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Rehabilitation counselor life care planners: a qualitative analysis of values and traits

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REHABILITATION COUNSELOR LIFE CARE PLANNERS: A QUALITATIVE ANALYSIS OF VALUES AND TRAITS

by
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CERTIFICATE OF APPROVAL

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PH.D. THESIS

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This is to certify that the Ph.D. thesis of

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To Randy,
For reminding me that I'm not being paid to believe in the power of my dreams.

To Anna and Oliver,
Things are looking up.

Try to understand men. If you understand each other you will be kind to each other. Knowing a man well never leads to hate and almost always leads to love.

~ John Steinbeck, 1938 journal

ABSTRACT

This study is a qualitative analysis of the values and traits of rehabilitation counselor life care planners. Rehabilitation counselors who support people with disabilities do so in a variety of settings and while there is literature on *what* counselors do in various settings (Leahy, Chan, & Saunders, 2003; Leahy, Muenzen, Saunders, & Strauser, 2009; Pomeranz, Yu, & Reid, 2010) there is less information on *what* traits and values those professionals have. This has implications for counselor education when supporting counselor trainees in finding a career path in which they will be successful and satisfied, as well as potentially provide information about misconceptions about counselors who work in private rehabilitation practices. More specifically, the well documented identity challenges among practitioners and professional organizations (Dunn, 2017; Fleming, Phillips, Manninen-Luse, Irizarry, & Hylton, 2011; Irons, 1989; Mpofu, 2000; Patterson, 1957; Stebnicki, 2009; Tarvydas & Leahy, 1993) have made it more challenging to fully understand the identity of those in the private rehabilitation counseling field, like life care planners.

Using the theoretical foundation of the Person-Environment fit theory, this study reviews the available literature on rehabilitation counselor life care planners and fills in a missing sub-category of research on Person-Group fit within the private rehabilitation field and life care planning. It contains a review of rehabilitation counselor identity in order to provide context to how rehabilitation counselor life care planners view themselves as practitioners, particularly the role of income in career fit given ethical concerns surrounding money in the practice of life care planning. The primary traits resulting from this study are emotional differentiation, counselor as educator/performer, desiring intellectual excellence, detail oriented, and financial awareness. The primary values resulting from this study are recognition of humanity, integrity, objectivity,

freedom in work, and social and financial responsibility. These results are discussed within the social culture of rehabilitation counseling to better understand their development.

This research has implications for counselor educators and their ability to provide informed and evidence-based guidance to students entering the field. It also provides information for rehabilitation counselor in practice who are considering a career change and are curious about whether these practices would be a good fit given their specific values and traits.

PUBLIC ABSTRACT

This study is a descriptive qualitative analysis of the values and traits of rehabilitation counselor life care planners. Using the theoretical foundation of the Person-Environment fit theory, it reviews the available literature on rehabilitation counselor life care planners and fills in a missing sub-category of research on Person-Group fit within the private rehabilitation field and life care planning. It contains a review of rehabilitation counselor identity in order to provide context to how rehabilitation counselor life care planners view themselves as practitioners, particularly the role of income in career fit given ethical concerns surrounding money in the practice of life care planning. The primary traits resulting from this study are emotional differentiation, counselor as educator/performer, desiring intellectual excellence, detail oriented, and financial awareness. The primary values resulting from this study are recognition of humanity, integrity, objectivity, freedom in work, and social and financial responsibility. These results are discussed within the social culture of rehabilitation counseling to better understand their development.

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CHAPTER I

PREAMBLE

Rehabilitation counselors have struggled with maintaining a consistent identity for decades (Dunn, 2017; Irons, 1989; Mpofu, 2000; Patterson, 1957; Stebnicki, 2009; Tarvydas & Leahy, 1993) and while specialty fields such as life care planning provide new career opportunities for counselors, they also stretch the boundaries of roles and functions of rehabilitation counselor. Life care planning is a specialty practice within forensic rehabilitation developed by rehabilitation counselors and began at a time when counselors were increasingly being called to inform the courts about the disability rehabilitation process. As a result, life care planning, or the process of creating a document outlining the lifetime care needs and associated costs for a person experiencing a catastrophic injury or illness, requires a professional with a unique set of character traits and personal values. This study describes the traits and values of the rehabilitation counseling life care planner, with special consideration of the how those traits and values shape the identity of private forensic rehabilitation counselors within the profession.

