example, in this study, the phenomenon is the rehabilitation counselor's experiences with treating persons with SCI and/or a physical disability with both disability and mental health needs. Using therapy for purposes of improving quality of life is an intentional experience of rehabilitation counselor's nonmental activities.

Counselor's therapeutic experiences with persons with SCI and/or a physical disability are intentional acts dependent on counselor consciousness. Therefore, the act of experience is related to the meaning of a phenomenon. Thus, the essence of the phenomenon is derived from the act of rehabilitation counselor's experiencing perceived competency of the needs of persons with SCI and/or a physical disability when providing

care. In addition, this study is concerned with understanding rehabilitation counselors experience with persons with SCI and/or a physical disability and how they perceive their competency of the unique challenges that come with this phenomenon to include training, preparation, and decision making.

Noema and Noesis

In descriptive phenomenology, intentionality has two dimensions, noema and noesis (Peoples, 2021). Noema is the rehabilitation counselor's experience or action, reflecting the perceptions and feelings, thoughts and memories, and judgments while working with persons with SCI (see Peoples, 2021). Noesis is the act of experience, such as perceiving, feeling, thinking, remembering, or judging while working with persons with SCI and/or a physical disability; The act of experience is related to the meaning of a phenomenon (see Peoples, 2021). In this study, while perceived competency of rehabilitation counselors was the noema of the experience, describing the experiences working with persons with SCI as a disability and/or a physical disability was the noesis of the experiences. Noema and noesis are interrelated and cannot exist independently or be studied without the other (Cilesiz, 2010).

Epoche

Epoche allows a researcher to be free from bias when describing the lived experiences using an objective perspective (Peoples, 2021). When interviewing the participants, I applied the process of epoche during phenomenological analysis process of the research. For example, bracketing my own experience and knowledge concerning challenges or benefits associated with the phenomena is encouraged to understand the

counselors' experiences entirely by staying away from confirmation biased results. Therefore, I bracketed my own views about the needs of persons with SCI and/or a physical disability, staying away from my own personal experience of having a spinal cord injury, and rely on statements described by participants.

Phenomenological Reduction

Phenomenological reduction involved describing individual experiences through textural language. Giorgi et al. (2017) explained it as adjusting the consciousness to take in objects from the experience as presented but not as objects that physically exist. However, when the object studied is an experience itself, it may be more beneficial to think of it as understanding the experience from the participant's description and understanding of it, not filtering the experience through a preconceived understanding or ideas about the experience (Giorgi et al., 2017; Shelton & Bridges, 2019). This mindset supported the bracketing process as I engaged in data analysis. To describe the general needs of the phenomenon, eliminating all elements that are not directly within conscious experience, eliminated overlapping, repetitive, and vague expressions specifically during the themes and coding process.

Relation to the Study

The phenomenological theoretical framework has been applied in numerous qualitative studies and used in a wide range of domains (see Hale & Bridges, 2020; Milan-Nichols & Bridges, 2019; Wanzer, Gray, & Bridges, 2021; Zazzarino & Bridges, 2019). In a t study by Milan-Nichols and Bridges (2019), data was gathered from

counselor educators to study their experiences with emotionally charged exchanges while teaching multicultural counseling. Authors then used descriptive phenomenology and an ecological systems framework to reveal the emotions counselor educators experienced and the outcomes of the exchanges. Hale and Bridges (2020) described the experiences of six counselor educators from across the United States who transitioned from teaching counseling courses in the classroom to teaching them online. Four themes of common experience emerged from the data: (a) high expectations and low support from university leaders, (b) limits to transitional enthusiasm among counseling faculty, (c) solutions for transitional success, and (d) support essential for the transition. Results of this study confirm a need for greater attention to the transitional process and increased opportunities for experience and university support. Additional research conducted by Zazzarino and Bridges (2019) used a transcendental phenomenological study, grounded in a Husserlian philosophical and minority stress model conceptual framework, to explore the experiences and perceptions of counselors who provide counseling services to sexual minorities with a Serious Mental Illness (SMI). In this qualitative descriptive phenomenological study data were collected from six participants using semistructured interviews and followed a thematic data analysis process, ensuring thematic saturation. The results of this study identified themes regarding the unique needs of sexual minorities with a SMI such as multiple minority stressors, negative counseling experiences, and the impact of family, as well as counselors' perceptions regarding the lack of preparation in graduate school to work with sexual minorities with a SMI. In a final study to support the relation to the study, Wanzer et al. (2021) applied a

hermeneutic phenomenological study to illuminate the lived experiences of professional counselors counseling gender diverse clients. In an earlier study, Patton (2015) described hermeneutics as interpreting how and why context matters. Authors Sloan and Bowe (2014) describe the use of a hermeneutic, phenomenological approach as allowing the researcher to identify the essence of the phenomena and interpret those phenomena for a richer description of the date. With these studies in mind, a hermeneutic, phenomenological approach could allow a place of importance on the context of SCI for exploring the certified rehabilitation counselor's competency, which was important to the uniqueness of the study.

The role of phenomenology as defined by Husserl (1970) is to explore the essence of consciousness as experienced from the first-person point of view. This research aims to gain an in-depth description of the experience of rehabilitation counselors' competency while working with spinal cord injured persons. Based on the purpose and research concept, the theoretical framework using a descriptive phenomenological approach is appropriate. This framework allows the researcher to construct meaning at a deeper level and to uncover the foundational research concepts during data analysis (Giorgi, 2018).

Literature Review Related to Key Variables and/or Concepts

Growth of Disability Globally

According to the WHO (2018) approximately 1 billion, or 15% of the world's population are living with a disability. Disability prevalence is higher for developing countries. One-fifth of the estimated global total, or between 110 million and 190 million

people, experience significant disabilities. WHO further stated that disability rates will continue to increase due to the growing number of chronic illnesses, and conditions in older adults who are living longer with the disability. The research reported by Emerson (2012) described disability as a global human rights issue and further noted that people living with disabilities encounter considerable barriers when accessing community services.

Emerson (2012) highlighted that disability rates disproportionately affect women and children around the world and people with disabilities have worse health and socioeconomic outcomes than those not living with disabilities. Globally, Chun et al., (2016) reported children and youth with disabilities are either not enrolled in school, never complete their education, or they are denied educational accommodations for their disabilities. The United Nation's Department of Economic and Social Affairs on Disability (2019) reported that only 45 countries have antidiscrimination and disability-related laws. Further work is necessary to ensure that people with disabilities, specifically SCI and/or a physical disability are afforded equal access to community, work, education, and mental health services to sustain long term stability.

Understanding Spinal Cord Injury

SCI is a debilitating neurological condition that blocks communication from the brain to the body (Alizadeh et al., 2019). The most common causes of SCI are traffic accidents, gunshot injuries, knife injuries, falls, and sports injuries. There is a strong relationship between functional status and whether the injury is complete or not complete, as well as the level of the injury. The results of SCI bring not only damage to

independence and physical function, but also leads to serious disability in the patient resulting in the loss of work, which brings psychosocial and economic problems. Whether complete or incomplete, SCI rehabilitation is a long process that requires patience and motivation of the patient and rehabilitation counseling team.

Every year, about 40 million people worldwide suffer from SCI (WHO, 2019). Rehabilitation counselors are expected to be prepared to assist individuals in adapting to the environment, assist in accommodating the needs of the individual, and work toward the full participation of individuals in all aspects of society, provided by the CRCC (2017) with a particular focus on independent living and work. The primary goal of rehabilitation counseling is to assist individuals with disabilities gain or regain their independence through employment or some form of meaningful activity (Hawley et al., 2014).

The convention on the rights of persons with disability (CRPD) and WHO's international classification of functioning, disability and health (ICF), are two programs that provide a greater understanding of what it is like living with a disability, specifically SCI. The convention outlines aspirations to promote, protect, and ensure the full and equal enjoyment of all human rights for persons with disabilities, but also human rights entitlements in health, and provider services. For individuals with a severe SCI and limited potential for neuro-recovery, rehabilitation approaches focus on utilizing techniques to optimize function (Burns et al., 2017). As the understanding of SCI and associated processes of recovery continue to grow, there is an increasing emphasis on the procedures needed to restore function.

SCI is described as a medically complex and life-disrupting condition (Alizadeh et al., 2019). Historically, it has been associated with very high mortality rates. In communities with adequate and available resources, SCI can be viewed less as the end of life and more as a personal and social challenge that can be successfully overcome. What this change can provide is better medical provision, which means that people are able to survive, and have a good quality of life with the injury. For example, according to the CDC (2018) people who develop SCI can benefit from improved emergency response, effective health and rehabilitation interventions, and technologies such as respirators and appropriate wheelchairs. The medical responses along with mental health care could provide SCI a collaborative plan that adds positive satisfaction and maximize functioning. With the support of rehabilitation counselors and knowledge of what persons with SCI need both physically and emotionally, SCI could anticipate a fuller and more productive life, than they would have had historically. Understanding SCI is essential to understanding how people live with the physical, social, and emotional environment in which they experience their day-to-day lives. The quality of life with SCI depends greatly on whether the environment has the resources and services are available, if there are supportive relationships and community inclusion, or whether it acts as a barrier when people must confront discriminatory attitudes and other obstacles (Jimenez, 2018). Studies of persons living with SCI and/or physical disabilities reveal the necessity of having resources available to support coping and quality of life. Although Jimenez (2018) found that if there are supportive relationships and community inclusion, discriminatory attitudes could act as a barrier. Singh et al., (2014) describe the complexity of the lived

experience of SCI and the variations in that experience globally as being a comparatively low-prevalence condition. What this suggests is the number of SCI cases in each population are relatively low, however SCI has wider implications for monitoring health care. In theory, an individual with SCI will experience nearly every clinical setting that his or her country provides. This entails emergency services, and particularly rehabilitation, including return to the community, and ongoing primary care.

For the counseling profession, it is important to provide culturally responsive services to which clients are entitled (Mental Health Services Administration, 2016). This includes persons who have been impacted by SCI. Given the mental health challenges experienced by individuals with SCI, Bauman and Milligan (2016) argued that when all factors of rehabilitation are not included in counselor training programs it creates an additional responsibility on counselors to help patients of SCI cope with this difficult life event.

Lastly, limited training available in serving clients with disabilities further hinders the profession's ability to advance and this may equate to the provision of inadequate care (Stuntzner, et al., 2014). Rehabilitation counselors' perspectives of SCI could help clinicians, health professionals, researchers and gatekeepers to understand the strengths and weaknesses of their rehabilitation plans. A person with SCI's ability to maintain stability within their communities are a good indicator of how the overall health system works or areas that need improving. Beyond rehabilitation needs, the person living with SCI will also benefit from services such as, self-help groups, patient groups and other

advocacy and disabled people's organizations (Retrieved from facingdisability.com). For this study, it is important to understand that the social impact of SCI depends on social and environmental factors, and the respect of disability needs, particularly the availability of appropriate and accessible mental health care.

Adjustment to Spinal Cord Injury

Acquiring SCI can be a challenge to an individual's self-esteem (Kraft & Dorstyn, 2015). A person who has been accustomed to having their own independence, may now not be able to accept not being in control of his or her own life, or even body, and may be dependent on help from others to include care givers, healthcare providers, and family members. Those with traumatic SCI may also have concurrent traumatic brain injury that complicates adjustment (Alizadeh et al., 2019). For this reason, adjustment to disability has been defined as a dynamic process whereby people with SCI move towards a better fit with their environment (Schwartz et al., 2019).

A systematic review of studies of life satisfaction of people with SCI (Castro et al., 2018) confirmed that people with SCI experience higher levels of distress and lower levels of life satisfaction compared with persons who do not live with SCI. However, there are differences and most people with SCI adapt well to their condition. For example, in a recent study, 75% of participants experienced a decrease in life satisfaction after SCI, but one year after SCI, 50% of participants were satisfied or very satisfied with their lives (Mashola & Mothabeng, 2019). In a review of the attitudes and relationships of SCI and mental health, responses revealed that 20−30% of people with SCI show

clinically significant symptoms of depression, which is substantially higher than the general population (WHO, 2019).

In review of the research, earlier evidence showed a percentage of 27% of people with SCI experience posttraumatic stress disorder (Otis et al., 2012). While this evidence is older, the low percentage in this population demonstrate that, despite a higher-than-average risk of mental health problems, most people with SCI can adjust well to their condition. To do this, risk factors of mental health needs in persons with SCI must be applied and understood to manage symptoms effectively.

Mental Health Needs of SCI and or Physical Disability

During the post-injury period, persons with SCI and or physical disability will often experience grief and a range of emotions including denial, sadness, fear, frustration or anger as they begin the process of adjustment (Craig et al., 2017). Personal factors including gender, age, personality, coping style and premorbid mental health conditions (e.g., depression, anxiety, alcohol or substance abuse) and associated conditions such as post-traumatic stress disorder (PTSD) will influence how well an individual adjusts to the injury. Environmental factors including cultural beliefs and values, attitudes, social supports, provision and socioeconomic status also have an influence on adjustment.

Depression is a common mental health condition to which people with SCI and or physical disability are particularly vulnerable in the post-injury phase. A recent review has estimated that 20–30% of people with SCI and or physical disability show clinically significant symptoms of depression (WHO, 2019). Depression can have consequences for both SCI, physically disabled persons and their family members, and for health care

systems. Depression is associated with fewer improvements in functioning, increased health complications such as pressure ulcers and UTIs, high rates of suicide, increased rates of hospitalization, and higher medical expenses (Moulton, 2017). Mental health conditions such as depression are often regarded as a natural consequence of SCI and physical disabilities and are therefore inadequately addressed (Lake et al., 2017).

