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RELATIONSHIP OF PERCEPTIONS OF CLIENTS' FUNCTIONING LEVELS TO REHABILITATION OUTCOME AND CLOSURE

A Thesis

Presented for the

Master of Science

Degree

The University of Tennessee, Knoxville

Linda Rae O'Dell

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DEDICATION

This thesis is dedicated to my parents

Ralph Ellis O'Dell and Earlene Rather O'Dell

because without their love and support

my education would not

have been possible.

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ABSTRACT

This research investigated the relationship between perceptions of clients' functioning levels and rehabilitation outcome and closure. A sample of forty-one (41) clients and nine (9) facility counselors was utilized. Existing data from the Client Goal Achievement Instruments (CGAI-I, counselor form and CGAI-II , client form) were utilized. In addition, follow-up client data obtained through the computer access information center was also studied.

The data were analyzed through chi-square analysis; the .05 level of significance was used to test null hypotheses. This study concluded that there was no relationship between clients' perceptions of their functioning levels and their rehabilitation outcome and closure. In addition, there was no relationship between counselors' perceptions of clients' functioning levels and clients' rehabilitation outcome and closure. The study also concluded that facility counselors perceived those clients who had unsuccessful rehabilitation outcome and closure to be higher on levels of functioning than those clients who were successful. Furthermore, the study concluded that those clients who had unsuccessful rehabilitation outcome were more likely to have successful closure than those clients who had successful rehabilitation outcome. Finally, the study concluded that clients' perceptions of their functioning levels were more accurate than facility counselors' perceptions of the clients' functioning levels.

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CHAPTER I

INTRODUCTION

Background

The state / federal vocational rehabilitation program is designed to assist people with disabilities to choose an appropriate occupation, prepare for and secure an appropriate job, and maintain regular employment (Rubin & Roessler, 1987). In the United States, each state has one or more state / federal vocational rehabilitation programs. The state / federal program in the state of Georgia is the Georgia Division of Rehabilitation Services (GDRS). The GDRS provides assessment, counseling, physical restoration, and job placement services to Georgia citizens with disabilities. These services are provided locally or in rehabilitation facilities located throughout the state of Georgia. The comprehensive rehabilitation center in Georgia is the Roosevelt Warm Springs Institute for Rehabilitation (RWSIR) which is located in Warm Springs. This center provides medical, vocational, and independent living rehabilitation services to clients who have a variety of severe disabilities and substantial vocational handicaps. Clients are referred to RWSIR by their local rehabilitation counselors.

The rehabilitation process provides for an initial assessment of the client by the counselor who makes a preliminary finding that the client will or will not be eligible for the state/federal vocational rehabilitation program. If the counselor believes that the client has a medical condition that results in a

substantial vocational handicap, the client is referred for medical and, maybe, psychological evaluations. The consultants' reports document the presence of medical and psychological impairments as well as functional limitations. The counselor will utilize the consultants' reports and the counselor's interview findings to support the counselor's decision that the client is or is not eligible for services from the rehabilitation agency. After the client is determined eligible for vocational rehabilitation services, a plan for achieving the long term objective is developed. The plan takes into consideration the client's interests, abilities, needs, and resources. This plan, formally recognized as the Individualized Written Rehabilitation Program (IWRP), lists the vocational objective, intermediate steps to goal achievement, services to be provided, date lines, and evaluation criteria. The final objective is job placement. Successful employment, or rehabilitation closure, is the ideal end product of rehabilitation services. If resources are available at the local level, services for eligible clients are implemented immediately. If the required resources are not available locally for needed services or for determining the person's eligibility for services, the rehabilitation counselor may refer the client to RWSIR.

Clients referred to RWSIR are provided a comprehensive vocational evaluation and consultative examination as necessary. The RWSIR facility counselor provides personal and vocational counseling to clients at the center and also monitor the clients' progress during all stages of center services (e.g., evaluation, work adjustment, independent living, and/or vocational training). Because of close and continuous contact with clients at RWSIR, the counselors should be well-qualified to judge the clients' level of functioning.

Statement of the Problem

A successful case closure in vocational rehabilitation means that the client is satisfactorily employed. Critical to successful employment is accurate assessment of the client functioning levels (Menapace, 1977). Perception of the client's functioning levels may be important to the client's rehabilitation. Frequently, perceptions of clients and counselors differ regarding the clients' vocational potential. These perceptual discrepancies may compromise the effectiveness of a rehabilitation program. Incongruent perceptions may cause miscommunication between counselor and client concerning what services are best for the client; therefore, a program of inappropriate services could result. Successful rehabilitation outcome and closure may also be affected by incongruent perceptions (Mattie, Campbell, Crisler, & Woodruff, 1991). Perceptions of client functioning levels are important for appropriate services and job placement.

It is important to determine if there is a relationship between discrepant perceptions and the rehabilitation outcome and closure. Such awareness is needed if rehabilitation service delivery and, consequently, rehabilitation outcome and closure will be successful.

Significance of the Problem

The rehabilitation program can be strongly influenced by perceptions of clients' potential held by rehabilitation counselors and clients (Schofield & Kunce, 1971). Discrepancies in these perceptions can result in difficulty in providing appropriate services for the clients which can lead to an unsuccessful rehabilitation closure (Ju & Thomas, 1977). If rehabilitation

counselors perceive client functioning levels as poor (which is many times the case), an inadequate service delivery program may result (Menapace, 1977). For example, if a counselor recommends training in an occupation which utilizes skills lower than those possessed by the client, the service delivery program has been deficient for the client. The client's maximum potential has not been recognized or realized.

It is important that all services be cost-effective because of exorbitant costs in vocational rehabilitation. An unsuccessful rehabilitation effort may be excessively costly in terms of both time and money. The client and the rehabilitation agency benefit when rehabilitation counselors make accurate perceptions of client functioning levels. Accurate perceptions provide a base from which appropriate services are provided to the client. The client receives services which are beneficial, and the counselor avoids unnecessary rehabilitation expenses when only appropriate services are provided.

