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Topical Manuscript

Disability Adjustment Counseling: Experiences and Perspectives of Certified Rehabilitation Counselors

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Background

Disability adjustment counseling (DAC) focuses on the diverse process of adjusting to chronic illness or disability, including responding to the initial diagnosis or the onset and adjusting to changes and barriers that arise from living with a disability. Although DAC is a primary role and function of rehabilitation counselors, there have been limited efforts to explore the use of DAC in the field.

Objective

The purpose of this study was to survey certified rehabilitation counselors (CRCs) about the extent of DAC utilization and its focus, the theoretical basis for DAC, and professional preparation.

Methods

A cross-sectional survey was completed with 109 CRCs recruited through the Commission on Rehabilitation Counselor Certification (CRCC). The research team developed a 35-item survey questionnaire for this study. Most respondents identified as white women with master's degrees (mean age = 51.41 years).

Results

Approximately two-thirds of the respondents (67.78%) reported engaging in DAC for approximately a third (31.15%) of their professional time. Many respondents reported wanting to spend more of their professional time providing DAC. Most respondents (75%) indicated they do not operate from a specific model of psychosocial adjustment to chronic illness or disability. Nearly half (48.6%) of the respondents reported that there were not adequate options for DAC counseling.

Conclusions

The survey results confirm that DAC is an important role and function for rehabilitation counselors. Although the sample was too small to permit broad generalizations, the results imply that further exploration of the research questions among a larger sample is warranted.

Living with a chronic illness or disability (CID), whether congenital, developmental, or acquired, can involve an ongoing process of psychosocial adaptation (Bishop et al., 2024; Livneh et al., 2019; Smedema et al., 2022). Although psychosocial adaptation is typically discussed in the rehabilitation research literature in the context of acute or critical periods (e.g., the period following the onset of a CID), it also describes the continuous process of responding or adjusting to CID-related changes in health; to psychological, social, identity, and functional changes; and to barriers arising in interactions with physical and social environments. In rehabilitation counseling, adjustment to disability may be the client's primary concern and focus, or it may be an ancillary concern, arising only to the extent that it impacts the client's progress toward other rehabilitation goals. The degree to which disability adjustment counseling (DAC) is a component of the rehabilitation counseling process also varies by professional setting. Regardless of these variations, being prepared to support clients through the psychosocial adaptation process is a fundamental rehabilitation counseling role and professional responsibility. Indeed, DAC, or counseling focused on supporting the client through the range of experiences and issues associated with adaptation to disability, has been

a core component of professional practice and education since the profession's founding.

Beginning with the earliest discussions of the purpose and role of a professional rehabilitation counselor, DAC has been identified as both a professional responsibility (e.g., Hamilton, 1950) and a necessary component in professional education and training for the nascent profession (e.g., Cantrell, 1958; Hall & Warren, 1956; Patterson, 1958; Usdane, 1953). Role and function studies spanning over 50 years have continued to demonstrate the importance of DAC in rehabilitation counseling (Beardsley & Rubin, 1988; Berven, 1979; Frain et al., 2016; Leahy et al., 1993, 2003, 2013, 2019; Muthard & Salomone, 1969; Rubin et al., 1984; G. N. Wright et al., 1987). These studies identify DAC as one of rehabilitation counselors' most important job tasks and underscore the importance to counselors of knowledge and skills in this area of practice. Since 1972, the agencies responsible for rehabilitation counselor accreditation (the Council on Rehabilitation Education [CORE], Council for the Accreditation of Counseling and Related Educational Programs, 2016; McAlees & Schumaker, 1975) and certification (Commission on Rehabilitation Counselor Certification, 2021) have incorporated adjustment counseling within the knowledge domains underlying rehabilitation counseling curricular and practice standards.

Yet despite its central position in rehabilitation counseling, efforts to define and describe DAC have been surprisingly limited. Outside of role and function studies, in which DAC has been identified but not explicitly defined, limited research has specifically examined the form, scope, focus, prevalence, or settings in which DAC is provided. Given the role of DAC in promoting positive psychosocial, vocational, and other rehabilitation outcomes (Aaby et al., 2020; Livneh et al., 2014; Livneh & Antonak, 1997; Livneh & Martz, 2016; Stuntzner & Hartley, 2014), this oversight is problematic on a number of levels.