According to WHO, (2018) persons living with SCI represent 10% of the world's population is affected by mental health disorders and the prevalence is even higher in individuals with disabilities (Williams & Murray, 2015). SCI is a condition that often causes major physical disability, as the damage to the spinal cord leads to a total or partial loss of sensation and movement below the lesion level (WHO-SCI, 2018). Authors Williams and Murray (2015) reported an increased risk of mental health disorders observed in individuals with SCI. Mental health disorders are identified as depression and anxiety with prevalence rates as high as 27%. Considering these figures, the need to better understand the mental health needs that impact the SCI population are important to support interventions applied by rehabilitation counselors.

Symptoms of mental health such as depression interferes with a person with SCI and persons with a physical disability quality of life at the emotional, psychomotor, cognitive, and consciousness levels (Probst, 2017). The application of these risk factors could be applied as a treatment measure so that rehabilitation counselors could help increase daily activities and therapy to reduce symptoms of major depression, however the research has not depicted how risk factors regarding the level of SCI or physical disabilities fractures relates to the development of major depression. Therapeutic

rehabilitation for the adjustment to the injury requires early assessment of mental health, education of the condition, information regarding available community resources, counselling and potentially medication, and long-term stability of care (WHO-SCI, 2018).

Peer mentoring and support is an additional resource that can contribute to the emotional health of SCI and or physical disability and is becoming an important component of rehabilitation programs. There is evidence that peer mentorship contributes to improved adjustment and functioning for the person with SCI and physical disability (Hoffman et al., 2019). PWD are a population who is often overlooked and underappreciated on a global realm, who form the largest minority in the country (United States Department of Labor, 2017). In the United States alone, the CDC and prevention (2019) reported that there are more than 61 million adults with a registered disability. What this means for the counseling profession is an awareness of barriers, and the knowledge of knowing how persons with disabilities deal with issues within their families, environment, and society.

Depending on the family's understanding of disability, negative messages can be perpetuated and further hinder the PWD, abilities and strengths. This is equally the same for the person with SCI. Depending on the person with SCI's limitations or physical limitations, families may assume the individual to be incapable. Due to these experiences, an understanding of how to work with clients with disabilities and the systems they navigate is vital to addressing concerns while providing culturally responsive care

(Tapia-Fuselier & Ray, 2019). Providing sensitive care begins with understanding the barriers faced by persons living with disabilities.

The CDC and prevention (2019) describe different types of environmental barriers that exist. These barriers place greater hardships on persons with disabilities. These include attitudinal barriers (such as the use of stereotypes, stigma, discrimination; communication barriers (such as means of communication that are inaccessible to persons with disabilities); physical barriers (such as those that hinder mobility); policy barriers (lack of familiarity or not adhering to enacted laws and regulations); programmatic barriers (such as difficulties with the provision of healthcare services and programming); social barriers (such as unequal employment rates and a lessened likelihood of graduating high school) and transportation barriers often due to inaccessibility. While clinicians without disabilities will not be able to truly understand the magnitude of barriers and their effects on persons with a disability, we must empathize and stay with clients in the process of maneuvering through various systems and encourage change on a communal level (Marini et al., 2018).

Rehabilitation Counseling

An official definition of rehabilitation counseling is provided by the CRCC (2017), in their scope of practice statement. CRCC (2017) defines rehabilitation counseling as a systematic process which assists persons with physical, mental, development, cognitive, and emotional disabilities to achieve their personal, career, and independent living goals in the most integrated setting possible through the application of the counseling process. The definition emphasizes that rehabilitation counseling focuses

specifically on the needs of the people with all different types of disabilities; that counseling is central to the process; and those integrated settings are emphasized in the pursuit of career and independent living goals. These goals assume that meaningful activity provides a rehabilitation plan to which individuals with disabilities can become productive members of society, establish social networks and interpersonal relations, and ultimately experience a good quality of life (Chan et. al, 2012).

While the goals of rehabilitation counseling are relatively unequivocal, the process by which rehabilitation counselor's work with clients to achieve these goals has become increasingly diverse and complex due to the broadening scope of disability groups served, and the various settings in which rehabilitation counseling services are provided (Chan et al., 2011). Rehabilitation counseling has been described as a process where the counselor works collaboratively with the client to understand existing problems, barriers and potentials to facilitate the client's effective use of personal and environmental resources for career, personal, social and community adjustment following disability. In carrying out this multifaceted process, the CRCC, (2016) adopted in the CRCC, (2017) that rehabilitation counselors must be prepared to assist individuals in adapting to the environment, assist environments in accommodating the needs of the individual, and work toward the full participation of individuals in all aspects of society. This process includes specifically the spinal cord injured population, with a particular focus on mental health as it pertains to anxiety and depression (Kraft & Dorstyn, 2015). The roles, functions, and perceptions of rehabilitation counselors working with disability

clients, specifically SCI is important because of the degree of severity and the diverse needs of this minority group when understanding quality and application of care.

Rehabilitation counselors can be found in private practice, in rehabilitation facilities, hospitals, universities, schools, government agencies, insurance companies and other organizations where people are being treated for congenital or acquired disabilities (CACREP, 2016). Over time, with the changes in social work and mental health services being more psychotherapy-oriented, rehabilitation counselors take on more and more community engagement work, especially as it relates to special populations (Lewis, 2018).

According to the CRCC (2017), rehabilitation counselors are aware that all individuals exist in a variety of contexts and understand the influence of these contexts on an individual's behavior. Rehabilitation counselors are aware of the continuing evolution of the field, changes in society at large, and the different needs of individuals in social, political, historical, environmental and economic contexts.

Biases and Community Attitudes

Before exploring the ways to improve serving SCI in therapy, we must address internalized biases about people with disabilities. Historically and in the present, people create an image in their mind of what they see when they read or see the term "disability." The image that appears may be representative of what society depicts as someone with a disability or based on personal experience (McDevitt, 2018). Examining the thoughts and feelings that we associate with the image are important to further work through biases concerning people with disabilities.

Authors Tapia-Fuselier and Ray, (2019) convey how taking an inventory of self as the therapist is essential to address necessary conversations with clients with disabilities regarding their disability and correlating identities. If internalized biases are not explored or addressed, clients with disabilities may encounter difficult experiences with a therapist, which could influence their disability identity in a negative or positive way. By working through misconceptions of persons with disabilities, therapists have more internal resources to inquire and manage aspects of the client's life that may be difficult or uncomfortable to discuss (Rohwerder, 2018). Working through these misconceptions can further counteract many of the negative attitudes toward disability, as well increase counselor knowledge and understanding about disabilities.

In a counseling relationship, therapists can expect to discuss areas of sex, relationships, barriers, quality of life, and the SCI perception of his or her disability. Rehabilitation counselors are to work in collaboration with their clients. This process is intended to promote client welfare and support clients in developing and progressing towards their developed goals (CRCC, 2017). RCs are expected to ensure that clients participate in all aspects of their goals and can make informed choices concerning care. Applying the information discussed will lead to more thoughtful and responsive care when working with persons living with SCI. Community attitudes on SCI has been seen as a negative representation over the past years. In earlier research cited in the Iranian Journal of Research, Hosseinigolafshani et. al. (2014) reported that cultural representations of and attitudes to disability influence every social interaction in the lives of people with disabilities. In more recent research, Irmo et al. (2017) reported negative

characteristics to include staring, ignoring, evading, stereotyping and marginalizing negative attitudes observed by persons in the community.

It is equally important to understand that attitudinal barriers can be just as inhibiting as physical barriers (Cole et al., 2016). Many persons living without a disability may be unaware of the reality of life for people with disabilities. Instead, they base their attitudes on stereotypes and negative imagery (WHO-SCI, 2018). Historically, disability was associated with dependency and passivity, and in some cultures, it was associated with witchcraft, sin or negative karma (WHO-SCI, 2013). While persons living without a disability can avoid these prejudices, disability is still considered to be incompatible with a good quality of life; for example, there are persons who views quadriplegia, which is paralysis to the upper and lower body to be worse than death (Graham, 2017). To further support this statement, A Kenyan study of families with children with spinal bifida revealed that only six of forty families found their community very helpful; seven had been shunned, while nine felt that they were cursed because of the birth of a disabled child (Veer et al., 2008). In Bangladesh, family members themselves had negative attitudes and low expectations about their relatives with disabilities (Maloni, et al., 2010).

A survey on the facilitators and barriers for people with mobility impairments in the United States indicated that the attitudes of family, friends and personal assistants had a large positive influence on recovery, while the attitudes of physicians and therapists were viewed as being barriers to receiving health care (Gray, 2008). However, this may differ according to the severity of injury. A Canadian study found that while about two

thirds of people with SCI in excellent health identified the attitudes of their family and friends as helping their rehabilitation, 25% of those in poor health cited attitudes of family and friends as obstacles to their rehabilitation (WHO, 2013). According to these lived experiences, it may be plausible that people may be unaware of what a positive attitude towards people with SCI is (WHO, 2013). Surveys of people with SCI have found that they perceive their lives more positively than do health-care professionals and the public (Piatt et al., 2016).

Addressing Community Barriers

Contact with people with disabilities improves attitudes (Armstrong et al., 2017). Attitudes include improvements in disability perception, physical attractiveness, mobility by wheelchair, employment opportunities, and community integration (Rohwerder, 2018). In essence, the more that people with SCI interact with society in relationships such as schools, traveling, community neighborhoods, and employment, the more that adults and children without disabilities will learn to understand and respect them as part of the diversity of society (Armstrong et al., 2017). When cultural venues are made more accessible, it becomes possible for people with disabilities to live normal lives all of which could help to improve attitudes.

Targeted interventions such as disability equality and awareness training delivered to service providers can challenge negative attitudes and increase understanding (Randell et al., 2017). Additional interventions to support acceptance, could also include educational interventions such as visits from disabled role models or advocates can improve children, adult, and provider awareness and understanding (Houlihan et al.,

2016). The presence of more varied and positive disability role models in the media may also influence attitudes and increase individual awareness. This could also challenge negative attitudes to disability and promote acceptance (Hosseinigolafshani et al., 2014).

Attitudes of Health Professionals

A systematic review conducted on bias in the healthcare profession, found that health professionals may sometimes be prejudiced against people with disabilities or may fail to treat them with respect (Fitzgerald & Hurst, 2017). For example, one study found that 8.2% of general practitioners in south-western France felt discomfort regarding people with physical impairments, and these attitudes were associated with less experience, lack of medical training about disability and inadequate consultation time (Disability and Developmental Report, 2018). An earlier Australian study found that occupational therapy students' attitudes were no better than those of business students (Brown et al., 2009). Another study reported by Hosseinigolafshani et. al., (2014) found that nurses working in acute SCI care had more negative attitudes to older people with SCI than did either nurses working in SCI rehabilitation or people with SCI. This could have been contributed by the experiences of seeing SCI individuals in a critical state, prior to becoming more stable.

This phenomenon may also explain the negative attitudes found among emergency care providers (Landau et al., 2018) and some rehabilitation workers (Hosseinigolafshani et al., 2014). These studies were mainly conducted in high-income countries. Less is known about the attitudes of health professionals in low- and middle-income countries (Landau et al., 2018), although analysis of the Model Disability Survey

(2018) found that, compared with nondisabled people, people with disabilities were twice as likely to find health-care provider skills and equipment inadequate to meet their needs, three times as likely to be denied care, and four times as likely to be treated badly.

Addressing Health Professional Barriers

Health-care professionals with supportive attitudes were seen by people with SCI and or physical disability as being central to their recovery, well-being, autonomy and hope (WHO-SCI, 2018). It has been found, for instance, that the positive attitudes of physicians can have more influence on patient attitudes towards their disability and rehabilitation than education of patients on their treatment options (Shakespeare and Kleine, 2013). Therefore, it is critical to help professionals to develop positive attitudes and better understanding.

Efforts to improve the attitudes of health professionals are included in the world health organization's, disability and health guide (2020). Suggested measures include techniques such as lectures and modules on the health needs and human rights of people with disability in undergraduate training. Lecture topics include exposure to people with disabilities or to disabled peoples' groups. In-service training and other forms of continuing education could help influence the thinking of core treatment providers to include rehabilitation counselors. Encouraging the training of rehabilitation counselors working with disabilities could also challenge the prevailing stereotype that people with disabilities are always patients (Jamal, 2019).

Addressing SCI and or Physical Disability Rehabilitation Barriers

Since the way people view themselves is predictive of how they adjust to physical disability (Magsamen-Conrad et al., 2016), perceptions of the SCI person's condition should be evaluated during the process of rehabilitation to help encourage positive self-esteem. Rehabilitation counselors can have a significant impact on the patient's self-image by, for example, providing information and creating opportunities such as group outings, which Magsamen-Conrad et al. (2016) reported to be beneficial in overcoming fears of being stared at. Evidence on psychological interventions following SCI is growing, however there a remains a need for further interventions. In support of this, the most widely used and studied intervention to reduce depressed mood in people with SCI is cognitive behavioral therapy (Kraft & Dorstyn, 2015). Applying the techniques of CBT could help facilitate the emotional and behavioral change on the part of the person with SCI.

Earlier techniques such as coping effectiveness training (CET) has also shown to be effective in people with SCI (Duchnick et al., 2009), and especially in those with more severe mental health disorders at baseline. The intervention may work by changing participants' negative appraisals of the implications of SCI and increasing their perception of its consequences, thereby improving their mood. Supportive group therapy (SGT), which emphasizes the sharing of experiences and information on topics related to living with SCI, the exploration of emotional and cognitive reactions, and the opportunity

for support and education from peers and healthcare providers, could also be effective in reducing depression and anxiety (Pfeiffer et al., 2013).