Purpose of the Study

The purpose of this study was to determine if a relationship exists between perceived client functioning levels and rehabilitation outcome and closure. This study followed previous research conducted by Mattie, et al., (1991) that found incongruent perceptions existing between clients and facility counselors, clients and referral counselors, and facility counselors and referral counselors.

Results from the Client Goal Achievement Instruments (CGAI) given to RWSIR clients and their facility counselors were evaluated as were existing records of clients' rehabilitation outcomes and closures. A copy of the

instruments are in Appendix A and Appendix B. The CGAI is a questionnaire which covers five dimensions important to the determination of client functioning levels. The five dimensions are as follows: Impact of family / home environment on rehabilitation efforts; Degree of client involvement in plan / progress; Client independence in decision-making; Client independence in activities of daily living; and Interpersonal communication. The purpose of this study was to determine if perceptions of clients' functioning levels were significant factors in the clients' rehabilitation outcomes and closures.

Hypotheses

Hypothesis One: There will be no significant difference between the clients' perceptions of their functioning levels and their rehabilitation outcomes.

Hypothesis Two: There will be no significant difference between facility counselors' perceptions of clients functioning levels and clients' rehabilitation outcomes.

Hypothesis Three: There will be no significant difference between clients' perceptions of their functioning levels and their rehabilitation closures.

Hypothesis Four: There will be no significant difference between the facility counselors' perceptions of clients' functioning levels and the clients' rehabilitation closures.

Hypothesis Five: There will be no significant difference between clients' rehabilitation outcomes and clients' rehabilitation closures.

Definition of Terms

For the purpose of this study, the following listed terms are defined:

Rehabilitation outcome: Graduation or no graduation from RWSIR. A successful rehabilitation outcome is considered to be graduation.

Rehabilitation closure: A successful rehabilitation closure is defined as appropriate employment for at least 60 days (status 26). In this study, closure was considered one year after clients left RWSIR. Closures indicate whether or not the rehabilitation program was successful or unsuccessful.

Clients: Persons who have physical and/or mental disabilities which prevent them from obtaining and retaining employment. For the purpose of this study, client subjects were former clients of RWSIR from the West and Central districts of Georgia.

Facility counselor: Rehabilitation counselors employed at the Roosevelt Warm Springs Institute for Rehabilitation (RWSIR), Warm Springs, Georgia.

Referral counselor (also known as field counselor): Rehabilitation counselors employed in a field office of DRS in Georgia. These counselors refer their clients to various agencies, including facilities such as RWSIR. For the purpose of this study, field counselors were based in the West and Central districts of Georgia.

Assumptions

For the purpose of this study, it was assumed that the clients and the facility counselors answered the questionnaire honestly and to the best of their ability and that this information was compiled accurately. It was also

assumed that all information compiled on the clients' rehabilitation outcomes was correct. Finally, it was assumed that the CGAI accurately recorded the perceptions of clients' functioning levels.

Delimitation of the Study

The study was limited to the former clients (N = 41) served at the Roosevelt Warm Springs Institute for Rehabilitation during 1989 from the West and Central districts of Georgia and the facility counselors of RWSIR (N = 9) who have completed the CGAI.

Organization of the Study

Chapter I, the introduction, contains background information, statement of the problem, significance of the problem, purpose of the study, definition of terms, assumptions, delimitation of the study, and organization of the study. Chapter II contains a review of related literature. Chapter III describes the research methodology. Chapter IV contains the results of the study and discussion of results. Chapter V contains a summary of the study, conclusions, and recommendations.

CHAPTER II

REVIEW OF LITERATURE

The following literature review covered three areas. First, the facility counselors and their perceptions of clients' functioning levels is discussed. The second section provides information concerning clients' perceptions of their functioning levels. The third and final section discusses the relationship of these perceptions on rehabilitation outcomes and closures.

Counselors' Perceptions of Clients' Functioning Levels

Counselors provide clients with vocational rehabilitation service options. These services are offered to clients based largely on how the counselors perceive client needs. Perceived needs are contingent on how counselors perceive client functioning levels (Bolton, 1978; Cook, 1983; Crystal, 1981). Research on counselor perceptions of client functioning levels, while limited, indicates that such perceptions are significant factors in the client rehabilitation programming (Bolton, 1978; Cook, 1983; Crystal,1981; Ju & Thomas, 1987; Kaplan, 1982; McGraw & Bitter, 1974; Schofield & Kunce, 1971). Kaplan & Thomas (1981) believe that rehabilitation outcomes can be affected (either positively or negatively) by the counselors' first impressions of their clients. These first impressions are many times based on counselors' preconceived attitudes and values (Cook, Kunce & Getsinger, 1976; Kaplan & Thomas, 1981). Further, effective counselors tend to be more objective with

clients than ineffective counselors (Cook, Kunce & Getsinger, 1971).

One study (Kerr, 1970) indicated that rehabilitation professionals have the ability to help or hinder the clients' rehabilitation program. Rehabilitation professionals can help clients through appropriate expectations and can hinder through inappropriate ones. Murphy and Salomone (1983) also found that expectations impact the delivery of rehabilitation services. Counselors' perceptions of clients' functioning levels guide service delivery choices for clients (Ju & Thomas, 1987). Inaccurate perceptions may result in the provision of inappropriate services (Bolton 1978), and inappropriate services may lead to unsuccessful rehabilitation. For example, if a counselor provides a service such as basic education and the client operates at a higher functioning level than what the service provides, the client may become discouraged and become an unwilling participant in the rehabilitation program. This situation may result in an ineffective rehabilitation program.

Counselor opinions of clients may originate from the type of client disabilities (Schofield & Kunce, 1971; Wicas & Carluccio, 1972). Goodyear (1983) found that counselors tend to favor physical and mental disabilities more positively than emotional disabilities. The study found that counselors considered people with physical disabilities as being more rehabilitative than people with emotional disabilities. Perhaps this view affects counselors' efforts in providing appropriate services. Counselors' awareness of these possible biases would help to alleviate the conflicts such attitudes can create.