First, the absence of such research limits the capacity to understand the form and nature of DAC being provided to consumers. This limitation extends to such basic questions as the theoretical orientation on which rehabilitation counselors are basing their practice of DAC, and the modalities and interventions employed. Second, from an evidence-based research perspective, this lack of clarity prevents the measurement and evaluation of the efficacy of different techniques and interventions, and the identification of the most effective counseling approaches for clients with specific adjustment concerns. There is no baseline from which to evaluate and track changes in the quality or quantity of DAC provided over time. Third, information about the settings, degree, form, and efficacy of DAC being provided by rehabilitation counselors is necessary for informing the development of rehabilitation counselor education.

In the present study we sought to begin to address this lack of information. The purpose of the study was to begin to enhance clarity and understanding about the practice of DAC among rehabilitation counselors. We surveyed certified rehabilitation counselors (CRCs) about their experiences with, education and training in, and the focus of their DAC with clients. Specifically, we examined the following research questions:

> **Research Question 1:** To what extent does DAC comprise CRCs' professional activity and time?
> **Research Question 2:** Which topics and client issues are a focus or frequent component of DAC?
> **Research Question 3:** From which theoretical orientation or models of adaptation or adjustment to disability do CRCs operate in DAC?
> **Research Question 4:** To what extent do CRCs evaluate the need for, and refer clients for DAC?
> **Research Question 5:** How do CRCs describe their professional preparation for DAC?

Method

Procedures

This study was reviewed by the Minimal Risk Research IRB at the University of Wisconsin-Madison and was determined to meet the federal criteria for exemption. Participants were recruited through the CRCC. The research team completed an email rental agreement with the CRCC and received email addresses for 1,000 CRCs randomly selected from the CRCC database. An initial email request to participate was sent to the 1,000 potential participants. Two additional follow-up requests were delivered to non-responders within two and four weeks of the initial email. Inclusion criteria included: (a) CRCs on the mailing list of the CRCC, (b) 18 years of age and older, and (c) currently employed. Potential participants were provided a link in the email to review the consent form and complete the survey electronically via a web-based survey hosted using the Qualtrics Survey Hosting Service (2020; Qualtrics, Provo, UT). Data were collected from April 11 through May 15, 2022. Twenty-six emails bounced (i.e., were returned as bad addresses). Of the 167 potential participants who started the survey, 109 (65.3%) completed and returned their survey. Based on the sampling frame (n = 974), this suggests a response rate of 11.2%. Participants were not provided incentives to complete the survey.

Participants

The majority of the respondents (n = 88; 80.7%) identified as women, 21 (19.3%) identified as men. The respondents' mean age was 51.41 years (SD = 12.72 years; range = 28-77). The largest proportion of respondents self-identified as White (n = 91; 83.5%), followed by Black or African American (n = 7; 6.4%), Multiracial or Biracial (n = 3; 2.8%), Asian American or Pacific Islander (n = 2; 1.8%), Native American or Alaskan Native (n = 1; 0.9%), and Other (n = 1; 0.9%); 6.4% (n = 7) identified as being of Hispanic, Latinx, or Spanish origin. The respondents were located across 37 states and Washington D.C. The largest proportion (43.1%) reported their geographic location as urban, 40.4% as suburban, and 16.5% as rural.

Most respondents reported the master's degree (n = 90; 82.6%) as their highest level of education (including 69 from CACREP-accredited and 21 from non-CACREP-accredited degree programs), followed by doctoral degree (15.6%),

Table 1. Respondent Professional Settings and DAC Activity

Setting	Number (% of sample) employed in setting	Number (% in setting) reporting DAC is part of current professional activities
State vocational rehabilitation program (including general, blind, and combined agencies)	25 (22.9%)	18 (72.0%)
Private practice	16 (14.7%)	11 (68.75%)
Other college/university position	11 (10.1%)	7 (63.64%)
Private/Proprietary rehabilitation	9 (8.3%)	7 (77.78%)
Veterans Administration	9 (8.3%)	6 (66.67%)
Community rehabilitation provider, Non-profit rehabilitation facility/organizations, or other community-based service organization	9 (8.3%)	5 (55.56%)
Medical center/clinic/hospital or other healthcare	7 (6.4%)	5 (71.43%)
Insurance company	6 (5.5%)	3 (50.00%)
All other	18 (16.5%)	10 (55.56%)