Positive cognitive factors, including self-efficacy and self-esteem, are consistently related to better quality of life. These variables may be seen as psychological resources that help people to regain their quality of life after SCI and or physical disability. For example, in a recent article, Cherry (2022) reports that people with high self-efficacy and high self-esteem might be more likely to take personal control of their future than people with low self-efficacy. The belief is that persons who have a stronger belief in their ability can influence their situation for the better.

Positive psychology interventions aimed at cultivating positive feelings, behaviors and thinking have shown effectiveness in other populations (Bolier et al., 2013), and could be applied as treatment interventions in people with SCI and or physical disability. Current evidence exists for the effectiveness of multidisciplinary interventions targeted at enhancing self-efficacy (Andersen et al., 2018). What is interesting about this study, is that this intervention is typically applied on women who are on long term sick leave. This suggests that positive psychological interventions are broadly used on a variety of populations successfully. Health professionals often recognize the importance of hope. From an attitudinal perspective in the initial period post-SCI, hope for recovery may be an effective coping mechanism in the face of a difficult health crisis (Dorsett et al., 2017). It may therefore be beneficial for rehabilitation counselors to keep in perspective the importance of hope for recovery.

Rehabilitation counselors could support the person with SCI and or physical disability emotional stability so that the condition of SCI and or physical disability does not stand in the way of active participation in the rehabilitation program. Screening for mental health problems in the early phase of SCI will identify those in need of psychological support. Psychological treatment for depressed people with SCI and or physical disability in initial hospitalization needs to be available as part of the functions of the multidisciplinary rehabilitation team. There are strong indications that psychological interventions at this stage are helpful and may prevent long-term adjustment problems (Menschner & Maul, 2016).

Multicultural Counseling Competence

According to the American Rehabilitation Counseling Association (ARCA) Task Force on Competencies for Counseling Persons with Disabilities (Chapin, et. al., 2018) counselors should become competent in working with PWDs to better understand individual needs to provide effective counseling. ARCA also recommend that counselors and counselor training programs support the attainment of these competencies among all counselors, in recognition of disability as a part of personal identity and cultural diversity. ARCA is organized by a list of five sections that cover various contexts and functions within the work of counselors (Chapin, et. al., 2018). Sections include the disability experience, support of their self-advocacy, counseling process and relationship, testing and assessment and lastly, working with or supervising persons with disabilities in a school, employment, or community setting.

Authors Chapin et al. (2018) report to be effective as rehabilitation counselors in how RC's work with persons with disabilities to include SCI, RCs should understand that PWDs, like SCI, can live full and productive lives, and they deserve to have encouragement and opportunities to develop and express themselves as they progress through every stage of the lifespan. Competent rehabilitation counselors understand that the process and timing of adapting to the onset of a disability, the way individuals develop a disability identity, and the ways in which that identity is expressed vary from individual to individual. With these factors in mind, this change, should not be interpreted as an abnormal adjustment, or delayed development.

According to ARCA (2019) this understanding makes assessment, diagnostic interpretations, counseling, and goal setting more valid and effective for the person with the disability. Competent counselors advocate for equality of opportunity to achieve full inclusion and participation in all aspects of society. The development and knowledge of skills, and commitment to social justice allows rehabilitation counselors to be effective at the individual, group, institutional, and societal level. The RC's commitment to persons with disability involves providing respectful and timely communication, taking appropriate action when cultural diversity issues occur, and being accountable for the outcomes as they affect people of all races, ethnicities, genders, national origins, religions, sexual orientations, or other cultural group identities (CRCC, 2017). To conceptualize this commitment, it is important to provide the foundation from whence this originated.

The multicultural model based on Glockshuber (2011) and Minami (2008) considered attitudes and beliefs to be a critical component in advancing counselor cultural competency. While this research is dated, the finings remain relevant especially as it relates to training counselors that awareness alone is not enough. Glockshuber (2011) reported that a counselor's self-evaluated cultural competence was directly related to their attitudes and beliefs and this should be a separate characteristic as it relates to growing in cultural competency. What this research suggests is that when training counselors to become self-aware, counselors should also examine their cultural attitudes and beliefs is an important attribute in developing cultural competency and increasing the effectiveness when caring for diverse clients.

An additional characteristic as reported by Sue and Sue (2013) is cognitive empathy. Sue and Sue (2013) define this as understanding and sharing the worldview of clients through cognitive empathy rather than affective empathy. Authors Tomilnson-Clarke (2013) found that direct ongoing cultural interactions facilitated cultural knowledge and cultural empathy. Each of these characteristics are said to help counselors connect with the cultural diversity of others, and to understand and appreciate the uniqueness of their daily lives. The research is clear on the factors that describe the importance of effective and competent care for persons with disabilities to include SCI.

The research included information with the WHO (2019), ARCA, (2019) and the NSCSC, (2017). All the information within these prominent organizations remains consistent with educating the importance of remaining aware of notable group differences among PWDs and exercise caution in interpreting data normed on the general population

or disability groups other than that with which the client identifies. When considering counselor competency while working with persons of disability and SCI, it was encouraged that all counselors follow and obtain these recommendations to assure effective counsel. The rehabilitation therapist's knowledge, attitudes, and skills are important factors to the long-term stability of the person with SCI and or physical disability. The application of these competencies could contribute to the improvement of counselor training models and preparedness to work with SCI and or physical disability. The ability to provide effective counseling interventions are maximized when counselors are continually working to develop the characteristics of cultural competence.

Summary and Conclusion

As educators, it is crucial to be aware of how our personal identities influence our instructional roles, perceptions, and interactions with students (Keiler, 2018). Specifically, as it relates to student centered and client centered environments. This concept is also relevant as counselors when providing individualized services to our clients. Shaping and cultivating positive attitudes toward people with disabilities, specifically SCI is an important task for all counselor programs that prepare future rehabilitation counselors. The identification of problematic attitudes and biases can prevent long term effects on quality of care for persons with SCI and or physical disability. It is imperative for counselor programs to prepare students and to understand this phenomenon.

The main objective of this literature review was to identify the factors that influence the mental health needs of persons with SCI and or physical disability,

understanding how counselors view their competency levels with supporting this population in the delivery of continuity of care for persons with SCI and or physical disability. In the next chapter, I described, in detail, my initial plan to use a descriptive phenomenological approach to explore rehabilitation counselors' perspectives while working with spinal cord injured persons and or persons living with a physical disability.

Chapter 3: Research Method

In this chapter, I provided the specific research plan for the study, including a description of the design and rationale. The 6-step data analysis is described in detail to support data collection procedures. This chapter also includes a discussion of the role of the researcher, central concepts, methodology, and ethical procedures.

Purpose of the Study

The purpose of this qualitative descriptive phenomenological study was to understand rehabilitation counselors perceived competency in addressing the mental health needs of a person with SCI and or physical disability. Specifically, my focus was to consider the factors that influence the mental health needs of persons with SCI and or physical disability and understand how counselors view their competency levels with supporting this population in the delivery of continuity of care for this population. In this study, I highlighted the importance of competency of SCI and or physical disability needs as it relates to addressing barriers, multicultural concerns, disability needs, and attitudes of health and community professionals.

Research Design and Rationale

Research Questions

RQ: What are the lived experiences of rehabilitation counselor's ability to support the mental health needs of SCI and/ or physical disability clients?

SQ: How does the preparation of rehabilitation counselors support the person with SCI's and/ or physical disability mental health needs?

Central Concepts

The central phenomenon studied was competency; more specifically, the personal lived experiences of the rehabilitation counselor when working with persons with SCI and or physical disabilities. The literature provided information on the importance of addressing attitudes and biases as it relates to the disability community in general. The literature also addressed the importance of understanding disability and described the lack of training psychotherapists receive as it pertains to working with clients diagnosed with a disability. In addition, the literature explained how PWD are frequently overlooked and underappreciated on a global realm. Mental health attitudes and barriers, community attitudes and barriers, and defining disability in a humanistic way are important. There was little understanding on how rehabilitation counselor's competency and training experience adds to the meaning of disability as it relates to the spinal cord injured person. To best address the research questions, I employed a qualitative descriptive research design.

Qualitative researchers seek to gain a deeper understanding of a specific phenomenon rather than a surface description of a population (Hameed, 2020). Phenomenology involves using techniques such as semi-structured interviews to gather data (Rodriquez et al., 2018). For descriptive phenomenological inquiry, Giorgi (2009) expressed that no less than three participants should be interviewed. To satisfy the supported ranges and ensure saturation, I recruited six participants and discontinued recruitment when data saturation was met. A quantitative design would not have provided me with a deep understanding in specific details as described by the rehabilitation

counselors' personal experiences working with SCI because of the use of information about quantities, and therefore numbers to describe, predict, or control variables (see McLeod, 2019).

According to the CRCC (2017), "the primary obligation of the rehabilitation counselor is to the client; therefore, rehabilitation counselors actively attempt to understand the diverse cultural backgrounds of the clients they serve and do not discriminate in their provision of rehabilitation counseling services" (p. 4). The most central concept of this descriptive phenomenological inquiry was the described competency of the rehabilitation counselors lived experience while working with SCI persons. The literature demonstrated how important competency is to the profession, those who are counselors in training, as well as to clients seeking services for their mental health needs.

ARCA (2018) has an approved list of competencies suggested for rehabilitation counselors that are encouraged to be implemented in training programs for new counselors. These competencies highlight the importance of understanding that various forms of prejudice against disability could influence counselor's ability to make discriminatory decisions, either consciously or unconsciously, that limit opportunities for persons with disabilities such as SCI. The application of these competencies is key to understanding of the rehabilitation counselor's role when servicing the person with SCI and or physical disability.

I used descriptive phenomenology in this qualitative study. Descriptive phenomenology is embedded in interpretation from which Husserl (1911, 1965) stated

must manifest itself in knowledge and in consciousness. Using descriptive phenomenology, the participant experiences are described exactly as they are presented (Shelton & Bridges, 2019). Additionally, a descriptive phenomenological approach allowed the focus of the lived experiences of rehabilitation counselors to articulate meaning which is important to the relevance of this study.

Role of the Researcher

In qualitative research, the researcher seeks to answer questions related to social behavior and interpersonal interactions that drive certain social phenomena (Auston & Sutton, 2014). In this study, my role as the researcher involved using empathy and compassion to understand human emotion. Gaining an understanding and describing competency of rehabilitation counselors about their perspectives and experiences with SCI persons has the potential to influence and meet the needs of larger communities. A descriptive phenomenological design requires the researcher to explore and describe the lived experience of individuals (Neubauer et al., 2019). Further, a descriptive design records the importance of being skilled with effective questioning and evaluating the questions throughout the data collection process (Shelton & Bridges, 2019). This was beneficial as I transcribed the interviews as they are collected. This process guided changes to questions and allowed for standard follow-up questions during member checking. My personal experience living with SCI influenced the purpose of this study. This curiosity grew into wanting a deeper understanding of the personal lived experiences of SCI and the mental health implications of the injury. I remained aware and mindful of how my personal experience with SCI could influence bias within the study. In

accordance with descriptive phenomenology, I bracketed my presumptions and personal experience to remain attentive and be fully present with the participants (see Shelton & Bridges, 2019). According to Giorgi (2018) the attention and intentionality allowed me to discover pure, flowing consciousness from the participant rendering it more intuitive. Bracketing also helped to remain focused on the chosen phenomenon without allowing my past experiences with SCI to influence data collection.

Positionality

As a mental health counselor, my professional identity was central to the study's design. As the primary researcher, having professional experience as a mental health counselor influences my role as the researcher. Ravitch and Carl (2016) referred to positionally as the researcher's role and identity as associated with the context and setting of the research. For example, participants may have felt more comfortable sharing their experiences believing my background would allow for better understanding than someone in an administrative or nursing role. Considering the internal act of consciousness, which refers to collaboration and development of the relationship between patient and counselor, is encouraged (Langdridge, 2007; Moustakas, 1994).

It was important that I was aware of my positionally and biases related to the phenomenon and the data I collected. The purpose of this study was to describe participant experiences without interpretation; therefore, I used a method that incorporated bracketing or the purposeful practice of awareness and restraint of personal thoughts and experiences related to the topic (see Shelton & Bridges, 2019; Yilmaz, 2013). I am a doctoral candidate and licensed counselor collecting the data living with a

SCI. To aid in the process of bracketing and personal awareness, I chose to follow the six-step data analysis as described by Giorgi (2017) for descriptive phenomenological analysis.

Addressing Researcher Bias

By being aware of my own experiences with SCI and as a mental health counselor, I was able to remain mindful of my personal views so that they did not influence the described experiences of the chosen phenomenon. The phenomenological perspective allowed me to maintain my positionality, introspection, and researcher role through the data collection process. To further address bias, I intentionally incorporated continued self-awareness, phenomenological reduction, and thought reflection when information is presented to me that is different from my own experiences. Giorgi et al. (2017) explained it as adjusting the consciousness to take in objects from the experience as presented but not as objects that physically exist. However, when the object studied is an experience itself, it may be more beneficial to think of it as understanding the experience from the participant's description and understanding of it instead of filtering the experience through a preconceived understanding or ideas about the experience. This mindset supported the bracketing process as I engaged in analysis.