The physical appearance of a client also tends to influence the evaluations and expectations from rehabilitation graduate students. Mercer, Andrews, & Mercer (1983), for example, found that attractive females were

rated more positively than unattractive females, regardless of disability type. Attitudes such as these may affect the services chosen by the counselors. If counselors perceive clients positively, counselors may be more willing to provide appropriate services. Negative perceptions of clients may result in the provision of inappropriate services.

Research also has shown that if counselors perceive clients as being rather difficult, the counselors tend to perceive them less favorably (Kaplan, 1982). Such perceptions might lead to counselors expecting limited results from the clients' rehabilitation program. Thus, low expectations may influence service delivery in a negative way (Kaplan, 1982). Counselors believe that unbiased perceptions are more common than biased perceptions when in fact research suggests the opposite (Cook, Kunce, & Getsinger, 1982). The implication is that counselors are not aware of their biases or how their biases may impact the clients' rehabilitation programs. Counselor biases might lead to inappropriate choices of services for clients and cause the rehabilitation outcome and closure to be unsuccessful. Cook, Kunce, and Getsinger (1982) found that counselors who avoid biased information and suspend judgment of clients' potential may be more effective counselors.

Clients' Perceptions of Their Functioning Levels

Clients' perceptions of themselves are important aspects of their rehabilitation programs. Research in this area is scarce, but the evidence suggests that clients' satisfaction, motivation and perceptions have an impact on their rehabilitation programs (Eisen & Grob, 1982; Ju & Thomas, 1987; Patterson & Leach, 1987; Tichenor, Thomas & Kravetz, 1975).

Clients' satisfaction with their rehabilitation programs can provide the counselors with important information on the types of services delivered (Patterson & Leach, 1987). Client feedback to counselors details whether services are deemed appropriate or inappropriate by the clients. The way in which clients perceive themselves (e.g., motivated, positive, negative) will determine to a degree their outcomes and closures (Eisen & Grob, 1982). Clients' opinions of themselves influence the choices they make concerning their rehabilitation programs (Ju & Thomas, 1987).

A research study conducted by Weinberg and Williams (1978) investigated how people with physical disabilities perceive themselves. This study supported the theory that personality and self-esteem, not disability type, have a critical influence on how clients perceive themselves.

Though clients may admit they have problems psychologically, they feel that their ability to make decisions about their rehabilitation programs should not be ignored (Murphy & Salomone, 1983). According to clients studied in this research, their perceptions of themselves should be considered valid.

Clients' perceptions of themselves may create problems in the rehabilitation process, especially if their perceptions are higher than their actual functioning levels. Research has shown that clients do perceive themselves to be functioning at a higher level than counselors perceive them to be functioning (Mattie, et al., 1991; Menapace, 1977). Such views may contribute to client failure. Although it is important to incorporate client views of their functioning levels into the rehabilitation program, it is equally important for the clients' views to be as realistic as possible.

Relationship of Perceptions on Rehabilitation Outcomes and Closures

Most research on the perceptions of clients' functioning levels related to clients' outcomes and closures suggests that an influence does exist (Crystal, 1981; Ju & Thomas, 1987; Kaplan & Thomas, 1981; Kaplan, 1982; McGraw & Bitter, 1974; Menapace, 1977; Tichenor, Thomas & Kravetz, 1975). The first area in which counselors and clients work together is determining the clients' rehabilitation needs and functional levels (Bolton, 1978). It is very important for perceptions to be as accurate as possible in the beginning of the counselor-client relationship.

Tichenor, Thomas, and Kravetz (1975) found that the more congruent the perceptions of counselors and clients, the greater the chance for successful rehabilitation outcome and closure. Tichenor et al. (1975) suggest there was considerable incongruence between clients and counselors in their perceptions. The achievement of the clients' goals was difficult if counselors and clients held discrepant views. The same study revealed that counselors ignored problems in all areas (except physical and appearance) which clients considered to be important. This finding confirmed that counselors and clients are able to agree more often when the variables considered are physical in nature. If variables are not concrete, variance in perceptions increases.

A study by Ju and Thomas (1987) found that perceptual accuracy was an important influence on counseling outcome. This finding indicated that similar perceptions positively influenced the rehabilitation process.

Menapace (1977) found that important topics relative to clients' employability were motivation, work skills, and client independence. The study recommended that affective education be considered an integral part of

the rehabilitation process.

A study by McGraw and Bitter (1974) found that differences in perception could negatively affect the rehabilitation process which would result in inappropriate assessments and vocational planning. These negative effects also could cause client dissatisfaction with vocational rehabilitation which could lead to overall ineffectiveness of services.

Mattie, et al. (1991) found that there was a lack of agreement among facility counselors, referral counselors, and clients regarding clients' functioning levels. The only consistent finding was that clients perceived themselves as functioning at higher levels that that perceived by either types of counselors. The research did not indicate which groups' perceptions were the most accurate.

Although most research would suggest that incongruency in perceptions influence rehabilitation outcomes and closures, Murphy (1988) found that incongruencies between counselors and clients had few negative effects on the rehabilitation process. Counselors did not reveal any problems disruptive to the rehabilitation programs and clients had successful rehabilitation closures despite incongruent perceptions.

The majority of the research discussed in this section revealed that differences in perceptions of clients' functioning levels do affect the rehabilitation process. Clients will be affected by differing perceptions of their functioning levels regardless of whether or not the rehabilitation outcomes and closures are successful or unsuccessful.

CHAPTER III

METHODOLOGY

This chapter describes the methodology utilized in this study, including the subjects, procedure, instrumentation, and the treatment of data.