and other (1.8%). Participants' academic majors included (a) rehabilitation counseling (n = 74; 67.9%) or clinical rehabilitation counseling (n = 5; 4.6%), (b) other counseling specialty (n = 10; 9.2%), (c) clinical mental health counseling (n = 5; 4.6%), (d) rehabilitation psychology (n = 5; 4.6%), (e) psychology (n = 4; 3.7%), (f) other rehabilitation specialty (n = 1; 0.9%), (g) social work (n = 1; 0.9%), and (h) other (n = 4; 3.7%). The participants' current professional settings are displayed in Table 1. The largest proportions of participants were in state vocational rehabilitation (VR) agencies (22.9%) or private practice (14.7%).

In addition to being CRCs, 5 participants (4.6%) were Certified National Counselors, and 10 (9.2%) were Certified Case Managers (CCM or other). A total of 27 (23.3%) participants reported holding counseling licensure, including 12 (11.0%) Licensed Professional Counselors (LPC), 3 (2.8%) Licensed Clinical Professional Counselors (LCPC), 3 (2.7%) Licensed Rehabilitation Counselors (LRC), and 8 (7.3%) Licensed Mental Health Counselors (LMHC). Three respondents (2.8%) were LPC in-training, and four (3.7%) were licensed as a psychologist or social worker. Twenty-five participants (21.6%) identified having additional certifications or licenses.

Table 2 depicts the participants' years of experience in rehabilitation counseling and in their current position. Years of experience in rehabilitation counseling was fairly-evenly dispersed across the categorical response set, with the largest proportion of the participants (n = 36; 33%) reporting having over 25 years of experience. Almost 40% reported having been in their current position for 5 years or less (see Table 2). Finally, we asked participants to identify characteristics of the population they typically work with in their current position. The responses are presented in Table 3. Over half of the participants (62.4%) reported working with people with a variety of different disabilities or chronic conditions, or a general caseload.

Although representing only a small subset of the population of CRCs, a comparison of the characteristics of the present sample with other recent publications based on national samples of CRCs (Bishop et al., 2015; Commission on Rehabilitation Counselor Certification, 2021; Leahy et al., 2003, 2019) suggests that the present sample was somewhat older and had a higher representation of woman participants, but otherwise the demographics and other characteristics of the current sample (e.g., practice setting) were generally consistent and appeared to reflect the broader population demographics for CRCs.

Materials and Data Analysis

The researchers developed a 35-item survey questionnaire that included fixed and open response sets and had several sections, including sections addressing participants' demographic characteristics, professional experience and settings, experiences with counseling clients in adjustment or adaptation to CID, and professional preparation related to adjustment counseling. For the purpose of data analysis, the participants' written responses were converted directly to spreadsheets and the descriptive statistics reported here were conducted using Version 28 of the Statistical Package for Social Sciences (SPSS) for Mac.

Results

Research Question 1. To What Extent Does DAC Comprise CRCs' Professional Activity and Time?

To address this question, we first provided the following definition of DAC: "Disability adjustment counseling is counseling focused on adjustment issues related to being diagnosed with and adapting/adjusting to living with a disability or chronic illness" and then asked the participants whether DAC is a part of their current professional activities. Among the 90 participants who self-identified that they were currently employed as a rehabilitation counselor or employed in a clinical position, 61 (67.78%) reported that DAC was a part of their current professional activities. As indicated in Table 1, this was true for approximately 72%

Table 2. Participants' Years of Experience in Rehabilitation Counseling and in Current Position

Years of experience in rehabilitation counseling	Number (%)	Years in current position	Number (%)
0-2 years	4 (3.7%)	0-2 years	31 (28.4%)
3-5 years	10 (9.2%)	3-5 years	12 (11.0%)
6-10 years	14 (12.8%)	6-10 years	21 (19.3%)
11-15 years	15 (13.8%)	11-15 years	18 (16.5%)
16-20 years	14 (12.8%)	16-20 years	8 (7.3%)
21-25 years	16 (14.7%)	Over 20 years	18 (16.5%)
Over 25 years	36 (33.0%)	Missing	1 (0.01)
Total	109 (100%)	Total	109 (100%)

Table 3. Participants' Characterization of Client Population in Current Position

Population	*n*	% of participants
People with a variety of different disabilities or chronic conditions, or a general caseload	68	62.4%
People with co-occurring conditions/disabilities	43	39.4%
People with an acquired disability	41	37.6%
People with a recent onset of disability or chronic illness	34	31.2%
College students	32	29.4%
Older adults	31	28.4%
Transition-aged youth	29	26.6%
People with a congenital disability	23	21.1%
People with a specific disability of chronic condition, or a specialized caseload	21	19.3%

Note. Total responses = 322. Participants were allowed to select all responses that applied.

of state-federal VR counselors and 69% of those in private practice.