Methodology

Participant Logic

When developing a dissertation capstone, it is important that the researcher consider the research design when identifying the target population, sampling procedures, and ethical issues (Bloomberg & Volpe, 2016). The research design must align with all of

the other elements of the participant recruitment methods, especially the guiding research approach (Giorgi et al., 2017). Therefore, in accordance with descriptive phenomenology, the target population for this study was rehabilitation counselors. For this study, the population of interest was licensed mental health or professional counselors who have a current certification to practice as rehabilitation counselors. In addition, certified counselors who have experience working with spinal cord injured physical disability persons and are knowledgeable of SCIs and physical disabilities.

I asked rehabilitation counselors to describe their experiences in providing support to persons with SCI and or physical disability and explain what factors contributed to preparing them to work with persons with SCI and or physical disability. After SCI or physical disability, a person's cognitive, emotional, or physical disability impairs their ability to advocate for themselves and their needs (Alizadeh et al., 2019). CCRC (2017) described how the rehabilitation counselor advocates on behalf of their clients, wherever they may require it. This includes working with the other members of a client's treatment team, including medical doctors and psychologists, to provide comprehensive, whole-patient care. My use of a qualitative descriptive approach allowed the rehabilitation counselors to share how they help clients adjust to the limitations of their disabilities while also emphasizing and improving their strengths.

Sampling Strategy

Participants for this study were recruited through the ARCA, ACA, and the Ohio Rehabilitation Association listservs. ARCA (2021) is an organization of rehabilitation counseling licensed practitioners, educators, and students who are concerned with

improving the lives of people with disabilities. Rehabilitation counselors are counselors with specialized training and expertise in providing counseling and other services to persons with disability. The ACA (2021) is a membership organization representing licensed professional counselors, counseling students, and other counseling professionals in the United States. The Ohio Rehabilitation Association (ORA, 2022) is a member organization whose mission is to provide opportunities for rehabilitation professionals, and others in the field of rehabilitation, through knowledge and diversity (ORA, 2022).

To participate or be eligible for the listservs, I had to hold an active membership. The listservs of the ARCA, ACA, and ORA are mailing lists of people who share a common interest. When I uploaded my recruitment flyer, all the individuals subscribed to that list received the message via e-mail. Subscribers were able to respond to the individual or the whole list. In addition to the listservs, participants were recruited from social media sites including Facebook groups, and LinkedIn.

The United States Bureau of Labor Statistics (2020) described rehabilitation counselors as professionals who work in a variety of settings, such as community rehabilitation centers, senior citizen centers, and youth guidance organizations. There are several factors to consider when selecting rehabilitation counselors for this study. I first considered the employment of rehabilitation counselors is projected to grow 10% from 2019 to 2029 (see United States Bureau of Labor Statistics, 2020). Secondly, the demand for rehabilitation counselors is expected to increase in the elderly population, in addition to the continued rehabilitation needs of other groups, such as veterans and people with disabilities (see United States Bureau of Labor Statistics, 2020), suggesting a sizable need

for care by rehabilitation counselors and meets criteria for this descriptive phenomenological study.

Participant Criteria

All potential participants met the following criteria: current master's-level counseling graduate student; attendance to a CACREP-accredited institution; licensed as a mental health counselor or professional counselor; certified to practice as a rehabilitation counselor; have experience working with persons with SCI and or physical disability; knowledgeable of what SCI and or physical disability is and, geographically located in the United States. The exclusion criteria were licensed social workers, psychologists, psychiatrists, and licensed school counselors.

Instrumentation

In this study, I collected data using semi-structured interviews. In qualitative research, semi-structured interviews are considered in-depth interviews where participants are asked to answer predeveloped open-ended questions. For the purpose of this study, interviews were 60 minutes each. To have the interview data captured effectively, all interviews was audio recorded, and saved in a double password-protected cloud storage account. I transcribed each interview after completion and will destroy all physical documents after five years of completing dissertation. Semi-structured interviews align best with this study's theoretical framework for the purpose of describing the lived experiences of rehabilitation counselor's competency when working with spinal cord injured persons. The semi-structured interview protocol (See Appendix D) consists of 11 open-ended questions and designed to illicit rich, in-depth data.

Procedures for Recruitment, Participation, and Data Collection

Participants was invited via ARCA, ACA and, ORA listservs, Facebook groups and LinkedIn social media sites. ARCA (2021) is an organization of rehabilitation counseling practitioners, educators, and students who are concerned with improving the lives of people with disabilities. Rehabilitation Counselors are counselors with specialized training and expertise in providing counseling and other services to persons with disability. According to the ARCA website, in order for ARCA to share my request on the ARCA Listserv, I need to be an ARCA member, and 2) provide proof that the study is IRB approved. Once my ARCA membership is confirmed and ARCA receive documentation that the study is IRB is approved, my request will be sent through the "Contact Us" link or arcaoffice@arcaweb.org.

The ACA is a membership organization representing licensed professional counselors, counseling students, and other counseling professionals in the United States (ACA, 2021). The ACA also requires an active membership to participate in any of the established listservs like COUNSGRAD and DIVERSEGRAD-L. The Ohio Rehabilitation Association is a member organization whose mission is to provide opportunities for rehabilitation professionals, and others in the field of rehabilitation, through knowledge and diversity (ORA, 2022). The listservs of the ARCA, ACA and ORA are a mailing list of people who share a common interest. I uploaded my participant recruitment flyer and all the individuals subscribed to that list received the message via e-mail. I requested all potential participants to respond directly to me.

Invitations for participation to the study through the ARCA, ACA, and ORA listservs and social media sites was provided an informed consent prior to participating in the study and was asked to respond "I consent" via e-mail in lieu of a signature. Requests for participation was posted based on the set of rules provided by the organizations. Participants were selected based on the inclusion criteria for the study. Information concerning the study included contact information, the criteria of being a licensed mental health counselor, licensed professional counselor, certification as a rehabilitation counselor and actively working with a person with SCI and or physical disability.

As part of the informed consent process, participants were informed of their right to remove themselves from the study if there was any reason for concern or discomfort. As a part of the interview process, I asked participants to complete and return a brief demographic form by e-mail (See Appendix C). The rationale for using this demographic form is so that I was able to tell which population is being represented according to the study's requirements. Interviews was conducted using a Zoom video conference platform lasting 60 minutes. Participant behavior was observed, and I audio recorded all interviews using the zoom teleconference platform (See Appendix D). I transcribed and analyzed all audio recordings. I assigned each participant a pseudonym to protect their identities and maintain confidentiality.

Data Analysis Plan

Qualitative data analysis, specifically with Giorgi's descriptive method, is the most fundamental aspect of research because it is the process where researchers attempted to discover a deeper understanding of the lived experiences of an identified

phenomenon of interest (Shelton & Bridges, 2019). Using Giorgi's descriptive phenomenological data analysis approach to guide this research inquiry, there are six steps described in the data analysis method, based on principles of phenomenological philosophy (Broome, 2011; Giorgi, 2018). Giorgi's (2018) descriptive phenomenology data analysis steps was used when conducting data analysis using semi-structured 60-minute interviews (See Appendix D).

A proposed sample size of 6 rehabilitation counselors provided data to describe the lived experiences and understand rehabilitation counselor's competency while working with SCI client's; this competency influenced the counselor's ability to support long term rehabilitation and mental health needs. In phenomenological data analysis, an important first step is reading through the entire transcript before notations and breaking the information into meaning units (Giorgi, 2017; Shelton & Bridges, 2019). This process allowed me to fully absorb the described experience as a whole before entering analysis. According to Giorgi et al. (2017), the normal, natural attitude and thought process is sufficient to engage in this step, and researchers do not need to intentionally question how they are reading or processing the information.

As a second step, assuming an attitude of phenomenological psychological reduction was one of the most difficult to grasp. Giorgi et al. (2017) explained it as adjusting the consciousness to take in objects from the experience as presented but not as objects that actually exist. However, when the object studied is an experience itself, it may be more beneficial to think of it as understanding the experience from the participant's description and understanding of it, not filtering the experience through a

preconceived understanding or ideas about the experience. This mindset supported the bracketing process as I engaged in analysis.

During step three, I read each transcript and separated the information into meaning units (Giorgi, 2017; Shelton & Bridges, 2019). The initial meaning units was intended to be succinct parts that reflect the language and understanding of the participants (Giorgi, 2017; Shelton & Bridges, 2019). During this step, the meaning units was intended to reflect rehabilitation counselor's competency while working with spinal cord injured persons. Experiences included counselor preparedness and initial training systems.

During step 4, I transcribed the meaning units into phenomenologically psychologically informed descriptions. With this step, I evaluated the meaning units and rephrased them based on the stated experiences. The purpose of rephrasing the meaning units was to express the meanings directly and allow for integration with other meaning units for theme development (Giorgi, 2017; Shelton & Bridges, 2019). Steps three and 4 refer to the noesis, which is to think about or interpret and the noema which is what is being thought about (Giorgi, 2018). The noesis according to Giorgi is to be considered intentionally actualizing the phenomena as it is seen in the present.

In step 5, Giorgi et al. (2017) suggests that researchers determine how to structure the themes for reporting the findings. In this step, I take my meaning documents and combine with actual quotes from the transcripts. Lastly, during step 6, there was an integration of the meaning units, participants' lived experiences, and phenomenological and psychological sensitive expressions, using free imaginative variation that aids in

determining the psychological essence of the lived experience, with the experience of being eidetic, not universal (Giorgi, 2018).

Issues of Trustworthiness

Credibility

In qualitative research, Korstjens and Moser (2018) defined credibility as the confidence that can be placed in the truth of the research findings. Credibility establishes whether the research findings represent plausible information drawn from the participants' original data and is a correct interpretation of the participants' original perceptions (Korstjens & Moser, 2018). Strategies that I used to assure credibility include prolonged engagement and member check to ensure I accurately captured the rehabilitation counselors perceived competency when working with SCI and or physical disability patients.

Transferability

Transferability was concerned with the degree to which the results of qualitative research can be transferred to other contexts or settings with other respondents. The researcher facilitated the transferability judgment by a potential user through thick description (Ravitch & Carl, 2016). For example, the perceptions made by rehabilitation counselors did not translate to experiences for rehabilitation counselors in other areas, but some findings of the SCI and or physical disability experiences of mental health implications within rehabilitation or community settings for coping with the physical and mental health needs of this population were applicable across demographics.

Dependability

Dependability was concerned with the stability of findings over time (Patton, 2015). This process involved the participants' evaluation of the findings, interpretation and recommendations of the study such that all are supported by the data as received from participants of the study (Korstjens & Moser, 2018). Here, the focus is on the interpretation process of analysis. The strategy needed to ensure dependability and confirmability is known as an audit trail. Within this process I was responsible for providing a complete set of notes on decisions made during the research process, reflective thoughts, sampling, research materials adopted, emergence of the findings and information about the data management. Authors Korstjens and Moser (2018) stated that this enables the transparency of the study for the research path.

Confirmability

Confirmability was the degree to which the findings of the research study could be confirmed by other researchers (Ravitch & Carl, 2016). Confirmability was concerned with establishing that data and interpretations of the findings are not figments of the inquirer's imagination, but clearly derived from the data (Korstjens & Moser 2018). For example, remaining mindful of personal biases that may influence interpretation of the data.

Ethical Procedures

This study was conducted following the ethical requirements of the ACA (2014) Code of Ethics and the Walden (2021) Institutional Review Board (IRB). The Walden IRB granted permission for the study before any data were collected. This study was

considered a minimal risk to participants due to the focus for data collection being on the rehabilitation counselor and not the person with SCI. Participants' anonymity was protected through utilizing pseudonyms. The study included an informed consent and participation in this study was voluntary. All participants were free to withdraw from the study at any time. None of the participants chose to withdraw from the study. All data was kept confidential through password-protected electronic files and documents kept in a locked cabinet with myself having sole access. After 5 years of study completion, all data will be destroyed.

Summary

I described in this chapter the specific research plan for this descriptive phenomenological study, including rationale for the research design. Also included in this chapter was discussion on the role of the researcher, methodology, issues of trustworthiness, and ethical considerations. In Chapter 4, the results of the data are presented as findings.

Chapter 4: Results

The purpose of this qualitative descriptive phenomenological study was to understand rehabilitation counselors perceived competency in addressing the mental health needs of a person with SCI and/or physical disability. After reviewing the literature, I found gaps in the knowledge related to trainings and comprehension of how to provide individualized mental health care for persons living with SCI and/or physical disability, so I conducted this study aiming to address this gap. The main research question was "What are the lived experiences of rehabilitation counselor's ability to support the mental health needs of SCI and/or a physical disability client?" The sub question was "How does the preparation of rehabilitation counselors support the person with SCI and/or a physical disability mental health need?" In Chapter 4, I present the demographics of the participants, data collection methods, and findings of the study. A discussion of the data analysis procedures and evidence of trustworthiness is also included.

Research Setting

I began data collection in August 2021 after receiving IRB approval (IRB Approval #08-26-21-1008583, expiration August 25, 2022). Data collection was completed within 43 weeks. All interviews were completed via Zoom teleconference, following data collection procedures, and scheduled at times mutually convenient for me and the participant. Zoom teleconference interviews allowed for participants from across the United States to be interviewed as well as adherence to recommended social distancing guidelines due to the ongoing COVID-19 pandemic. Affecting many countries

globally, COVID-19 is the infectious disease caused by the most recently discovered coronavirus, which was previously unknown before the outbreak began in Wuhan, China in December 2019 (WHO, 2020). The CDC (2020) recommended that individuals keep a safe space of at least 6 feet between themselves and other people who are not from their household to prevent the spread of infection, which is transmitted when an infected person coughs, sneezes, or talks and droplets are launched into the air and land in the mouths or noses of people nearby or inhaled into the lungs.