Subjects

The subjects consisted of rehabilitation clients from the Georgia Division of Rehabilitation Services who had been referred to RWSIR from the West and Central districts of Georgia for evaluation and/or treatment purposes during 1989 and facility counselors employed at RWSIR during 1989. There were forty-one (41) rehabilitation clients who had been referred by their field counselors to RWSIR for evaluation and/or treatment. The facility counselor group consisted of nine (9) facility counselors employed by RWSIR.

Data were obtained from existing files at RWSIR. Responses to the completed CGAI forms were analyzed to test each hypothesis.

Procedure

CGAI - I and CGAI - II forms were utilized in this study. The forms were kept at RWSIR in the event a follow-up study (of a previous research project) might be conducted. Information on clients who graduated from RWSIR and clients who did not was collected through a manual search via the

clients' RWSIR files. Follow-up data on clients were collected through the use of Georgia On-Line Network by the Computer Access Information Center at RWSIR. The follow-up data consisted of client status one year after departure from RWSIR. After data collection was completed, the data were statistically analyzed in order to test the identified hypotheses:

- The relationship between clients perceptions of their functioning levels (CGAI - II) and their rehabilitation outcomes.
- The relationship between facility counselors' perceptions of clients' functioning levels (CGAI - I) and the clients' rehabilitation outcome.
- The relationship between clients' perceptions of their functioning levels and their rehabilitation closures.
- The relationship between the facility counselors' perceptions of the clients' functioning levels and the clients' rehabilitation closures.
- The relationship between rehabilitation outcomes and rehabilitation closures.

Instrumentation

The Client Goal Achievement Instruments (CGAI - I & II) were developed by RWSIR staff (see Appendix A & B). The items on the CGAI relate to the clients' functioning levels. A Likert type scale is the survey format. The range is from one to five with one being the lowest functional level and five being the highest. The purpose of the CGAI is to provide counselors with information about the clients' functioning levels.

There are two forms of the CGAI. The CGAI - I form is for rehabilitation counselors (Appendix A) while the CGAI - II form is for clients

(Appendix B). The two forms include the same items except that the CGAI - I form has two additional items. However, the two additional items on the CGAI - I were not used in this study. Items C and G were deleted from the counselor form; therefore, Items D, E, and F became C, D, and E respectively. The dimensions addressed in this study were as follows: 1) impact of family/ home environment on rehabilitation efforts; 2) degree of client involvement in plan/progress; 3) client independence in decision - making; 4) client independence in activities of daily living; 5) interpersonal communication.

The difference between the two forms lies in the language presentation. The CGAI - I (counselor form) is written in language that a rehabilitation professional could relate to while the CGAI - II (client form) presents the same dimensions, but in a different format.

Statistical Treatment of Data

A chi - square design was used to determine if there were significant relationships between the responses of the CGAI forms I and II to the clients' rehabilitation outcome (successful/not successful) and the responses of the CGAI forms I and II to the clients' rehabilitation closure (successful/not successful). In addition, the design compared the relationship of the clients' rehabilitation outcome and the clients' rehabilitation closure.

Derived hypotheses were rejected or not rejected using the .05 probability level to determine significance. Further, row percentages were used to identify salient features of observational data.

CHAPTER IV

ANALYSIS OF DATA

This chapter presents the analysis of data.

Hypothesis Testing

A Chi - Square was conducted in order to compare the results of the CGAI forms and clients' rehabilitation outcomes and closures. These rehabilitation outcomes and closures are also compared with the results of the CGAI forms in order to determine the success rate of clients who leave RWSIR.

The items included on the CGAI forms are:

Item A: Impact of family/home environment on rehabilitation efforts.

Item B: Degree of client involvement in plan/program.

Item C: Client independence in decision making.

Item D: Client independence in activities of daily living.

Item E: Interpersonal communication.

For purpose of analysis, ratings 1 and 2 of each item were collapsed into a single cell as were ratings 4 and 5 with rating 3 (the midpoint) not affected. The .05 level of significance was used to test for significant differences.

Hypothesis One: There will be no significant difference between the clients' perceptions of their functioning levels and their rehabilitation outcomes.

CGAI Item A: The chi-square indicated no significant difference

between the clients' perceptions of their families on their rehabilitation efforts and their rehabilitation outcomes, $x^2 = .058$, $p > .05$.

CGAI Item B: The chi-square indicated no significant difference between the clients' perceptions of their degree of involvement in their programs and their rehabilitation outcomes, $x^2 = .224$, $p > .05$.

CGAI Item C: The chi-square indicated no significant difference between the clients' perceptions of their independence in decision making and their rehabilitation outcomes, $x^2 = .769$, $p > .05$.

CGAI Item D: The chi-square indicated no significant difference between the clients' perceptions of their independence in activities of daily living and their rehabilitation outcomes, $x^2 = .075$, $p > .05$.

CGAI Item E: The chi-square indicated no significant difference between the clients' perceptions of their interpersonal communication abilities and their rehabilitation outcomes, $x^2 = .057$, $p > .05$.

Hypothesis one should not be rejected due to all items (except for Item D) showing no significant difference to rehabilitation outcomes (See TABLE 1).

Hypothesis Two: There will be no significant difference between facility counselors' perceptions of client functioning levels and client rehabilitation outcomes.

CGAI Item A: A significant difference was indicated by chi-square analysis between facility counselors' perceptions of the impact of clients families and their rehabilitation outcomes, $x^2 = .019$, $p < .05$.

CGAI Item B: The chi-square indicated no significant difference

Table 1 Relationship between clients' perceptions of their functioning levels and their rehabilitation outcomes.

Item	df	value	p
A	2	5.685	.058
B	2	2.992	.224
C	2	.527	.769
D	2	5.174	.075
E	2	5.714	.057

between facility counselors' perceptions of clients involvement in their rehabilitation programs and their rehabilitation outcomes, $x^2 = .076$, $p > .05$.

CGAI Item C: The chi-square indicated no significant difference between facility counselors' perceptions of clients' independence in decision making and their rehabilitation outcomes, $x^2 = .132$, $p > .05$.