Despite the obvious medical and legal challenges that people with disabilities face, there are some questions about what motivates rehabilitation counselors to work in the crossover fields of medicine and law. Given the potential for higher earnings in forensic practices, questions of the financial motivations of counselors (Vierling, 2003) and ethics (Dunn, 2017; Field, 2017) contribute historically to doubts about their altruistic motives. In other words, the traditional conception of rehabilitation counselors as public advocates for the basic human rights and social vocational inclusion seem inconsistent with objectively practicing in the forensic area.

While there have been several studies demonstrating that rehabilitation counselors in both public and private practices fall under the same umbrella of common practices (Leahy, Chan, &

Saunders, 2003; Leahy, Muenzen, Saunders, & Strauser, 2009), it is the expert knowledge of disability and work that allows counselors to fill additional needs in private industry (Rausch, 1985). Still, despite the need for rehabilitation counselors in the private sector to advocate for the life-long needs of people with disabilities, there are suspicions that counselors are engaging in these practices more to benefit themselves financially than the person with the disability due to the earning potential. This is particularly true for the multidisciplinary practice of life care planning where the way life care plans are being used challenges the ethics of its original intent. Specifically, life care plans were originally developed as a guide to help the person with a disability coordinate their future care (Weed & Berens, 2012; Weed & Field, 2012), however they have also come to be used primarily as litigious vehicle by some for quantifying legal settlements or awards (Gonzales, 2017). While both are possibilities in terms of what life care plans can be used for, there are no known studies on how specialty practices affect rehabilitation counselor identity.

The purpose of this study is to conduct a descriptive qualitative analysis to better understand the professional identity of rehabilitation counselor life care planners. Given the suspected ethical intentions of those in the forensic rehabilitation practices and the medical and legal working environment of life care planners that deviates somewhat from the nature of the more traditional counseling environment, life care planners are prime candidates for exploring the values and traits that make them an ideal fit for their practices. In order to investigate these values and traits, the researcher will interview rehabilitation counselors practicing life care planning to better understand the values that underly the practice of life care planning and the traits that make them especially suited for their work. Based on the theoretical constructs of Person-Environment (P-E) fit theory, particularly the fit within the social group (Person-Group or P-G fit), this study

will provide information about how the values and traits of life care planners shape the identities of rehabilitation counseling.

RESEARCH QUESTIONS

1. How do rehabilitation counselor life care planners describe their professional identity?
2. What values and traits do life care planners describe as important for practicing as a life care planner?

ESSENTIAL DEFINITIONS

Rehabilitation Counselor – A rehabilitation counselor is a counselor who possesses the specialized knowledge, skills, and attitudes needed to collaborate in a professional relationship with persons with disabilities to achieve their personal, social, psychological, and vocational goals (RCC, 2005 as cited in Maki & Tarvydas, 2012, p. 4). For the purposes of this study, a rehabilitation counselor must also be certified by the Commission on Rehabilitation Counselor Certification (CRCC) with a Certified Rehabilitation Counselor (CRC) certification. They must also possess a master's degree from a rehabilitation counseling program accredited by the Council on Rehabilitation Education (CORE) or the Council for Accreditation of Counseling and Related Educational Programs (CACREP).

Life Care Planner – There is currently no standardized definition of a life care planner, except to say that a life care planner is one who authors life care plans. In this study, the definition of life care planner will be one who holds a Certified Life Care Planner (CLCP) certification which is accredited by the International Commission on Health

Care Certification (ICHCC) and endorses the standardized practices and methodologies outlined by the International Academy of Life Care Planners (IALCP). If a counselor has been practicing life care planning for longer than 15 years but does not have a CLCP certification, they are also accepted to participate in the study due to the extensive experience in the practice. For a longer explanation of what a life care planner is, see Appendix G.

Professional Identity – "one's professional self-concept based on attributes, beliefs, values, motives, and experiences" (Slay & Delmonize, 2011).

Values – "goals or objectives sought through engagement in work" (Super, 1973; Super & Sverko, 1995)

Trait – "A distinguishing quality or characteristic, typically one belonging to a person" (Oxford University Press, 2018).