Although the interviews were conducted during a downturn of the COVID-19 pandemic, many outpatient, inpatient, and residential health care facilities serving persons with SCI and/or physical disabilities continued to adhere to the recommended guidelines of the CDC due to the ongoing risk of compromising the high-risk immune system of these individuals. Therefore, interviews conducted using a Zoom video conference platform was appropriate and helped to prevent transmission by eliminating in-person contact.

Demographics

Participants were required to meet the inclusion criteria of current master's-level counseling graduate student, attendance of a CACREP accredited institution, licensed as a mental health counselor or professional counselor, certified to practice as a rehabilitation counselor, have experience working with persons with SCI and/or physical disability, knowledgeable of what SCI and/or physical disability is, and be geographically located in the United States. The exclusion criteria were licensed social workers, psychologists, psychiatrists, and licensed school counselors (see Table 1). The definition

of SCI, physical disability, and rehabilitation therapy I used for this study was that SCI is a debilitating neurological condition that blocks communication from the brain to the body (see Alizadeh et al. 2019), Physical disability was defined as a physical and or mental limitation that impacts one or more major life activities (CDC, 2019), and rehabilitation therapy as a process where the counselor works collaboratively with the client to understand existing problems, barriers and potentials to facilitate the client's effective use of personal and environmental resources for career, personal, social and community adjustment following disability (CRCC, 2017). I excluded rehabilitation counselors that did not meet the inclusion criteria.

Table 1

Participant Demographics

Participant	Race	Age	Gender	Education	CACREP	Licensed (L) /Certified (C)
1	Caucasian	55+	Female	PhD (CES)	Yes	L & C
2	Caucasian	46+	Female	MS	No	C
3	Caucasian	46+	Female	MS	No	C
4	Bi-Racial	31	Male	MS	Yes	L & C
5	Caucasian	51	Female	PhD (CES)	Yes	L & C
6	Caucasian	41	Female	MS	Yes	C

Data Collection

I was granted IRB approval for this study on 08-26-2021, and the initial request for participants was posted on 08-27-2021. Requests for participation were posted on a biweekly cycle over the course of 31 weeks on different days and times of the week to reach a larger audience (See Appendix A). Due to challenges in accessing a participant pool using the approved recruitment procedure, a new request to IRB was submitted to make changes in the data collection procedures by adding rehabilitation counselors to participate in addressing the gap in knowledge of physical disabilities and/or SCI, and add social media to include Facebook groups and LinkedIn. Requests for participation with the approved added changes were submitted on a weekly basis over the course of 12 weeks on different days and times of the week until data saturation was obtained (See Appendix B). Saturation is used in qualitative research as a criterion for discontinuing data collection and/or analysis (Birks & Mills, 2015). In this qualitative descriptive phenomenological study, the data produced a meaningful response to coding's and themes.

Interested participants contacted me using my Walden email address. All participants responded to the consent form by emailing their understanding of study by stating, "I consent." As part of the informed consent process, participants were informed of their right to remove themselves from the study if there is any reason for concern or discomfort. As a part of the interview process, I asked participants to complete and return a brief demographic form by e-mail (See Appendix C). The rationale for using this demographic form was so that I could identify which population was being represented

according to the study's requirements. Interviews were conducted using a Zoom video conference platform lasting 60 minutes. All interviews were audio recorded using the Zoom platform. I then transcribed and analyzed all audio recordings (See Appendix D). Each participant was assigned a pseudonym to protect their identities and maintain confidentiality. All participant information is saved in a password encrypted file.

Data Analysis

I used Giorgi's (2018) descriptive phenomenological data analysis approach to guide this research study. I applied the six steps described in the data analysis method, based on principles of phenomenological philosophy (see Broome, 2011; Giorgi, 2018). As a first step in phenomenological data analysis, I began by reading through the entire transcripts of all participants before notations and breaking the information into meaning units (see Giorgi, 2017; Shelton & Bridges, 2019). This process allowed me to fully absorb the described experience before entering analysis. According to Giorgi et al. (2017), the normal, natural attitude and thought process is sufficient to engage in this step, and researchers do not need to intentionally question how they are reading or processing the information. I documented during my notations that participants were of varying age and years of experience as a rehabilitation counselor. Regardless of age and experience, participants shared many commonalities as rehabilitation counselors. For example, all participants recognized the importance of developing relationships with treatment providers, within and outside of their current work environments, as well as seeking guidance and support from supervisors. In addition, participants all identified with the need to continue learning and developing skills as a rehabilitation counselor to

serve the disability population to include SCI. Participants worked in diverse rehabilitation settings, which I viewed as a benefit to the study by capturing a broader picture of competency and application of skills. I also observed that all participants were comfortable during the interviews and genuinely intrigued by the study. Participants were eager to share their experiences, and my initial concerns about data collection, such as participant interest in the study, were alleviated.

As a second step, I assumed an attitude of phenomenological psychological reduction. Giorgi et al. (2017) explained it as adjusting my consciousness to take in objects from the experience as presented but not as objects that exist. For example, as I interviewed each of the participants, I received the participant experiences just as it was being communicated and did not assume their interpretation to mean anything other than what the participant communicated at the exact time of the interview.

During Step 3, I read each transcript and separated the information into meaning units (see Giorgi, 2017; Shelton & Bridges, 2019). This allowed me to have organization as I prepared to transcribe. During Step 4, I transcribed all the meaning units into phenomenologically psychologically informed descriptions. With this step, I was able to evaluate the meaning units and rephrased them based on the stated experiences. The purpose of Steps 3 and 4 was to allow me to rephrase the meaning units and to express the meanings directly and allow for integration with other meaning units for theme development (see Giorgi, 2017; Shelton & Bridges, 2019). Steps 3 and 4 refer to the noesis, which allowed me to think about and interpret the noema which is what is being

thought about (see Giorgi, 2018). The noesis according to Giorgi is to be considered intentionally actualizing the phenomena as it is seen in the present.

In Step 5, Giorgi et al. (2017) suggested that I determine how to structure the themes for reporting the findings. In this step, I gathered my meaning documents and combined with actual quotes from the transcripts (see Table 2). Lastly, during Step 6, I integrated the meaning units, which is the participants' lived experiences, and phenomenological and psychological sensitive expressions (see Giorgi, 2018). All transcripts were analyzed using a descriptive phenomenological approach. Each transcript was printed and coded so that themes could be identified.

Table 2

Preliminary Meaning Units

Participant 1	Clinical Factors	"When I am visiting with someone during intake or consult, I am asking if they are at a place where he/she is safe at home…?
	Mental Health	"Clients have an adjustment period."
	Clinical Skills	"Be attentive, be a good listener, especially to non-verbal cues. Their situation is completely different."
	Supporting CRC's	"It will be shocking at first."
	Social change	"Do not forget how important independent living is and how to teach students about independent living."
Participant 2	Clinical Factors	"I think resources help to support problems and having patience especially if it is a client new to SCI."

	Mental Health	"Clients with SCI experience symptoms of depression and anxiety, alcoholism and drug use."
	Clinical Skills	"Active listening and being open to their individualized needs."
	Supporting CRC's	"It's nothing like in the class. You have to be able to accept personal limitations in this field."
	Social Change	"Persons with SCI, may have the same diagnosis, but they are all different in how they respond to and cope with their disability."
Participant 3	Clinical Factors	"You really have to listen to the individual you are working with. Rapport building and trust is very important to people with SCI."
	Mental Health	"When you have a disability you see a lot of depression, and anxiety and self-worth concerns."
	Clinical Skills	"Being mindful, have keen physical observance, and have a sharp memory of what the client is saying and be able to access at the same time."
	Supporting CRC's	"It is important that you are knowledgeable and understand how the disability impacts the individual person."
	Social Change	"Persons with a SCI and/or a physical disability is a person just like you. We know a lot clinically, but often clients need a person to listen and not be judgmental. Get your CRC."
Participant 4	Clinical Factors	"I think in some cases you have to adapt your skills to be more patient.
	Mental Health	"Persons with SCI that I see are lonely, actively struggling with temptations to resist the use of drugs and alcohol."
	Clinical Skills	"Empathy, understanding, empathizing, and autonomy."
	Supporting CRC's	"Listen well. Do not make assumptions."

	Social Change	"Listen to your clients. Having a good understanding of what disability is and how it impacts the person with SCI differently."
Participant 5	Clinical Factors	"Lack of support, lack of independence, and resistance by client."
	Mental Health	"It depends on the nature of the SCI or the disability. Mostly it's an adjustment."
	Clinical Skills	"Allow yourself to use assistive technology, use reflection, interpretation, paraphrasing and communication skills."
	Supporting CRC's	"One hundred percent educate yourself because you are not going to get enough education in your counseling program."
	Social Change	"Learn the person's individual story."
Participant 6	Clinical Factors	"The lack of support for individuals who have SCI and the lack of identifying the growing number of persons who have SCI."
	Mental Health	"I see a lot of boredom, alcohol and drug use, and loneliness."
	Clinical Skills	"Empathy, understanding, empathizing, and autonomy."
	Supporting CRC's	"Get to know other fields and connect with them so you can understand pain management."
	Social Change	"Get your certification as a rehabilitation counselor."

I reviewed each transcript multiple times focusing on preliminary meaning units of participants' specific phrases to make connections between those preliminary meaning units to form specific themes. I read each transcript separately, and then, each question

together across all interviews. Applying Giorgi's (2018) descriptive phenomenological approach, influenced by Husserl's (1974, 1977) framework of phenomenology, allowed me to gather rich, thick descriptions in its original existence. For the final step, I connected the themes relative to the specific research questions and began to form general descriptions of the phenomenon. The following five major themes were identified: (a) clinical factors and certified rehabilitation counselors, (b) mental health and environmental concerns of clients, (c) necessary clinical skills and practice requirements for rehabilitation counselors, (d) supporting certified rehabilitation counselors in training, and (e) impacting social change for clients with disabilities.

Evidence of Trustworthiness

Credibility

Credibility establishes whether the research findings represent plausible information drawn from the participants' original data and is a correct interpretation of the participants' original perceptions (Korstjens & Moser, 2018). As shown in Table 2, I used direct quotes to demonstrate the data is represented accurately. In qualitative research, quotations can bring content to life (White et al., 2014), and a sound application of research ethics prevents the (mis)use of catchy phrases (Silverman, 2014). All participant quotes were applied in a way that shows respect to participants and that they are presented in a reliable manner, including that they maintain participants ' confidentiality as evidenced by the application of pseudonyms (Polit & Beck, 2016). Each participant was contacted via email to participate in member checking where I

provided a brief summary and interpretation of the interview transcripts for 20-30 minutes.

Transferability

Transferability was concerned with the degree to which the results of qualitative research can be transferred to other contexts or settings with other respondents. The researcher facilitated the transferability judgment by a potential user through thick description (Ravitch & Carl, 2016). Some findings of the experiences of rehabilitation counselors in an inpatient counseling setting and strategies for coping with and managing SCI and or physical disability duties was applicable across demographics, but the unique challenges faced by rehabilitation counselors may not translate to experiences for rehabilitation counselors in other areas such as rural communities or workman compensation settings. Although participants represented diverse areas of practice and levels of experience, the number of participants limited transferability.

Dependability

Dependability was concerned with the stability of findings over time (Patton, 2015). This process involves the participants' evaluation of the findings, interpretation and recommendations of the study such that all are supported by the data as received from participants of the study (Korstjens & Moser, 2018). In this study, the focus was on the interpretation process of analysis. The strategy needed to ensure dependability and confirmability was known as an audit trail. For this study I provided a complete set of notes on decisions made during the research process, reflective interpretation of findings, and the emergence of the findings and information about the data collected. I also

participated in member checking where I provided a brief summary and interpretation of the interview transcripts for 20-30 minutes with participants.

Confirmability

Confirmability was the degree to which the findings of the research study could be confirmed by other researchers (Ravitch & Carl, 2016). Confirmability is concerned with establishing that data and interpretations of the findings are not figments of the inquirer's imagination, but clearly derived from the data (Korstjens & Moser 2018). I was able to increase confirmability through reflective interpretation of findings and member checking.

Study Results

Five major themes emerged from this study, including a) clinical factors and certified rehabilitation counselors, (b) mental health and environmental concerns of clients, (c) necessary clinical skills and practice requirements for rehabilitation counselors, (d) supporting certified rehabilitation counselors in training, and (e) impacting social change for clients with disabilities. These themes repeated throughout each participants' interview. The themes emerged from the research questions of what are the lived experiences of rehabilitation counselor's ability to support the mental health needs of SCI and/or a physical disability client and how the preparation of rehabilitation counselors supports the person with SCI and/or physical disabilities mental health needs.

Clinical factors and Certified Rehabilitation Counselors

A common theme that emerged from this study was clinical factors and certified rehabilitation counselors. Participants spoke to their experiences of what it means to be a

rehabilitation counselor and how the role of rehabilitation counseling is different from other fields of counseling. Each participant identified their role as assisting individuals with exploring what they can do despite of their functional limitations so that person's SCI and/or physical disabilities can return to a quality of life not defined by their disability. As certified rehabilitation counselors, to counsel in this role, participants reported a different type of skill set than mental health or professional counseling. Participant 1 stated, "I'm really mindful of mechanism of injury, how much neuropathic pain they're managing, how they're doing with their bone, bladder, skin integrity. You can't explain nerve pain to people until you have actually lived it."