CGAI Item D: A significant difference was indicated by chi-square between facility counselors' perceptions of clients' independence in activities of daily living and their rehabilitation outcomes, $x^2 = .031$, $p < .05$.

CGAI Item E: The chi-square indicated no significant difference between facility counselors' perceptions of the clients' interpersonal communication abilities and their rehabilitation outcomes, $x^2 = .809$, $p > .05$.

Hypothesis two should be rejected as significant differences were found on only two items (A & D). Three items (B, C & E) were found to have no significant difference between items and rehabilitation outcomes (See TABLE 2).

Hypothesis Three: There will be no significant difference between clients' perceptions of their functioning levels and their rehabilitation closures.

CGAI Item A: The chi-square indicated no significant difference between clients' perceptions of the impact of family and rehabilitation closures, $x^2 = .242$, $p > .05$.

CGAI Item B: The chi-square indicated no significant difference between clients' perceptions of their involvement in their programs and their rehabilitation closures, $x^2 = .689$, $p > .05$.

CGAI Item C: The chi-square indicated no significant difference

Table 2 Relationship between facility counselors' perceptions of clients' functioning levels and clients' rehabilitation outcomes.

Item	df	value	p
A	2	7.940	.019 •
B	2	5.155	.076
C	2	4.043	.132
D	2	6.945	.031 •
E	2	.424	.809

• Indicates significance at the .05 level.

between clients' perceptions of their independence in decision making and their rehabilitation closures, $x^2 = .211$, $p > .05$.

CGAI Item D: The chi-square indicated no significant difference between clients' perceptions of their independence in activities of daily living and their rehabilitation closures, $x^2 = .49$, $p > .05$.

CGAI Item E: The chi-square indicated no significant difference between clients' perceptions of the their interpersonal communication abilities and their rehabilitation closures, $x^2 = .713$, $p > .05$.

Hypothesis three should not be rejected due to all items showing no significant difference to rehabilitation closures (See TABLE 3).

Hypothesis Four: There will be no significant difference between the facility counselors' perceptions of client functioning levels and the client rehabilitation closures.

CGAI Item A: The chi-square indicated no significant difference between facility counselors' perception of the impact of client families on client rehabilitation closures, $x^2 = .255$, $p > .05$.

CGAI Item B: The chi-square indicated no significant difference between facility counselors' perceptions of clients involvement in their rehabilitation programs and their rehabilitation closures, $x^2 = .947$, $p > .05$.

CGAI Item C: The chi-square indicated no significant difference between facility counselors' perception of client independence in decision making and their rehabilitation closures, $x^2 = .45$, $p > .05$.

CGAI Item D: The chi-square indicated no significant difference between facility counselors' perception of clients' independence in activities of

Table 3 Relationship between clients' perceptions of their functioning levels and their rehabilitation closures.

Item	df	value	p
A	2	2.837	.242
B	2	.744	.689
C	2	3.114	.211
D	2	1.426	.49
E	2	.675	.713

daily living and client rehabilitation closures, $x^2 = .455$, $p > .05$.

CGAI Item E: The chi-square indicated no significant difference between facility counselors' perception of the clients' interpersonal communication abilities and client rehabilitation closures, $x^2 = .953$, $p > .05$.

Hypothesis four should not be rejected due to all items showing no significant difference to rehabilitation closures (See TABLE 4).

Hypothesis Five: There will be no significant difference between clients' rehabilitation outcomes and clients' rehabilitation closures.

The chi-square indicated no significant difference between clients' rehabilitation outcomes and clients' rehabilitation closures, $x^2 = .35$, $p > .05$.

Hypothesis five should not be rejected as there is no significant difference between clients' rehabilitation outcomes and clients' rehabilitation closures (See TABLE 5).

Although the p values fail to show any significant differences in the hypotheses, the row percentages presented in the following tables do show interesting results. Ratings 1 - 5 on each item of the CGAI are compared to the variables of outcomes and closures separately. Ratings 1 and 2 have been collapsed, as have ratings 4 and 5. This collapsing allows for a more important percentage. Rating 3 has been untouched due to it being the midpoint. See Appendices A & B for definitions of ratings (See FIGURE 1-5).

Table 4 Relationship between facility counselors' perceptions of clients' functioning levels and clients' rehabilitation closures.

Item	df	value	p
A	2	2.737	.255
B	2	.109	.947
C	2	1.595	.45
D	2	1.577	.455
E	2	.096	.953

Table 5 Relationship between clients' rehabilitation outcomes and their rehabilitation closures.

df	value	p
1	.859	.354

Impact of family / home environment on rehabilitation efforts

	ratings		
outcomes	1-2	3	4-5
0	17	8	75
1	0	3	97

Degree of client involvement in plan / progress

	ratings		
outcomes	1-2	3	4-5
0	8	8	83
1	3	0	97

Client independence in decision-making

	ratings		
outcomes	1-2	3	4-5
0	8	17	75
1	3	14	83

0 = unsuccessful rehabilitation outcome / 1 = successful rehabilitation outcome

Figure 1 Relationship between clients' perceptions of their functioninglevels and their rehabilitation outcomes (row percentages).

Client independence in activities of daily living

outcomes	ratings 1-2	3	4-5
0	17	8	75
1	0	7	93

Interpersonal communication

outcomes	ratings 1-2	3	4-5
0	0	58	42
1	3	21	76

0 = unsuccessful rehabilitation outcome / 1 = successful rehabilitation outcome

Figure 1 (Continued)

Impact of family / home environment on rehabilitation efforts

outcomes	ratings 1-2	3	4-5
0	8	67	25
1	0	31	69

Degree of client involvement in plan / progress

outcomes	ratings 1-2	3	4-5
0	17	42	42
1	0	55	45

Client independence in decision-making

outcomes	ratings 1-2	3	4-5
0	42	42	17
1	14	69	17

0 = unsuccessful rehabilitation outcome / 1 = successful rehabilitation outcome

Figure 2 Relationship between facility counselors' perceptions of clients' functioning levels and clients' rehabilitation outcomes (row percentages).