INTRODUCTION

In order to fully understand who rehabilitation counselor life care planners are, it is helpful to understand the context for how the specialty practice was shaped by the development of the profession of rehabilitation counseling. Both the context of the counseling and the context of the research are important to consider as influencing the data available, so this chapter will begin with a review of my own personal experience with professional identity in order to describe my motivation as a counselor and a researcher. This practice of qualitative reflexivity seeks to build trust in the reader that the following methods of the qualitative process take precedence over

researcher bias, or said differently, the methods build trustworthiness in the process and credibility in the results. Qualitative inquiry in the field of rehabilitation counseling is considered to be underutilized, so this chapter will also include a justification for the methodology. It will end with a brief history of the emergence of private rehabilitation and the practice of life care planning, as well as the roles of professional organizations in defining the identity of the field. Ultimately this study will provide some understanding of how life care planners fit within the larger context of the rehabilitation counseling field.

THE PRACTICE OF PRIVATE REHABILITATION COUNSELING

Private Rehabilitation Counseling essentially grew out of the recognition that people with disabilities had various vocational needs. Robinson (2014) describes the process of vocational rehabilitation in both the public and private sector as being "more like a divided highway running parallel with both groups moving in the same direction" (p. 1). In the broadest sense, private rehabilitation counselors work in many different settings that serve people with disabilities including private-for-profit rehabilitation companies, medical centers, private non-profit facilities (like sheltered workshops), or other non-federally funded programs. Rasch (1985) defines it as primarily "private-for-profit rehabilitation companies, self-employed rehabilitationists, and in-house corporate programs; all of which are involved primarily in the provision of rehabilitation case management services to industrially injured workers" (p. 5).

While this definition certainly fits the concept of who the counselor is, it does not adequately describe the setting in which a private rehabilitation counselor may work, including within the insurance industry and at intersections between law and medicine. For the person with a disability, particularly one acquired in industrial accidents, it is almost inevitable that they fall into the workers compensation system which often places them in a system of unfamiliar medical

providers, claims adjusters, and benefit lawyers. Others who are living with a disability may find themselves appealing rejected benefit applications from the social security administration, in which case a rehabilitation counselor is called on to provide witness to the employability of the applicant. Occasionally, rehabilitation counselors are hired by lawyers or insurers to develop rehabilitation plans. When the practice enters the legal arena it is referred to as forensic rehabilitation counseling. Forensic counseling is a subset of the practice of private rehabilitation counseling, however "clinical services are also delivered in the private sector" (Robinson, 2014, p. 8).

For the purposes of this study, the life care planning is a specialty practice within the larger field of rehabilitation and often work within the forensic sphere by assisting with the legal process of understanding disability for the purposes of legal decision-making. Many rehabilitation counselor life care planners engage in the counseling process as well, which includes evaluation, planning, treatment, and termination (Rubin & Roessler, 2008). However life care planning most often happens within the forensic setting "when disability-related lifetime needs and associated costs must be determined" (Pomeranz, Yu, & Robinson, 2014).

While the rules, practices, and setting within which the counselor is working may differ, "the public and private sectors share a common rehabilitation process that moves from case evaluation through termination" (Robinson, 2014, p. 1). The rehabilitation counselors in this study come out of an evolution of law and policy that in many ways shaped the settings in which counselors practice. Even though the foundations of the practice are seen as the same or similar by several authors (Rasch, 1985; Robinson, 2014; Weed, 2012), there still exists perceptions of crucial difference in many writers (Dunn, 2017; Irons, 1989; Mpofu, 2000; Patterson, 1957; Stebnicki, 2009; Tarvydas & Leahy, 1993). This study will assume that these practices are more

similar than different, however the following section will discuss some of the legal and policy changes that led to the practice of life care planning.

A Brief History of Rehabilitation Counseling Practices

While this study is interested in the self-descriptions of counselors, those descriptions cannot be understood fully without some contextual information of the relationship between the public and private rehabilitation counselors. An important context to note about this brief history of the relationship between these two social groups is that many of the source comments about the relationship come from the rehabilitation counselor life care planners. Given the investment I have as an author, the relationship I have with many in the field, and the emphasis of this research on the self-descriptions of counselors, it is necessary to state this at the beginning. Much like providing marital counseling with only one spouse present, important descriptions can be gathered about how the client views the relationship. Yet, it is not a complete picture and, given the scope of the research, does not intend to be. This brief history, as well as the study, will collect the voices of one group among many who make up the full profession of rehabilitation counseling.