Participants in this study reported necessary factors to include a focus on understanding the disability; exploring how the disability impacts the areas of the person's life holistically to include, mental health, psychosocial relationships and sexual relationships; knowing the labor market; knowing standardized testing; medical diagnosis; prognosis and stability of condition; learning the process of requesting accommodations and resources, and how the need to normalize and use universal models that include all populations.

Participants in this study all identified with the importance of being prepared to assist individuals in adapting to the environment, being aware of personal biases, assisting and accommodating the needs of the individual, and work toward the full participation of individuals in all aspects of society, with a particular focus on independent living and work.

According to Participant 5:

> I do think that people have different perceptions of disability. They have what's a visible disability, such as, I see that the person has an either physical disability or maybe a visual or motor impairment. There are different perceptions around who feels comfortable working with a population of persons with disabilities.

The identified goals of rehabilitation counseling by participants in this study confirmed how the needs of SCI and/or a physical disability has become increasingly diverse and complex due to the broadening scope of disability groups served, and the various settings in which rehabilitation counseling services are provided.

Mental Health and Environmental Concerns of Clients

Another major theme that emerged was mental health and environmental concerns of clients. All participants reported mental health and environmental concerns for persons living with SCI and/or a physical disability. Mental health concerns are reported as adjustment, anxiety, depression, grief, substance use, and paranoia. While conducting the interviews, I found a healthy balance in what participants reported in reference to how the topic of mental health is initiated. All participants report that it is important to give the client a space to share what their needs are in an environment where the client feels safe and ready to share. However, when it comes to SCI and/or a physical disability, the physical stability becomes priority over the mental health stability. Often times, until the client is stable, mental health needs are not as presentable.

All participants identified with the importance of support for the client and how instrumental this concept is to the client's ability to cope with the symptoms of their condition to include, physical, emotional, and mental health. Participants agreed that

when it comes to addressing mental health, it depends on the nature of the spinal cord injury.

According to Participant 6, "They're able to let you know and communicate what they are needing." Participants perceive that if it is a relatively new disability, it will be very common to see clients go through a period of adjustment, depression, and grief and substance abuse. According to Participant 6, "Due to their boredom and lack of support groups in their community, they are having a lot of legal issues and substance abuse. About 15% of my clients have both criminal backgrounds and are active drug users."

As the person with SCI and/or a physical disability adjust and receive continuous care for their injury, clients may then show symptoms of anxiety and paranoia and struggle with substance use. Participants identified this change as a result of the client concerns with boredom, loneliness, returning to work, level of functioning, pain management, reconnecting with their community, concern with how will they be received by society, and the stability and availability of family or friends.

In addition, CRC's perceive clients are concerned with the physical and environmental responses to SCI or disability to include bowel and bladder accidents while at work, intensity of pain, home health, supplies, medication, health benefits, handicap accessibility, access to a powered wheelchair, transportation, available support groups, and community resources. Provider's perceived experiences in this study support the research in that understanding SCI and/or a physical disability is essential to understanding how people live with the physical, social and emotional environment in which they experience their day-to-day lives. The quality of life with SCI and/or a

physical disability depends greatly on whether the environment has the resources and mental health services are available.

Necessary Clinical Skills and Practice Requirements for Rehabilitation Counselors

Necessary clinical skills and practice requirements were another major theme that emerged from this study for CRCs. When asked what clinical skills are most useful when working with clients with SCI and/or a physical disability, Participant 1 stated, "being attentive, being a good listener, especially to nonverbal cues." Participant 4 added to this perception by stating, "You have to be mindful that certain disabilities may appear something that they're not. You really have to have keen physical observance, and a sharp memory." Participants throughout the study consistently identified active listening as a necessary skill. Participant two stated, "It is important to be open to their needs and what they have to say." Participant three confirmed this perception by stating, "You really have to listen to the individual you are working with." In addition to active listening skills, participants identified with rapport building, autonomy, reflection, interpretation, paraphrasing, and communication skills.

To practice as a CRC, all participants reference their course work within their master's program. All participants report once all course work was completed, they all entered their field work trainings to include practicum and internships.

Participant one, stated:

> I got into the internship and I'm like a fish out of water. It was just like all new learning. When I started working, probably the first five years of my career, I

> was like, I have no idea what I am doing, but I am just going to try to be a good counselor. I felt like I learned a ton in my internship, and I probably learned so much more on the job in the first five to ten years.

Participant three had a similar experience stating, "The counseling program provided the internship training, but as far as my primary role in workman's compensation, the course was not applicable, you just use your skills and try to learn as you go. "All of the participants reported their internship experiences as being a good experience with useful training. Participant 2 stated, "It was the most important or the most educational to me because it was in person and hands on. The internship experience prepared me for what to expect after graduation."

Participants all agreed that while they all had good internship training experiences, they had very diverse experiences in how their master's program prepared them for the real-life experiences of working with SCI and/or a physical disability. As expressed by Participant 5, "Not enough in my opinion. I really don't feel like my master's program did. It is not a criticism of them, but there was not a lot of content on disability and multicultural counseling." However, Participant 6 reported, "A lot of the research I did was on SCI. I would say my master's program definitely taught me the medical and psychological parts of SCI."

Participant 4 reported:

> We were very hands on. In our honors club we had a rehabilitation counseling student association and being involved in the community. So not only learning within my textbooks, but also the psychosocial impacts of disabilities and how it

> affects the individual in their mind, but also working side by side so you can hear their own individual story.

The findings in this study as it relates to necessary skills and the practice requirements for CRCs individual experiences presented to be consistent with the hands-on experience that the internship provide. There is evidence in the study that illustrates how different RC programs are for each of the participants specifically as it involves course work and how much emphasis the program focuses on SCI specifically. Based on participant interviews SCI disability was not a primary focus within their master's program as reported by Participant three who stated, "The program focused on all individuals with disabilities." It sounds like a benefit to this was that it allows CRCs in training to "look at the person as a unique individual and actually take each step to identify what the barriers are and how you can help people get through those barriers (P4, 2022)."

According to Participant 5:

> In my counselor program, there was a lesson on disability, but that lesson on disability included a lot of disabilities. So, I guess we received content on that, but I honestly think it was my internship, and my work experience that gave the most preparation and were the most helpful to me then what I learned in class.

The results of this study demonstrated a consistent perception by all participants that counselor programs provide an informative and hands on internship experience that contributes greatly to the training and preparation of CRCs. While the course curriculum includes a section on disability, CRCs in this study describe how their understanding of

disability and the person living with SCI came from the application of skills learned through their internship and work experiences.

Supporting Certified Rehabilitation Counselors in Training

An additional theme shared by participants was supporting CRCs in training. All participants conveyed the importance of continuing education for CRCs in training. Participant 1 shared, "I hope that for the field of rehabilitation counseling, that we don't forget how important independent living is and how to teach students about independent living". Participant 5 states, "I would say one hundred percent, educate yourself, because you don't get enough education in your school program." Throughout the study all participants spoke to the importance of "getting to know other fields" (Participant 6).

In addition to encouraging education post graduate studies, I observed participants sharing real life experiences not influenced by the course program. For example, Participant two shared, "It is nothing like in the class. In the real world, you're going to have struggles. There are going to be lessons where you think you failed. You have to be able to accept personal limitations in this field." Participant one shared, "You are going to be scared out of your mind, it is shocking. Remember, they are still a person first." Participants in this study provided a healthy balance to CRCs in training that not only encouragers competency through education, but also competency with being open to learn the human side of the person living with SCI and/or a physical disability.

As perceived by participant 6:

> Listen well. It is not a drug. It is not attention seeking. This is their life. They are telling you're their concerns. They are expressing their deepest issues to you.

> There is pain. That was one of my assumptions. I just thought, you are paralyzed. Encourage mental health counselling, because they don't always understand the full picture of life for them moving forward.

Impacting Social Change for Clients with Disabilities

The final theme that emerged from this study was impacting social change for clients with disabilities. Throughout the interviews, all participants perceived the most important to understand when providing care for clients with SCI and/or a physical disability is actively listening and never forgetting the persons with SCI or disability is a person first.

Participant 4 states:

> They are a person, just like you. They want to be happy and healthy and live their best life. We know a lot clinically, but often they just need a person to listen and not judge them, and that's what we are here to do.

According to participant one, "This is the will to live and not being afraid of having that conversation. Don't ever try to dismiss someone's conversation about that." Participant 5 shared, "You need to learn the person's individual story and do not make assumptions about their disability." To have an impact on social change for persons in the community of disability to include SCI, participants encouraged counselors in training to get to know your client individually and holistically. Participants encouraged the need for additional accommodations to support community resources and mobility. Most importantly, participants stated counselors in training are encouraged to see persons with SCI and/or a physical disability as a person first and not defined by their disability. All

participants reported the importance of being mindful of your biases and assumptions about who the person is with the disability.

Competency of CRCs is critical for the continued care of SCI and/or a physical disability to include CRCs in training and the development of counselor programs. The perceived competencies of all participants perceptions conveyed that social change for the community of SCI and/or a physical disability begin in the classroom, but in order to demonstrate competency, counselors in training must apply clinical skills as well as the skill of being human while working with persons living with SCI and or/a physical disability in order to impact change on the community and the future of counselor education programs.

Summary

In Chapter 4, I discussed the demographics of participants, data collection methods, and findings of the study. Data analysis and discussion on evidence of trustworthiness was included followed by the themes that emerged from analyzing the main research questions. Five major themes emerged from this study including a) clinical factors and certified rehabilitation counselors, (b) mental health and environmental concerns of clients, (c) necessary clinical skills and practice requirements for rehabilitation counselors, (d) supporting certified rehabilitation counselors in training, and (e) impacting social change for clients with disabilities. In Chapter 5, I discuss my findings of the study as they connect to the literature. I discuss the limitations of the study and recommendations for additional research, school counseling resources, and training opportunities. Finally, I include implications for positive social change.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this qualitative descriptive phenomenological study was to understand rehabilitation counselors perceived competency in addressing the mental health needs of a person with SCI and/or physical disability. Using Giorgi's (2018) descriptive phenomenological data analysis to guide this research inquiry, I specifically considered the factors that influenced the mental health needs of persons with SCI and or physical disability and tried to understand how counselors view their competency levels with supporting this population in the delivery of continuity of care for persons with SCI and/or physical disability. Five major themes emerged from this study: (a) clinical factors and certified rehabilitation counselors, (b) mental health and environmental concerns of clients, (c) necessary clinical skills and practice requirements for rehabilitation counselors, (d) supporting certified rehabilitation counselors in training, (e) impacting social change for clients with disabilities.

The main research question was "What are the lived experiences of rehabilitation counselor's ability to support the mental health needs of SCI and/or a physical disability client?" The sub question was "How does the preparation of rehabilitation counselors support the person with SCI and/or a physical disability mental health need?"

In Chapter 5, I discuss the findings of this study and their connections to the literature; the limitations of the study; as well as recommendations for additional research, rehabilitation counseling resources, and training opportunities. The chapter also includes the implications for positive social change. Finally, I conclude the chapter and study with a summary.

Interpretation of Findings

The findings of this study provide additional understanding of the perceived competencies of rehabilitation counselors while working with SCI and/or a physical disability, specifically on the similarities and differences between their course experiences with SCI and trainings. How RCs apply their counseling skills and competencies are also shared. Chapin et al. (2018) reported that to be effective as rehabilitation counselors when working with persons with disabilities including SCI, rehabilitation counselors should understand that these clients can live full and productive lives and they deserve to have encouragement and opportunities to develop and express themselves. Competent rehabilitation counselors understand that the process and timing of adapting to the onset of a disability, the way individuals develop a disability identity, and the ways in which that identity is expressed vary from individual to individual. The following five themes emerged from this study to included (a) clinical factors and certified rehabilitation counselors, (b) mental health and environmental concerns of clients, (c) necessary clinical skills and practice requirements for rehabilitation counselors, (d) supporting certified rehabilitation counselors in training, and (e) impacting social change for clients with disabilities.

Clinical Factors and Certified Rehabilitation Counselors

All participants spoke to the importance of returning persons with SCI and/or a physical disability back to a place where they have purpose and meaning. Participants spoke that being a rehabilitation counselor includes being a good listener, advocating, and

helping to identify strengths and skills despite unexpected challenges. In addition, all participants spoke to their role as identifying options and give persons hope.

Participant 1 stated:

> It's tremendously different. There is so much to it that it is different than mental health. It's once a person is stable and medically stable, and they can begin to address living independently and going to school or career options, it's putting someone on that path, and it takes a whole different skill set. You have to know the labor market, standardized testing, transferrable skills, the projection for careers in the future, what an accommodation is, or what is a disclosure.

In summary, all participants in this study identified with the perception that competent rehabilitation counselors understand that the process and timing of adapting to the onset of a disability, the way individuals develop a disability identity, and the ways in which that identity is expressed vary from individual to individual. Findings from the study affirms the need to apply a holistic approach when identifying specific needs of the person living with SCI and/or a physical disability.

Participant 4 shared:

> We look at how that impacts the person overall between friends, family, job implications, and looking at accommodations. It's so much more than just a clinical outlook. We are called to advocate for our clients. Teach client advocacy skills. It's more than a license or credential. It's much more of a lifestyle change and how the SCI and/or person with disability see themselves and how he or she see the world.

Participant perceptions solidified the research in that positive psychology interventions aimed at cultivating positive feelings, behaviors, and thinking have shown effectiveness in other populations (see Bolier et al., 2013), and could be applied as treatment interventions in people with SCI and/or a physical disability. Participant 1 stated, "Be attentive, be a good listener, especially to the nonverbal cues. Pay attention and be really mindful." This perception helps to confirm the current evidence exists for the effectiveness of multidisciplinary interventions targeted at enhancing self-efficacy (see Andersen et al., 2018).