Client independence in activities of daily living

outcomes	ratings 1-2	3	4-5
0	25	0	75
1	3	24	72

Interpersonal communication

outcomes	ratings 1-2	3	4-5
0	17	67	17
1	10	76	14

0 = unsuccessful rehabilitation outcome / 1 = successful rehabilitation outcome

Figure 2 (Continued)

Impact of family / home environment on rehabilitation efforts

outcomes	ratings 1-2	3	4-5
0	8	8	84
1	0	0	100

Degree of client involvement in plan / progress

outcomes	ratings 1-2	3	4-5
0	4	4	92
1	6	0	94

Client independence in decision-making

outcomes	ratings 1-2	3	4-5
0	8	20	72
1	0	6	94

0 = unsuccessful rehabilitation outcome / 1 = successful rehabilitation outcome

Figure 3 Relationship between clients' perceptions of their functioning levels and their rehabilitation closures (row percentages).

Client independence in activities of daily living

outcomes	ratings 1-2	3	4-5
0	8	8	84
1	0	6	94

Interpersonal communication

outcomes	ratings 1-2	3	4-5
0	4	32	64
1	0	31	69

0 = unsuccessful rehabilitation outcome / 1 = successful rehabilitation outcome

Figure 3 (Continued)

Impact of family / home environment on rehabilitation efforts

outcomes	ratings 1-2	3	4-5
0	0	36	64
1	6	50	44

Degree of client involvement in plan / progress

outcomes	ratings 1-2	3	4-5
0	4	52	44
1	6	50	44

Client independence in decision-making

outcomes	ratings 1-2	3	4-5
0	16	68	16
1	31	50	19

0 = unsuccessful rehabilitation outcome / 1 = successful rehabilitation outcome

Figure 4 Relationship between facility counselors' perceptions of clients' functioning levels and clients' rehabilitation closures (row percentages).

Client independence in activities of daily living

outcomes	ratings 1-2	3	4-5
0	8	12	80
1	13	25	62

Interpersonal communication

outcomes	ratings 1-2	3	4-5
0	12	72	16
1	13	75	12

0 = unsuccessful rehabilitation outcome / 1 = successful rehabilitation outcome

Figure 4 (Continued)

outcomes \ closures	0	1
0	50	50
1	66	34

0 = unsuccessful / 1 = successful

Figure 5 Relationship between clients' rehabilitation outcomes to clients' rehabilitation closures (row percentages).

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This study was designed to determine if there was a relationship between clients' and facility counselors' perceptions of clients' functioning levels and rehabilitation outcomes and closures. The research questions which the study considered are as follows:

1) Is there a relationship between how clients perceive their functioning levels and their rehabilitation outcomes?

2) Is there a relationship between how facility counselors perceive clients' functioning levels and the clients' rehabilitation outcomes?

3) Is there a relationship between how clients' perceive themselves and their rehabilitation closures?

4) Is there a relationship between how facility counselors' perceive the clients' functioning levels and the clients' rehabilitation closures?

5) Is there a relationship between the clients' rehabilitation outcomes and the clients' rehabilitation closures?

6) Is there a relationship between the clients' perception of their functioning levels and their outcomes and closures to facility counselors' perceptions of clients' functioning levels and clients' outcome and closure?

The study included forty-one (41) rehabilitation clients and nine (9) facility counselors. The components of this study were the CGAI forms (I & II: counselor & client), the rehabilitation outcome (graduate/not graduate

from RWSIR), and the rehabilitation closure (DRS status 26/not DRS status 26 one year after leaving RWSIR). The data was analyzed using a chi-square. The results of this analysis are discussed in this section.

Summary

Hypothesis One: There was no significant difference found between the clients' perceptions of their functioning levels and their rehabilitation outcomes. However, the row percentages show an interesting perspective. This finding is important because it shows that those clients who graduated from RWSIR were more likely to give themselves a 4 or 5 rating than were clients who did not graduate. Clients perceptions of themselves were related to the rehabilitation outcomes.

Hypothesis Two: No significant differences were found on three of the five items. Two items (B: degree of client involvement in plan/progress and E: interpersonal communication) did show significant differences.

It is important to know that difference exist on these two items because facility counselors spend considerable time with their clients, and should be able to accurately assess the clients' functioning levels. Research has shown that attitudes toward clients have an important effect on the rehabilitation program (Pederson & Carlson, 1981). Kaplan (1982) found that these attitudes do have an effect on service delivery decisions. It is important for counselors to view the clients' functioning levels as accurately as possible; otherwise, ineffective service delivery options may be selected which can lead to rehabilitation failure. Counselors provide the knowledge of available services for clients; therefore, counselors' perceptions are crucial to the clients'

service delivery programs (Cook, 1983).

Hypothesis Three: There was no significant difference between clients' perceptions of their functioning levels and their rehabilitation closures. However, the row percentages revealed interesting trends. Clients who were in status 26 one year after they left RWSIR were more likely to have given themselves a 4 or 5 rating than those clients who were not status 26.

This finding is important because clients' perceptions of themselves may be fairly accurate. Clients need to be actively involved in their rehabilitation program to ensure that appropriate services are being delivered. Client involvement is very important to rehabilitation (Eisen & Grob, 1982). Without involvement, clients risk being misjudged by counselors, and inappropriate services may be the result. It is important for counselors to encourage clients to actively participate in their own rehabilitation program.

Hypothesis Four: There was no significant difference between the facility counselors' perceptions of clients' functioning levels and the clients' rehabilitation closures. However, the row percentages show an interesting trend. Facility counselors consistently gave more ratings of 4 or 5 to those clients who were not a status 26 one year after leaving RWSIR (except for item C: client independence in decision making). This finding suggests that facility counselors inaccurately assessed clients' functioning levels. Counselors need to be as accurate as possible in their assessment of clients' functioning levels; otherwise, critical client variables that relate to successful rehabilitation closures may be missed and services will not be appropriately provided (Ju & Thomas, 1987).