We then asked those participants who reported providing DAC to estimate the percentage of professional time they spend in this activity. The mean percentage of professional time was 31.15% (*SD* = 23.9) and the modal response was 20.0%. Responses ranged from 3% to 85%. Interestingly, 53 respondents (48.6%) stated they would like to spend more of their professional time engaged in adjustment counseling if they could, compared to 39 (35.8%) who find the current amount "just right", and only 2 (1.8%) would like to spend less time providing DAC.

Research Question 2. Which Topics and Client Issues Are a Focus or Frequent Component of DAC?

To identify topics that are a focus or frequent component of DAC, the respondents who reported conducting DAC were provided a list of potential topics, gleaned from a review of the literature, and asked to select any that applied. An "other" option was also provided, and respondents were asked to list any additional topics. As indicated in Table 4, the topics endorsed by the largest percentage of respondents included: (a) understanding and knowledge of one's condition/disability (selected by over 95%); (b) career assessment, maintenance, or transition (selected by over 85%); and (c) self-advocacy (selected by over 75%). Self-management, planning for change and expectations, and community resource connections were each selected by over 70%. Over 81% of the topics listed were selected by at least half of the respondents. Only two respondents identified additional topics (meditation and social and independent living service development).

We also provided a list of disability adjustment topics, again based on review of the literature, and asked the participants to indicate any that were a focus or frequent component in their DAC. As indicated in Table 5, the topics endorsed by the largest percentage of respondents included: (a) coping strategies, (b) self-esteem, and (c) depression (each selected by over 80% of respondents). Additional topics, including anxiety, social support, role changes, and familial support, were endorsed by over 70% of respondents. The complete list of client concerns and response rates are included in Table 5. Seven respondents suggested additional topics, including developing relationships, motivation, and several primarily related to employment (e.g., employer attitudes, employment barriers, and employment obligations).

Table 4. Topics Identified as a Focus in DAC

Topics	*n*	%*
Understanding and knowledge of one's condition/disability	59	95.16%
Career assessment, maintenance, or transition	53	85.48%
Self-advocacy	47	75.81%
Self-management	45	72.58%
Planning for change and expectations	44	70.97%
Community resource connections	44	70.97%
Grief or loss	43	69.35%
Identifying and confronting negative beliefs / stereotypes	43	69.35%
Accommodation, training, adaptive skills, and assistive devices	43	69.35%
Resilience	35	56.45%
Educating others	32	51.61%
Identity development / exploration	32	51.61%
Family and relationships	31	50.00%
Legal rights and options	29	46.77%
Navigating public systems	24	38.71%
Intimate/romantic partner relationships	19	30.65%
Other	3	4.84%

* Based on 62 participants

Table 5. Specific Client Issues That Are a Focus in DAC

Specific Client Issue	*n*	%*
Coping strategies	55	88.71%
Self-esteem	51	82.26%
Depression	50	80.65%
Anxiety	48	77.42%
Social support	45	72.58%
Role changes	44	70.97%
Familial support	44	70.97%
Identity	36	58.06%
Financial health	34	54.84%
Trauma (disability-related)	32	51.61%
Feeling like a burden	32	51.61%
Societal attitudes	28	45.16%
Family or partner attitudes	22	35.48%
Self-blame	21	33.87%
Trauma (not disability-related)	21	33.87%
Suicide ideation	21	33.87%
Spirituality/religion/faith	13	20.97%
Other	7	11.29%

* Based on 62 participants

Research Question 3. From Which Theoretical Orientation and Models of Adaptation or Adjustment to Disability Do CRCs Operate in DAC?