Mental Health and Environmental Concerns of Clients

According to ARCA (2019), the effectiveness of multidisciplinary intervention makes assessment, diagnostic interpretations, counseling, and goal setting more valid and effective for the person with the disability. All participants spoke to the mental and environmental concerns of clients with SCI and/or a physical disability. Participant 5 shared an interesting perception stating, "I think we're thinking about mental health issues versus mental illness. I think that it also depends on the nature of the SCI or the disability." To help narrow this perception, Participant 6 stated:

> If you look at the resources that are available for my SCI clients to get out and do things in the community, it's very limited even with public transportation. SCI and/or persons with physical disabilities experience loneliness, isolation, depression, adjustment, and struggle with alcohol and substance abuse.

Participant 3 also shared "alcoholism and drug use." Additional diagnostics as reported by Participant 3 included "adjustment, anxiety, and depression." All participants in this

study perceived anxiety, depression, and isolation as being primary factors for mental health and report environmental concerns of homelife, transportation, family or friend support, and lack of community resources.

As research suggested, during the postinjury period persons with SCI and/ or a physical disability will often experience grief and a range of emotions including denial, sadness, fear, frustration or anger as they begin the process of adjustment (Craig et al., 2017). Participant 3 shared, "They are anxious, angry, and frustrated because they don't know what is going to happen. The unknown factors are always playing on them." The results of this study aligned with the research which describes rehabilitation counseling as a process where the counselor works collaboratively with the client to understand existing problems, barriers and potentials to facilitate the client's effective use of personal and environmental resources for career, personal, social and community adjustment following disability (see Hawley et al., 2014).

Necessary Skills and Practice Requirements for Rehabilitation Counselors

According to the ARCA Task Force on Competencies for Counseling Persons with Disabilities (Chapin et. al., 2018) counselors should become competent in working with PWDs to better understand individual needs to provide effective counseling. All participants in this study identified with the clinical skills that they perceived to be most useful when working with clients with SCI and/or a physical disability. Participant 4 shared, "Being mindful that certain disabilities may appear to be something that they are not. You have to have a keen physical observance, sharp memory of what the client is saying and being able to access at the same time." All participants identified with active

listening and patience. Participant 5 stated, “You have to adapt your skills to be patient or to allow the person to use assistive technology device or a different level of communication. You are still using reflection, interpretation, and paraphrasing”.

The CRC code of ethics (2017) states

> Rehabilitation counselors recognize the need for continuing education to acquire and maintain a reasonable level of awareness of current scientific and professional information in their fields of activity. They maintain their competence in the skills they use, are open to new procedures, and keep current with professional and community resources for diverse and specific populations with which they work.

In summary, all participants in this study provided their perceived experience with training while participating in their master counseling programs. Trainings provided hands on experience with working with actual persons living with a physical disability, however the experience did not always include persons living with SCI. All participants shared the process of obtaining their masters to include coursework, practicum, and field trainings adhering to the required training hours of internship and practicum experience. There were subtle differences of experience that spoke to the individual path of how they come to select a CRC program. Participant 5 shared

> I sort of backdoored the CRC (certified rehabilitation counselor) process because when I was working at UCP, I really wanted to find a vocational rehabilitation program specifically, but where I was geographically, I couldn't find one near me and the closest college to me that I could get to and I could afford, was a state college. They had a counseling program and they had a special Ed program, so I

> kind of had to decide like which of those two do I really want to do. I had been a prior special education teacher prior to working in rehabilitation, so I chose the counseling program. Later on, I started a Masters in special Ed. I used the disability coursework and the special Ed coursework, which is when a counselor recommended, I get my CRC. I applied through this option. I had to do an internship under a CRC in order to get my CRC and of course, passed the exam. I'm a little different than those who maybe went through a rehabilitation counseling program through CORE or CACREP. I went through a generic masters in counseling and then later on in life, I got my license at mental health counseling.

The consistency with all participants included the attention to SCI persons within their master's program. For all participants the focus of SCI was minimum and not enough to prepare them fully for field training or employment experience. Participant 3 shared, "We learned the importance of seeing the person as a unique individual and actually take each step to identify what the barriers are and how you can help people get through those." The participants in this study all agreed and aligned with the identified RC Code of Ethics (2017), which states:

> Rehabilitation counselors are aware that all individuals exist in a variety of contexts and understand the influence of these contexts on an individual's behavior. Rehabilitation counselors are aware of the continuing evolution of the field, changes in society at large, and the different needs of individuals in social,

> political, historical, environmental and economic contexts (RC Code of Ethics, 2017).

In summary, the CRCC (2017) believes and encourages all rehabilitation counselors to obtain their CRC in support of the development of professional counselors, educational programs, and trainings. These standards assure that the community of SCI and/or physically disabled persons are provided adequate service and RC's upholding the code for standard of care.

Supporting Certified Rehabilitation Counselors in Training

All participants in this study perceived the importance of supporting CRCs in training. Participant 1 shared, "I remember counseling theories and practicing counseling. I remember a diversity culture and diversity class." The importance of this experience is shared by Participant 2 who stated,

> It is nothing like in the class. In the real world, you're going to have struggles. I think we all or most people, or at least when I was in school, I thought I am going to go out and make this a wonderful impact. And you do, but there's going to be lot of times where there are going to be lessons where you feel like you've failed. You have to be able to accept personal limitations in this field.

According to WHO (2019), every year about 40 million people worldwide suffer from SCI. CRCs are expected to be prepared to assist individuals in adapting to the environment, assist in accommodating the needs of the individual, and work toward the full participation of individuals in all aspects of society, with a particular focus on independent living and work (CRCC, 2017).

In support of this research, Participant 1 stated, “I hope that for the field of rehabilitation counseling, that we don't forget how important independent living is and how to teach students about independent living.” Participant 4 shared, “I think it's important that they are knowledgeable and understand how the disability impacts the individual person and see the person for what they are and not the disability and realize it impacts everyone differently.” To assist individuals with disabilities, gain or regain their independence through employment or some form of meaningful activity, it is imperative to build relationships with providers in other fields (Hawley et al., 2014). Participant 6 shared:

> Get to know your other fields too because that has been amazing with me. But definitely get to know your other professions. Get to connect with them, even as a mental health counselor. Connect with them so you can understand pain management when they're talking about their pain.

According to Participant 5, “One hundred percent educate yourself, because you don't get enough education in your school program.” All participants in this study provided a powerful message that when one supports CRCs in training a strong foundation is being built to develop and maintain knowledge, personal awareness, sensitivity, and skills and demonstrate a disposition reflective of a culturally competent rehabilitation counselor working with diverse client populations.

Impacting Social Change for Clients with Disabilities

All participants in this study provided valuable perceptions of how to impact social change for clients with SCI and/or physical disabilities. The consistency with all

participants is in order toto impact social change, the masters ’programs must include a course outline for SCI specifically. Participant 6 shared, “I would say my master’s program definitely taught me the medical and the psychological parts of spinal cord injury.” The findings of the study highlighted areas where programs lack consistency. According to Participant 5,

> Not enough in my opinion. I really don't feel like my master’s program did. There really wasn't a lot of content and even later on probably as a component of multicultural counseling, there was a lesson on disability, but that lesson on disability included a lot of disabilities.

Participant 1 recalled a similar experience: “I remember counseling theories and practicing counseling. I remember a diversity culture and diversity class.” To support where master’s programs could provide more experience with comprehending SCI, all participants shared the importance of collaboration to include, instructors, supervisors, rehabilitation, and inpatient programs. However, the results of the study suggest that all participants had a very informative and hands on internship experience. Participant 3 shared, “As far as the counseling portion, we got a lot of that in training.” Participant 4 shared,

> I've had quite an array of clients to work with, but I think my internship practicum really sets you off. It is important to distinguish that even with a wonderful internship experience, it is suggested that nothing can prepare you for the real-life

experience while working with persons living with SCI and/or a physical disability.

Participant 1 shared, "I had a wonderful, wonderful adviser and dissertation chair. I had my courses, and then I went to do my internship which was great but nothing prepared me for this. I got into the internship and I'm like a fish out of water."

To impact social change for the SCI and/or physical disability, master's program must be consistent in how programs are outlined specifically for SCI to have a greater understanding of the person living with SCI. Most importantly, as all participants shared, regardless of the disability, persons living with SCI and/or a physical disability are a person first. The perceptions of all participants aligned with the research that understanding SCI and/or a physical disability is essential to understanding how people live with the physical, social, and emotional aspects of their condition or whether it acts as a barrier when people must confront discriminatory attitudes and other obstacles including the failure to provide supportive and facilitating services and resources (see Jimenez, 2018).

Limitations to the Study

The first limitation arose in meeting data saturation while also producing a manageable amount of data within a reasonable timeline. Queiros et al., (2017) stated that with qualitative research there are some limitations and pitfalls, because it is time-intensive and it is not generalizable. One barrier I encountered was difficulty in recruiting participants for interviews. Through the recruitment process, I learned that available CRCs did not have experience working with persons living with SCI specifically. I also

learned that some CRC's were not licensed to counsel persons with SCI and were using they're certification primarily in the vocational setting. Based on this understanding I received IRB approval to broaden my recruitment strategies to include physical disability. Including physical disability helped to broaden the participant pool allowing for qualitative data analysis, specifically with Giorgi's descriptive method, to discover a deeper understanding of the lived experiences of the identified phenomenon of interest (Shelton & Bridges, 2019). However, accessing participants posed some challenges for face-to-face interviews due to the distance, time required for travel, and ongoing COVID-19 restrictions for rehabilitation and hospital settings. The Centers for Disease Control and Prevention (2020) recommended social distancing.

Transferability may also be a limitation due to the perceived competence of RC while working with SCI and/or a physical disability. Ravitch and Carl (2016) described transferability as applying qualitative findings to broader settings while still maintaining the context-specific results. The results of the study are limited to only certified and licensed rehabilitation counselors who have experience working with SCI and/or a physical disability, and may not be applicable in other settings. Although participants practiced in multiple states across the United States, this study was limited in the ability to transfer the results to a larger population. I used note taking (memos) and member checking to address researcher bias, which may be another potential limitation because I am also a person living with SCI.

Recommendations

As participants shared their experiences on competency areas for working with persons with SCI and/or a physical disability, I found concerns in how well prepared they all felt after completing their graduate programs and entering employment. Each participant perceived their practicum and internship experiences as being very helpful. Coursework in their identified programs seemed to lack enough attention on the SCI community as a physical disability specifically, and physical disability included several examples that could cause, so upon entering practicum and internship, participants perceived not being prepared to connect the coursework content with the field experience. With this in mind, I have the following recommendations in the areas of research, resources, and training.

The first recommendation is in the area of research. All participants shared their experiences with their master level programs as CRC counselors in training and expressed the benefit of having a more specific experience on learning what SCI is including a desire to learn and understand more of the person living with SCI experience and specific counseling needs. More research is needed to capture the experiences of persons living with SCI and/or a physical disability in order to further prepare rehabilitation counselors across all RC programs. As discussed in Chapter 2, the literature indicated that rehabilitation counseling has been described as a process where the counselor works collaboratively with the client to understand existing problems, barriers and potentials to facilitate the client's effective use of personal and environmental resources for career, personal, social and community adjustment following disability.

In carrying out this multifaceted process, the CRCC, (2016) adopted in the CRCC code of ethics, (2017) that rehabilitation counselors must be prepared to assist individuals in adapting to the environment, assist environments in accommodating the needs of the individual, and work toward the full participation of individuals in all aspects of society. This process includes specifically the spinal cord injured population, with a particular focus on mental health as it pertains to anxiety and depression (Dorstyn & Kraft, 2015).

All participants shared their experiences with how the course curriculum within their master programs provided several examples of what a physical disability could be and a perspective of what the client could experience in order to help increase competency in rehabilitation counselor's ability to get to know the persons with a physical disability mental and emotional needs while simultaneously observing how well the person with a physical disability is adapting to change and responding to various skills (Fuseini et al., 2019). Based on conversations within this study, participants found this to be helpful as it provided a broader perspective of conditions that would translate to a physical disability.

Research suggests that rehabilitation counselors can have a significant impact on the patient's self-image by providing information and creating beneficial opportunities such as group outings to overcoming fears (Magsamen-Conrad et al., 2016). Based on these findings, it is a recommendation that counselor education programs prepare CRCs in training by having more specific distinctions of what separates the individual as it relates to coping and independent living. This could have a significant impact on preventing the disability community from being grouped under one category.

The next recommendation is in the area of resources. Each participant shared their recommendations for increased support and resources for the community of SCI persons and/or a physical disability. All participants perceived the lack of community resources as a barrier to their client's mental health and the amount of time it could take for clients to meet their individualized goals and return to a reasonable functioning or independence.

It is important to note, that all participants in this study reported that community resources as well as support groups were lacking specifically in their local area of work for the person with SCI. However, other identified physical disability groups existed and are obtainable. Specific examples were shared by four participants as deaf-and-hard of hearing and intellectual disabilities. As a rehabilitation professional, understanding the factors that influence support mechanisms to assist the transition to home and community during the counseling process can facilitate social integration of the individual with SCI and/or a physical disability, (WHO, 2018). All participants suggested resources for the person with SCI and/or a physical disability to aid in the increased access to transportation, the addition to community social support groups that are specifically for persons living with SCI, easier access to home health care needs, access to medication, increased family support, and specific community educational groups on persons living with SCI and/or a physical disability. All participants shared that the SCI or the physical disability community do not receive the attention deserved.