Hypothesis Five: There was no significant difference between clients'

rehabilitation outcome and clients' rehabilitation closures. The row percentages again show an interesting result. Half of those clients who did not graduate from RWSIR had a successful closure. By comparison, approximately 34% of those clients who did graduate from RWSIR had a successful closure. If this finding is correct, clients who are non-graduates of RWSIR have a better chance of obtaining a successful closure than those who graduate. RWSIR provides a therapeutic environment in which clients are able to receive training services. It is possible that program completion is an act of passive compliance more so than aggressive goal pursuit.

The study also revealed that clients who had successful rehabilitation outcomes gave themselves a rating of 4 or 5, proportionately more than clients who had unsuccessful rehabilitation outcomes. Facility counselors gave a high rating to those clients who had successful outcomes. In addition, clients who had successful rehabilitation closures rated themselves much higher than the facility counselors rated them. In fact, on all items except for Item C (client independence in decision making), the facility counselors rated those clients who did not obtain successful closures higher than those who did obtain successful closures. This finding confirms the difficulty involved in assessing client functioning levels.

Conclusions

This study on perceptions and their relationship to rehabilitation outcomes and closures relates to previous research. There exists an incongruency between facility counselors' ratings and actual client achievement. According to this study, such incongruency does not tend to

negatively impact rehabilitation outcome as previous research suggested. In the long run, however, service delivery programs that are based on incorrect perceptions of client needs may result in rehabilitation failure. Failure may be followed by reopened client cases, which can lead to costly and time-consuming follow-up services.

Facility counselors need to improve upon their assessments of clients' functioning levels. Without accurate assessments, counselors may do harm to their clients. For example, if facility counselors provide a training program which requires a higher functioning level than that possessed by the client, the client may fail. Facility counselors need to become more in tune with how the clients perceive themselves. The results of this study show that clients accurately assessed their functioning levels more often than did facility counselors. By listening to clients, counselors may become more effective in assessing functioning levels. Counselors should seek improvement in appropriate service delivery. Cost -effective services, timely rehabilitation services, and job placement services are benefits of service delivery improvement. The first step may be for counselors to become aware of their perceptions of their clients and analyze the reasons for these perceptions. Through this analysis, counselors may become more objective in their perceptions and objectivity may increase counseling effectiveness.

Although rehabilitation clients may do a better job than counselors in assessing client functioning levels, clients also need to improve upon their perceptions. Clients, in this study, who did not have successful rehabilitation closures tended to rate themselves higher than their success rate suggested. It is important to understand that clients may inflate their views of themselves

and not be able to objectively assess their potential. Biased views may have a negative effect on the clients' rehabilitation program. For example, clients may resist services for which they see no need and thereby fail to experience improvement. It is important that counselors be aware that some clients may need help in assessing their functioning levels and that other clients may not. This awareness can be hampered if counselors are not able to determine clients' functioning levels accurately. Most clients need counselor assistance in developing appropriate rehabilitation goals. Facility counselors and clients need to work together and assess the clients' functioning levels openly and honestly. Perhaps this method will correct inaccurate perceptions and help to ensure that clients receive appropriate services.

This study indicated that successful rehabilitation outcome (graduation from RWSIR) does not necessarily mean successful rehabilitation closure. In fact, the majority of the RWSIR graduates did not have a successful rehabilitation closure. Many unknown factors may contribute to this result (e.g., clients entering to new training areas after leaving RWSIR, or a lack of job opportunities in the clients' hometowns). However, it is the goal of RWSIR that successful rehabilitation outcomes result in successful rehabilitation closures. This study suggests that this goal is not being met.

Facility counselors and their clients should work together to improve perceptions of clients' functioning levels. Accurate perceptions of functioning levels undoubtedly help to improve clients' rehabilitation outcomes and rehabilitation closures.

Recommendations

The results of this study have led to the development of several recommendations for further research. These recommendations are listed below:

1) Regarding Hypothesis One, clients' perceptions should be assessed at different stages in the rehabilitation process, including time of entering RWSIR as well as time of leaving, returning home, and after securing employment or not securing employment.

2) Regarding Hypothesis Two, a differential analysis of recommended services for clients should be undertaken for the purpose of ascertaining precisely how services might be programmed as a consequence of the counselors' perceptions of clients' needs.

3) Regarding Hypothesis Three, a study should be conducted which would assess the relationship of client involvement in rehabilitation programming and clients' perceptions of self.

4) Regarding Hypothesis Four, a study should be conducted to ascertain why facility counselors consistently gave higher ratings to clients who did not become gainfully employed.

5) Regarding Hypothesis Five, a study should be conducted to ascertain why clients who failed to complete their rehabilitation center program are most likely to become gainfully employed.

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APPENDICES

APPENDIX A

Client Goal Achievement Instrument - I

(counselor form)