To address this question, we asked those participants indicating that they conducted adjustment counseling with which counseling theory/approach(es) they primarily identified. Out of the 124 total responses (some respondents identified more than one), the most frequently reported was cognitive behavioral therapy (n = 34; 27.42%), followed by solution-focused therapy (n = 28; 22.58%), eclectic or integrated approaches (n = 11; 8.87%), and person-centered n

Table 6. Participant Reported DAC Theories or Models

Theory or form of therapy	*n* (% of responses*)
Cognitive behavioral	34 (27.42%)
Solution-focused	28 (22.58%)
Eclectic or integrated approaches	11 (8.87%)
Person-centered	9 (7.26%)
Family systems	8 (6.45%)
Humanistic	5 (4.03%)
Narrative	5 (4.03%)
Acceptance and Commitment Therapy (ACT)	4 (3.23%)
Integration	3 (2.42%)
None	3 (2.42%)
Psychodynamic	3 (2.42%)
Cognitive	2 (1.61%)
Dialectic behavior therapy (DBT)	2 (1.61%)
Motivational interviewing	2 (1.61%)
Trauma-informed approaches	2 (1.61%)

* Based on 124 responses. Participants were allowed to identify multiple choices.

= 9; 7.26%). As presented in Table 6, several additional theories and approaches were identified.

We then we asked whether the participants operated from a specific theory or model of adaptation or adjustment to disability. The majority indicated they did not (75%). Among those reporting operating from a specific theoretical framework, the most frequently identified was cognitive behavioral therapy (CBT), followed by humanistic or person-centered therapy, solution-focused therapy, rational emotive behavior therapy (REBT), Livneh's 2001 model, the Tuttles' model of phases of adjustment to vision loss (Tuttle & Tuttle, 2004), and the World Health Organization International Classification of Functioning, Disability and Health (WHO ICF; World Health Organization, 2001).

Research Question 4. To What Extent Do CRCs Evaluate the Need for, and Refer Clients for DAC?

To address this research question, we first asked whether the participants evaluate their clients' need for adjustment counseling. Among the 90 participants who were currently employed as a rehabilitation counselor or employed in a clinical position, approximately one in four respondents reported doing so at intake (n = 22; 24.4%), while 27 (30.0%) reported doing so "occasionally, as needed," and the largest percentage (n = 34; 37.78%) reported that they do not assess or screen for the need for DAC at all.

We then asked about referral actions if the participants determine that a client would benefit from DAC, providing four response options as reflected in Table 7. The largest proportion (n = 46; 51.11%) reported they do this counseling themselves and the next largest percentage (n = 31; 34.4%) reported they typically refer the client to another professional.

Finally, we asked the respondents (a) what type of professional they typically refer clients to for DAC, providing several response options and an "other" option, and (b) whether there are adequate options available in their area for clients seeking DAC. As reflected in Table 8, among the 193 responses provided (respondents were able to select all options that applied), the most frequently identified professionals were mental health counselors (28%), rehabilitation counselors (18.7%), and psychologists (18.1%). Almost half (48.6%) of the respondents reported there are not adequate options available in their area for clients seeking DAC. Interestingly, although respondents who worked in rural settings were more likely to report inadequate referral options than those in urban or suburban settings, the proportion of responses did not differ significantly by setting ($X^2(2, n = 93) = 2.05$, $p = .358$).

Research Question 5. How Do CRCs Describe their Professional Preparation for DAC?

We asked a series of questions related to participants' perspectives on their professional and educational preparation for adjustment counseling. First, we asked how well their graduate professional training prepared them to provide adjustment counseling. As reflected in Table 9, less than half (approximately 44%) of respondents reported being "well" or "very well" prepared, and about 24% reported being "not well" or "not at all" prepared.

We then asked participants whether they have pursued post-graduate professional development training specific to developing competence in adjustment counseling. The majority (n = 63; 57.8%) reported that they had not done so, and 22% (n = 24) had pursued post-graduate training. Comments, provided by eight participants, suggested they would do so if opportunities were available, but that professional development training on this topic was not generally available.

Table 7. Referral Actions When Clients Would Benefit from DAC.

Response options	*n*	%
I do this counseling myself.	46	51.11%
I typically refer.	31	34.44%
I would refer if I could but lack access to counseling services.	12	13.33%
I would refer, but don't know who to refer to.	6	6.67%

Note. Based on 90 participants; participants were allowed to select all responses that applied.