A final recommendation is in the area of training for rehabilitation counselors and leadership specifically on SCI and how SCI is considered a disability. As the research indicated as the numbers for persons living with a disability increase, specifically SCI,

the need for rehabilitation counselors to possess competence of the person with SCI and/or a physical disability is preeminent. All participants shared a lack of clinical supervision specific to SCI post masters, as well as, understanding the unique needs of the SCI person. All participants shared supervision focused on physical disability with many examples, however SCI was rarely discussed. The competency of CRCs in this study confirmed that the image of a physical disability is changing and well defined as disability groups broaden and grows globally. Counselor education programs could benefit from having a more specific curriculum or specialization tailored to the unique needs of SCI persons and the diverse physical disability approaches applied by rehabilitation counselors. Four participants in this study shared they're adaption of micro and macro skills for the SCI community to include physical disabilities such as cerebral palsy, spina bifida and traumatic brain injuries all developed during employment training. Two participants disclosed adapting skills from their experience as licensed mental health counselors when working with these specific populations of physical disability. All participants shared their perceived lack of preparation to work with this population in their counselor programs once transitioned to employment.

Implications

Through conducting this research, a few implications for social change developed. The social change implications would be beneficial to certified rehabilitation counselors, supervisors, student counselors in training and other stakeholders. Findings from this study, can impact people for social change by addressing competency levels for rehabilitation counselors; increasing the awareness and knowledge of the SCI and/or a

physical disability community; and identifying successful strategies that rehabilitation counselors in training can employ to effectively counsel persons living with SCI and or/a physical disability. Additionally, insights from this study can aid counselor educators in better preparing future rehabilitation counselors to work in multiple rehabilitation settings, as well as, provide practicing rehabilitation counselors with ideas on how to utilize available resources for managing SCI and other physical disabilities mental health and advocate for their independent living.

SCI and/or a Physical Disability Community Awareness

Participants provided important information on areas they found to be lacking in the community as it relates to the exposure of the SCI population and as a disability. All participants identified other physical disabilities to be more common and discussed by their community. Specific examples identified by four participants were intellectual disabilities, cerebral palsy, and the deaf-and-hard of hearing community. Social change implications can result from addressing those challenges. According to the research, every year, about 40 million people worldwide suffer from SCI and about 15% of the world's population lives with some form of disability, of whom 2-4% experience significant difficulties in functioning (WHO, 2019). However, when the term disability is used all participants reported a lack of discussion for persons living with SCI. In 1990 the American Disability Act (ADA) was passed but it was not implemented until two years later, allowing business owners and the general public time to become aware of the existence of SCI. Conversations within this study concluded that most people still don’t know anything about SCI, the severity of injury levels and common complications. More

importantly, the community continue to hold bias concerning the quality-of-life persons with SCI and/or a physical disability can have. The community requires ongoing education and exposure to break down low expectations and outdated stereotypes. Progress has come slowly and not without considerable advocacy.

What appeared to be lacking is awareness and education. The gap in the research as shared by all participant experiences is consistent with the identified experience with competency during their counselor education programs and how it is specifically tailored to discussing physical disability. Findings from the study also included underlying attitudes and biases that seem to separate how comfortable the community and providers are in discussing and/or treating physical disabilities such as the deaf-and hard of hearing and intellectual disabilities as compared to the person living with SCI.

The perceived attitudes that are reported by all participants amongst providers and the community is developed from a perception of what independent living can look like for persons with a physical disability and the hope that exists for this group in comparison to the existing stereotypes and presumptions of the SCI persons perceived quality of life and options for independent living. To support these changes in biases one participant identified independent living as the clients will to live. Factors that seem to influence based on findings in the study include the instability of family support, available community resources, and continued biases.

The research reported by Emerson (2012) described disability as a global, human rights issue and further noted that people living with disabilities encounter considerable barriers when accessing community services. As an identified human rights issue,

findings from this study allowed CRCs to provide their real-life experiences while working with SCI and/or a physical disability, to expose the community as well rehabilitation counselors in training on the importance of having competence and understanding persons with SCI and/or a physical disability holistically, the existing barriers encountered, and as a person first in order to work with this growing population.

SCI and/or Physical Disability Mental Health Success Strategies

Another possible social change implication from this study focused on rehabilitation counselors in training application of SCI and/or a physical disability mental health success strategy. Participants from this study shared and identified the mental health needs of the person with SCI and/or a physical disability and agree that in some cases it depends on the onset or length of time the person has had the injury. Participants identified depression, anxiety, adjustment, grief, and substance abuse as the primary mental health concerns perceived within this population. According to WHO, (2018) persons living with SCI include 10% of the world's population is affected by mental health disorders and the prevalence is even higher in individuals with disabilities (Williams & Murray, 2015). A recent article called "Prevalence of Disabilities and Health Care Access by Disability Status and Type Among Adults" found that adults with disabilities report experiencing more mental distress than those without disabilities. According to authors Okoro et. al (2018), an estimated 17.4 million adults with disabilities experienced frequent mental distress, defined as 14 or more reported mentally unhealthy days in the past 30 days. Frequent mental distress is associated with poor health behaviors, increased use of health services, mental disorders, chronic disease, and

limitations in daily life. During the COVID-19 pandemic, isolation, disconnect, disrupted routines, and diminished health services have greatly impacted the lives and mental well-being of people with physical disabilities (CDC, 2020).

Conversations within the participant interviews determined that the future of mental health care for persons with SCI and or/a physical disability depends largely on changes being implemented by counselor education programs to include specific content within the course curriculum that provides more concrete and detailed information about the factors and barriers that hinder quality of life and return to independent living. Success strategies for rehabilitation counselors working with this population look like considering whether the person is aware or resistant to mental health care.

All participants shared success strategies are implemented holistically and individually. All participants disclosed that in order to support clients coping with mental health the application of interpersonal skills is needed. Identified skills shared are, autonomy, empathy, active listening, mindfulness, verbal and non-verbal communication skills, and the willingness to learn. In addition, educating persons with SCI and/or a physical disability on the importance of mental health care is a vehicle for successful and long-term independent living. The results of this study could be used to encourage counselor educators to train future rehabilitation counselors on advocacy and clinical skills which will be necessary in their roles.

Preparation

A final significant social change implication would be further discussion on how to prepare rehabilitation counselors for the real-life experiences of the person living with

SCI and/or a physical disability. All participants shared that the experiences while working with this population is nothing like what you receive in the classroom or field training. Four participants perceived their experiences as being overwhelming and scary at times while all participants disclosed the significance of the work to impact their perceptions of their own competency as well as the potential for burnout. Conversations from the participant interviews revealed the importance of rehabilitation counselors in training to be mindful of their own expectations for themselves and having balance. Findings from this study reveal that in order to prepare rehabilitation counselors in training for the real-life experiences working with this population, counselor education programs must expand their curriculum on multicultural counseling. Participants reported this was minimum in their programs and could play a significant role in preparing students during their master programs.

The American Rehabilitation Counseling Association (ARCA, 2018) support this recommendation by implementing and also recommend that counselors and counselor training programs support the attainment of these competencies among all counselors, in recognition of disability as a part of personal identity and cultural diversity. Authors Chapin et al. (2018) report to be effective as rehabilitation counselors in how RC's work with persons with disabilities to include SCI, RCs should understand that PWDs, like SCI, can live full and productive lives, and competent rehabilitation counselors are prepared to apply this understanding while working with this population. Preparing rehabilitation counselors according to ARCA looks like understanding the disability experience, support of their self-advocacy, counseling process and relationship, testing

and assessment and lastly, working with or supervising persons with disabilities in a school, employment, or community setting.

Conclusion

Certified rehabilitation counselors have found their experiences working with persons living with SCI and/or a physical disability to be a valuable and rewarding experience. Perceptions of course curriculum, field trainings, supervision, and work experience combined have influenced and contributed to professional growth and achievement of successful outcomes for the care of SCI and/or a physical disability. The profession of rehabilitation counseling has been shaped significantly by graduate training programs that have, for many years, been grounded in providing students with the knowledge and skills necessary for working with persons with physical and mental disabilities. As the research shows, the image of disability is changing and well defined as disability groups broaden and grows globally. Results from this study highlighted the importance of competency for rehabilitation counselors while working with persons with SCI and/or a physical disability. The lived experiences shared by participants included rich descriptions and anecdotal details to further the conversation of certified rehabilitation counselors ‘competency which begin in counselor master programs, increased awareness of the disability population to include SCI, and increased awareness of opportunities for support and education within the community.

Five major themes emerged from this study including a) clinical factors and certified rehabilitation counselors, (b) mental health and environmental concerns of clients, (c) necessary clinical skills and practice requirements for rehabilitation

counselors, (d) supporting certified rehabilitation counselors in training, and (e) impacting social change for clients with disabilities. The emerging themes explored the perceived competencies and experiences of certified rehabilitation counselors while working with persons living with SCI and/or a physical disability. Results from the data confirmed that all certified rehabilitation counselors perceived their competency was not adequate within the coursework of their master programs and field experiences gave more of a hands-on approach to working with this population. All perceived competencies developed during employment and continued education courses. All expressed a desire for increased support of this population, increased conversation, increased education, and the importance of collaborating and working with other fields.

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Appendix A: Research Flyer 1

Research study: seeks participants providing care for Spinal Cord Injured persons as a Rehabilitation Counselor

There is a new study called "*Rehabilitation Counselor Perspectives When Working with Spinal Cord Injured Persons"* that could help care providers like counselors to better understand and help their clients. For this study, you will be asked to describe your experiences working with spinal cord injured persons.

This research is part of the doctoral study for Denise Anderson, a Ph.D. student at Walden University.

About the study:

- One brief demographic information form
- One 60-minute interview via Zoom video conference
- To protect your privacy, pseudonyms will be assigned

Volunteers must meet these requirements:

- 18 years old or older
- Licensed as a Mental Health Counselor & Certified as a Rehabilitation Counselor

- Licensed as a Professional Counselor & Certified as a Rehabilitation Counselor
- Work with clients living with a Spinal Cord Injury

If you are interested in participating in this study, please email me at.

Appendix B: Research Flyer 2

Research study: seeks participants providing care for persons with Physical Disabilities and/or Spinal Cord Injury as a Rehabilitation Counselor

There is a new study called "*Rehabilitation Counselor Perspectives When Working with persons with Physical disabilities and/or Spinal Cord Injury"* that could help care providers like counselors to better understand and help their clients. For this study, you will be asked to describe your experiences working with persons who have a physical disability and/or spinal cord injured persons.

This research is part of the doctoral study for Denise Anderson, a Ph.D. student at Walden University.

About the study:

- One brief demographic information form
- One 60-minute interview via Zoom video conference
- To protect your privacy, pseudonyms will be assigned

Volunteers must meet these requirements:

- 18 years old or older
- Licensed as a Mental Health Counselor & Certified as a Rehabilitation Counselor
- Licensed as a Professional Counselor & Certified as a Rehabilitation Counselor
- Work with clients living with a Physical Disability and/or Spinal Cord Injury

If you are interested in participating in this study, please email me at.

. . Appendix C: Demographic Questionnaire

You are invited to take part in a research study to address the gap in knowledge of spinal cord injury and/or physical disabilities. This study seeks to describe the perceived competency of rehabilitation counselors when working with SCI and/or physical disabilities. The researcher is inviting Rehabilitation Counselors to be in the study. This form is part of a process designed to allow the researcher to understand more about your background. This study is being conducted by a researcher named Denise Anderson, who is a Counselor Education and Supervision PhD candidate at Walden University.

Gender:

What gender do you identify as?

a) Male

b) Female

c) _____ (Short Answer Space)

d) Prefer not to answer.

Age:

What is your age?

a) 25 - 35 years old

b) 36 - 45 years old

c) 46 - 55 years old

d) 55+

e) Prefer not to answer

Ethnicity:

Please specify your ethnicity.

a) Caucasian

b) Black or African American

c) Latino or Hispanic

d) Asian

e) Native American

f) Native Hawaiian or Pacific Islander

g) Two or More

h) Other/Unknown

i) Prefer not to say

Location:

What region of the United States are you currently practice?

a) North America/Central America

b) South America

c) Midwest

d) West

e) Other: _____

f) Prefer not to say

Education:

What is your current education level?

a) Master's Degree

b) Ph.D.

Was the school you graduated from CACREP or Non-CACREP?

a) CACREP

b) Non-CACREP

Licensure or Certification:

Are you currently licensed and certified as a Rehabilitation Counselor?

a) Yes

b) No

c) Both

Appendix D: Interview Questions

1. Tell me what it means to be a rehabilitation counselor.
   a. How is this role different from other types of counselors?
   b. What type of clients have you seen in your work?
   c. How do you believe that bias can impact the work of clients when it comes to different diagnoses in rehabilitation counseling?
2. What type of training did you receive to begin working with your specific population of clients?
3. How would you define Spinal Cord Injury (SCI) and/or physical disability?
4. How did your master's program educate you to work with these clients?
5. Are there any differences between how you formulate and develop care for SCI clients and clients with other physical disabilities?
6. As a rehabilitation counselor, what factors contribute to the individualized needs of your clients with SCI and or physical disability?
7. What type of mental health needs do you see in persons with SCI and/or physical disability?
   a. How do you support these needs?
8. What clinical skills are most useful when working with clients with SCI and/or physical disability?
9. What would you say to counselors in training, concerning the care provided for persons with SCI and/or physical disability?
10. What do you believe is most important to understand when providing care for

clients with SCI and/or physical disability?

11. Is there anything else, you would like to add?