CLIENT GOAL ACHIEVEMENT INSTRUMENT-I

ROOSEVELT WARM SPRINGS INSTITUTE FOR REHABILITATION

NAME _____ INST. # _____ DRS # _____

Date of Admission _____

Date	1				DC	GOAL
COUNSELING						
A. IMPACT OF FAMILY/HOME ENVIRONMENT ON REHABILITATION EFFORTS**						
5. VERY SUPPORTIVE	5	5	5	5	5	5
4. SOMEWHAT SUPPORTIVE	4	4	4	4	4	4
3. NONE	3	3	3	3	3	3
2. SOMEWHAT RESISTIVE	2	2	2	2	2	2
1. VERY RESISTIVE	1	1	1	1	1	1
B. DEGREE OF CLIENT INVOLVEMENT IN PLAN/PROGRAM						
5. TOTAL, INITIATING	5	5	5	5	5	5
4. SOMEWHAT INITIATING	4	4	4	4	4	4
3. NONE, PASSIVE	3	3	3	3	3	3
2. SOMEWHAT OBSTRUCTIVE	2	2	2	2	2	2
1. TOTAL, OBSTRUCTIVE	1	1	1	1	1	1
C. CLIENT PROGRAM COMPLETION STATUS						
5. ALL COMPLETE NONE ACTIVE	5	5	5	5	5	5
4. MOST COMPLETE SOME ACTIVE	4	4	4	4	4	4
3. SOME COMPLETE SOME ACTIVE	3	3	3	3	3	3
2. NONE COMPLETE SOME ACTIVE	2	2	2	2	2	2
1. NONE COMPLETE NONE ACTIVE	1	1	1	1	1	1
D. CLIENT INDEPENDENCE IN DECISION-MAKING						
5. TOTAL INDEPENDENCE	5	5	5	5	5	5
4. INDEPENDENT > DEPENDENT	4	4	4	4	4	4
3. EQUIVOCAL	3	3	3	3	3	3
2. DEPENDENT > INDEPENDENT	2	2	2	2	2	2
1. TOTAL DEPENDENCE	1	1	1	1	1	1
E. CLIENT INDEPENDENCE IN ACTIVITIES OF DAILY LIVING						
5. TOTAL INDEPENDENCE	5	5	5	5	5	5
4. INDEPENDENCE > DEPENDENCE	4	4	4	4	4	4
3. EQUIVOCAL	3	3	3	3	3	3
2. DEPENDENCE > INDEPENDENCE	2	2	2	2	2	2
1. TOTAL DEPENDENCE	1	1	1	1	1	1
F. INTERPERSONAL COMMUNICATION						
5. ALWAYS DOES	5	5	5	5	5	5
4. USUALLY DOES	4	4	4	4	4	4
3. HARD TO SAY; EQUIVOCABLE; SOMETIMES DOES; SOMETIMES DOES NOT	3	3	3	3	3	3
2. USUALLY DOES NOT	2	2	2	2	2	2
1. ALWAYS DOES NOT	1	1	1	1	1	1
G. OVERALL COUNSELING PROGRAM						
5. SUCCESS, TOTAL	5	5	5	5	5	5
4. PARTIAL SUCCESS	4	4	4	4	4	4
3. EVALUATION, EQUIVOCAL	3	3	3	3	3	3
2. PARTIAL FAILURE	2	2	2	2	2	2
1. TOTAL FAILURE	1	1	1	1	1	1

APPENDIX B

Client Goal Achievement Instrument - II

(client form)

CLIENT GOAL ACHIEVEMENT INSTRUMENT-II
ROOSEVELT WARM SPRINGS INSTITUTE FOR REHABILITATION

CLIENT'S RATING

NAME _____ DATE _____
COUNSELOR _____ CASELOAD # _____

TRANSFER TO SERVICE DELIVERY	D/C	D/C GOAL

WRITE IN THE COLUMN THE NUMBER IN EACH SECTION WHICH DESCRIBES YOU THE BEST.

A. IMPACT OF FAMILY/HOME ENVIRONMENT ON REHABILITATION EFFORTS:

5. Your family participates, supports, and is realistic toward your rehabilitation effort.

4. Your family is willing to participate and be supportive but will need guidance and direction for appropriate involvement.

3. Your family is passive. They do not help you or hinder you in your rehabilitation effort.

2. Your family tells you they support you but do not follow through with recommended steps.

1. Your family is unrealistic and divided. They do not help you at all in your rehabilitation effort.

B. DEGREE OF CLIENT INVOLVEMENT IN PLAN/PROGRESS:

5. You are involved in the rehabilitation program, demonstrate initiative, use rehabilitation staff, and function independently and appropriately.

4. You are involved in the rehabilitation program, (e.g. you keep appointments and participate in activities). You cooperate and require minimal direction from staff.

3. You are passive about the rehabilitation program and you do only what is required.

2. You do not participate unless required and must be constantly monitored.

1. You refuse to participate or become involved in the rehabilitation program.

C. CLIENT INDEPENDENCE IN DECISION-MAKING:

5. You are totally independent. You are capable of making appropriate and necessary decisions.

4. You are independent for most decision making in daily affairs and activities. You still need some assistance.

3. You are clearly independent in some decision-making and dependent in others.

2. You are dependent for most decisions. You need assistance and supervision in most daily affairs and activities.

1. You are dependent on others. You make no decisions for yourself.

	TRANSFER TO SERVICE DELIVERY	D/C	D/C GOAL
D. CLIENT INDEPENDENCE IN ACTIVITIES OF DAILY LIVING:			
5. You are completely independent in all activities. You need no assistance.			
4. You are independent in most activities. You need assistance for a few specific physical tasks. (e.g. you may need some assistance in morning to get started or in the evening to go to bed).			
3. You are both independent and dependent in daily living activities.			
2. You are dependent in most activities. You need assistance in almost all physical tasks.			
1. You are totally dependent on others in all activities.			
E. INTERPERSONAL COMMUNICATION:			
5. You always express your feelings appropriately and demonstrate understanding of others.			
4. You usually express feelings appropriately and demonstrate understanding of others.			
3. You sometimes do and sometimes do not express feelings appropriately and demonstrate understanding of others.			
2. You usually do not express feelings appropriately and demonstrate understanding of others.			
1. You always express feelings appropriately and demonstrate understanding of others.			

_____
Client signature

_____
Assessment Counselor assisting with completion of Instrument

VITA

Linda Rae O'Dell was born in Bristol, Tennessee on December 27, 1967. She graduated from Tennessee High School in June, 1986. The following August she entered Queens College in Charlotte. Her sophomore year, she attended East Tennessee State University. She graduated from Purdue University with a Bachelor of Arts in Anthropology in May 1990. In January 1991, she entered the University of Tennessee, Knoxville and in December 1992 received a Master of Science degree in Rehabilitation Counseling.