Table 8. Type of Professional Client Referred to for DAC

Professional	*n*	% of responses
Mental health counselor	54	27.98%
Rehabilitation counselor	36	18.65%
Psychologist	35	18.13%
Peer-support group	26	13.47%
Social worker	17	8.81%
Psychiatrist	10	5.18%
Other	8	4.15%
Physician	7	3.63%

Note. Total responses = 193. Participants were allowed to select all responses that applied.

Table 9. How Well Graduate Professional Training Prepared Participants to Provide DAC

Response	*n*	%
Very well	21	22.3%
Well	20	21.3%
Adequately	30	31.9%
Not well	21	22.3%
Not at all	2	2.1%

Note. Based on 94 participants.

Discussion

The purpose of this study was to better understand the extent to which practicing CRCs were providing DAC, the nature and prevalence of DAC being provided across rehabilitation counseling settings, and the degree of relevant educational and professional preparation. The results, albeit limited due to the small sample size, provide several important insights and inform directions for further research. We discuss key findings in this section, in terms of the specific research questions.

With the first research question we sought to investigate the extent to which DAC comprises rehabilitation counselors' professional time. Approximately two-thirds of practicing rehabilitation counselors reported that DAC was a part of their current professional activities, with higher rates reported by those in VR, medical or healthcare settings, private/proprietary rehabilitation, and private practice settings. Interpreting this result in the context of prior research is difficult, due to variations in defining and measuring DAC. For example, recent rehabilitation counseling role and function studies have generally been based on the Knowledge Validation Inventory (KVI; Leahy et al., 1993) or its revisions (KVI-R; Leahy et al., 2001, 2013, 2019), which include approximately 100 items assessing the perceived importance of major job functions and knowledge domains underlying rehabilitation counseling practice. While various domains and functions that may comprise DAC (e.g., items concerning the medical aspects of disability, individual counseling for adjustment, or vocational implications of disability) have individually been consistently rated as being of high importance, they are represented across different factors or domains in the KVI and KVI-R, rather than as a unified factor. The present findings do, however, suggest that DAC remains a distinct, important, and prevalent component of rehabilitation counseling practice. Indeed, among those participants who indicated that they provide adjustment counseling, most suggested that at least 20% of their professional time, or the equivalent of one day each work week, is spent engaged in DAC, and approximately 45% of the participants reported that they need more time for providing DAC to their clients.

In future research it may be helpful to explore the first research question using a more specific definition of DAC

and its components. In the present study we elected to use a broad and non-specific definition ("counseling focused on adjustment issues related to being diagnosed with and adapting/adjusting to living with a disability or chronic illness"). Use of a more detailed definition may provide a different, and possibly more specific, assessment of the amount of time rehabilitation counselors spend providing DAC. Although, as described in the introduction and by others (e.g., Chan et al., 2020; Livneh, 2022), DAC may encompass a range of life domains and client concerns, the nature, focus, and outcomes of adjustment counseling distinguish it from other aspects of rehabilitation counseling. The list of topics and client concerns identified in this study (see Tables 4 and 5), may inform the development of a more specific definition.

It is notable that "career assessment, maintenance, and transition" was among the two most frequently indicated areas of DAC focus. This finding is consistent with the focus of rehabilitation counseling on employment, but also suggests the degree to which career, vocational identity, and employment status may interact with and mediate the psychosocial adaptation process. Many individuals with CID experience challenges and barriers in terms of adjusting to changes in work capacity, career goals, and the work environment after the onset of the disability, or in the process of post-secondary transition. Alternately, career maintenance or employment provides resources (e.g., social, economic, health) that can support and promote psychosocial adaptation (Bishop, 2012; Fetsch et al., 2018; Phillips et al., 2021). It is appropriate therefore that DAC in rehabilitation counseling settings would frequently involve issues of career maintenance and transition. Many of the other DAC topics identified may be relevant to and aligned with employment, and support career maintenance and transition, such as self-advocacy, planning for change and changing expectations, making community resource connections, and knowing one's legal rights and options.

In future research it will be important to evaluate and understand whether these topics cluster in different rehabilitation counseling settings or professional subgroups. Given the relatively small sample in this study, the reliability of subgroup analysis of the DAC topics would be limited. In future research, however, it would be informative to explore whether there are meaningful setting- or population-based differences in the disability adjustment topics or concerns that clients identify. Understanding such differences would be helpful in terms of understanding rehabilitation counseling clients' needs and in developing continuing education. From a rehabilitation counselor education perspective, understanding the specific client issues that are most frequently a focus in DAC may help educators to focus instructional content to ensure rehabilitation counseling students are prepared to identify and work with clients on highly prevalent issues, such as coping strategies, self-esteem, depression and anxiety, and social support.

The third research question explored the theoretical orientation and models of adaptation and adjustment to disability used by rehabilitation counselors in adjustment counseling. Results indicated that rehabilitation counselors mainly relied on various general counseling theories, such as CBT, solution-focused therapy, and person-centered therapy, as their theoretical orientation and guidance to provide adjustment counseling services. It is concerning that only a limited number of disability-specific models and theoretical orientations were mentioned by respondents. Individuals with CID face unique challenges and barriers resulting from both the nature of the condition and negative social and contextual impacts. Understanding theories and models related to CID and psychosocial adaptation to CID is crucial for rehabilitation counselors. These frameworks provide practitioners guidance about the nature of adaptation to disability and can inform assessment, planning, and counseling responses. In the sole reliance on general counseling theories, critical psychosocial, environmental, and contextual factors may be overlooked without a guiding DAC framework. As it is not clear from the data collected whether the participants were aware of models of adaptation and adjustment to disability and simply do not apply them, or were unaware of these models, the present results raise interesting questions and concerns about both the education of rehabilitation counselors and the practical utility of these models.

With respect to research question four, concerning the extent to which rehabilitation counselors evaluate and refer clients for DAC, an interesting dichotomy was observed. Although approximately 44% of the survey respondents reported being prepared to provide adjustment counseling, and two-thirds regularly provide DAC, these results do not parallel the findings with respect to assessment. The results suggest that only 25% of CRCs are assessing for adjustment to disability at intake. Regardless of the client's outcome goal, without an assessment of adjustment to disability, factors associated with disability adjustment that may impinge on goal attainment could be easily missed or attributed to other causes. These factors include (a) depression (Livneh & Antonak, 1997), (b) negative feelings and emotional distress (Lane, 1999), (c) self-esteem (B. A. Wright, 1983), and (d) dysfunctional career thoughts (Dipeolu et al., 2002). Addressing adjustment to disability is an important rehabilitation counselor responsibility and is associated with positive outcomes for people with disabilities, including employment outcomes (Araten-Bergman et al., 2015). The fact that only one out of four participants assessed clients for disability adjustment at intake suggests a missed opportunity for intervention and support for people with disabilities.

This finding has clear implications for rehabilitation counselor education and highlights the need for increased attention to assessment of adjustment issues. This may include emphasizing, in relevant counseling coursework and practice experiences, the importance of assessing client's adjustment experiences early in the counseling process, and of incorporating DAC in case conceptualization and rehabilitation planning when appropriate. In terms of formal assessment, students in assessment courses should be exposed to the various adjustment-related assessment instruments (see Bishop et al., 2024; Livneh & Martz, 2012;

Martz, 2015; Livneh & Antonak, 2009 for examples and relevant discussion). As noted by Livneh and Martz (2012), measures of disability adjustment may be grouped in terms of several broad categories including: (a) QOL-based measures; (b) unidimensional or multidimensional clinical measures of, for example, depression or anxiety; (c) CID-specific measures that assess acceptance of or adjustment to CID; and (d) physical or functional capacity measures. Many general adjustment measures have been developed, as have measures of adjustment specifically designed for assessment among persons with a specific condition or disability (Bishop et al., 2024).

Finally, it is interesting to note that clients needing adjustment counseling appeared more likely to be referred to mental health counselors than rehabilitation counselors. This may be a function of several factors, including the prevalence of mental health counselors relative to rehabilitation counselors, but the finding bears further investigation and, perhaps, professional advocacy and awareness raising. Stuntzner and Hartley (2014) pointed out that disability adjustment is typically misunderstood by counselors and professionals who do not specialize in working with this population. Numerous researchers have indicated that mental health counselors, school psychologists, and marriage family therapists are not prepared to work effectively with clients with disabilities (Feather & Carlson, 2019; Smart & Smart, 2006; Strike et al., 2004). In part, the limited knowledge and experience are due to the lack of clear standards in the CACREP curriculum. The revision to the CACREP standards in 2023 introduced the infusion of disability into the standards. The present results underscore the importance of this content, especially regarding DAC.

Feather and Carlson (2019) investigated counselor education programs and educators and found that only 21% of their study population had completed any disability courses in their counselor education program. Close to 40% of the respondents' programs did not have any clinical requirements for working with individuals with disabilities for counselors-in-training. The programs reported to Feather and Carlson that disability-related content was infused into courses. The top five courses for this content diffusion were (a) multicultural counseling (50% of respondents), (b) school counseling (33.8%), (c) human development (31.7%), (d) assessment (27.5%), and (e) introduction to counseling (23.9%). Ultimately, over half of the counselor educators in Feather and Carlson's study believed that more disability-focused experience and knowledge needed to be incorporated into their curriculum. This suggests that too few counselors are prepared to provide adjustment counseling to individuals with disabilities.

In this context, the responses to question five provided the troubling information that less than half of CRC respondents reported that their graduate professional training prepared them "well" or "very well" to provide DAC, and about one in four reported being "not well" or "not at all" prepared. This result suggests that rehabilitation counselor education programs must evaluate their professional preparation in this area. This suggestion is underscored by the fact that so few of the participants pursued or were able to access post-graduate training or continuing education on this topic. As rehabilitation counselor education programs consider their curriculum and their students' professional preparation, expanding content and capacity in this area must be a focus.

Limitations

A descriptive survey research design was used in this study. This simple and efficient method allowed the researchers to analyze a snapshot of how DAC is used within the field of rehabilitation counseling. However, there are several limitations inherent to this study design. First, a major limitation common to self-reported surveys is poor response rate. A 50% response rate is generally regarded as a good or acceptable response rate for self-administered questionnaires (Coughlan et al., 2009). This study had an 11.2% response rate. Literature on survey designs recognizes that response rates have been falling, especially in the U.S. and Europe, due to an increase in non-response errors (Coughlan et al., 2009; Umbach, 2005). Email surveys are especially vulnerable to non-response errors, as some emails may never reach the intended recipient due to (a) being sent to the junk folder or (b) the email addresses being no longer used (e.g., change in affiliation). Even in the context of these considerations, however, the present response rate falls significantly below the generally acceptable rate and limits the generalization of the findings.

Another limitation common to descriptive, self-reported surveys is biased sample selection. Biased sample selection can occur when certain individuals are more likely to participate in the survey compared to other individuals in the larger population to whom the study seeks to generalize. Descriptive results reveal that the study participants are older (51.41 years old) than the large sample in the CRCC's most recent role and function study (48.09 years; Leahy et al., 2019). Also, more individuals from the sample were women (80.7% compared to 69.9%). Otherwise, the present sample appears similar to recent studies with larger CRCC samples, but not necessarily to the national population of CRCs or practicing rehabilitation counselors, and so should be generalized with caution.

Conclusion

Among counseling disciplines, rehabilitation counseling is distinct in its focus on the experiences of people living and working with a disability and chronic illness. Since the field's foundation, this focus has included adjustment to disability. DAC has consistently been associated with improving vocational and psychosocial rehabilitation counseling outcomes among individuals with CID. In this study, our intention was to examine several specific questions about this important but poorly defined aspect of rehabilitation counseling.

The results suggest that, among the participants, DAC is provided across rehabilitation counseling settings and engages a significant amount of rehabilitation counselors' time. The participants took diverse but limited professional approaches in terms of theoretical perspectives and use of

adjustment-specific models. The results provide meaningful information about the issues that are frequently a focus in DAC and should be prioritized in professional training. The results raise questions about the extent to which counselors are prepared for this essential function, however, and the limited extent to which the CRCs evaluate clients' need for adjustment counseling was also concerning.

Although the sample was too small to permit broad generalizations, the results imply that further exploration of the research questions among a larger sample is warranted. As the rehabilitation counseling discipline continues to analyze and revise its educational curriculum, accreditation, and evolving practice, the results of this study should be informative. Without a more specific understanding of the current practice reality, it will be impossible to move toward evidence-based and informed professional services in adjustment to CID or a more intentional approach to rehabilitation counselor education. This study provides an important beginning and demonstrates the need for and benefit of further research.

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