The modern historical beginnings of rehabilitation are generally attributed to the passing of the Soldiers' Rehabilitation Act of 1918 and the Smith-Fess act of 1920. These were generally efforts to support soldiers returning from the first world war and were limited to certain types of disabilities, excluding intellectual and emotional disabilities. Following the second world war, public rehabilitation expanded rehabilitation efforts to include intellectual and emotional disabilities. At this time, vocational rehabilitation efforts were essentially "authoritative in nature, with elements of consumer choice subjugated to professional judgement" (Dunn, 2017, p. 92). This authoritative method of providing services subjugated consumer choice to professional judgement of providers.

However, this changed in the 1960's and 1970's when American culture began emphasizing the importance of human and civil rights. While public rehabilitation services began expanding and prioritize service provisions to include people with the most severe disabilities, insurance providers were still hiring their own rehabilitation nurses and counselors for the purposes of reemployment (Lewin, Tamseur, & Sink, 1979; Matkin, 1980; Rausch, 1985). It was around this time that "proprietary [private] rehabilitation became prominent for the first time to meet the needs of those who might have been served by the pre- 1973 rehabilitation service model" (Dunn, 2017, p. 93). Philosophical differences in the way counselors were providing services began during this time and continued throughout the 1980's.

There were several differences between the public and private counselor in terms of how they practice. In addition to the authoritative focus on medical conditions and treatment in the private industry, compared to the more person-first focus on consumer choice in public rehabilitation, the legal and legislative environment made for different needs for people with disabilities. Laws such as the Rehabilitation Act of 1973 and the Americans with Disabilities Act that passed in 1991 emphasized the power of the person with a disability as a competent consumer of their own services. These laws influenced the educational communities and private businesses to attend to the needs of people with disabilities more, however for those who found themselves in Social Security appeals or legal battles over compensation for injury, there seemed to be little choice in their outcomes. The legal system still favored the expert opinions of medical providers and increasingly vocational experts. Gradually the burden of proof for the vocational counselor providing legal opinion focused less on the power of the consumer with a disability but on the scientific foundation of the expert (*Daubert v. Dow Merrill Pharmaceutical, 1993; General Electric v. Joiner, 1997; Kumho Tire Company v. Carmichael, 1999).* As rehabilitation counselors

adapted to meet the needs of people with disabilities within these different social settings, the identities of counselors practicing in these areas changed.

As it stands today, rehabilitation counseling services in the public and private sector have not changed much in the constituents they provide services to. The public sector is still primarily focused on serving those with the most severe disabilities and is centrally housed in government offices. The private forensic sector is still primarily a proprietary venture with many providers located all around the United States, however they are largely concentrated in areas where litigation is common and workers' compensation policies exist at the state level. What is even more troubling is that the private sector of rehabilitation counseling is still working within a medical model which essentially requires identification of loss of functioning for the purposes of compensation of injury rather than emphasizing rehabilitation as rebuilding functioning to pre-injury levels. As Hunt, Habeck, Owens, and Vandergoot state, "if individuals are being encouraged to 'maximize' their disability rather than their ability in order to receive cash or in-kind benefits, we will have a loss of both efficiency and equity" (p. 247). This is a recognition that systems meant to support people with disabilities are not functioning in a way that encourages rehabilitation.

While several external factors exist that point to differences in practice between public and private rehabilitation providers, just as important are the internal factors that influenced rehabilitation efforts. Decisions within the field of rehabilitation counseling, such as the focus of training programs of counselors and the allegiances of professional organizations, also played a central role in setting the stage for life care planning as a practice situated in the legal and medical communities of rehabilitation. These professional organizations contributed to the way counselors new and old identify with the profession. The development of a code of ethics outline values for

the rehabilitation counseling profession (CRCC, 2017) and was created by members of many of these organizations. It is an example of how the culture of the profession shapes the environment for its members.

PROFESSIONAL REHABILITATION COUNSELING ORGANIZATIONS

Internal factors within professional organizations in the field of rehabilitation counseling have done just as much to change the shape of the profession as the external factors described above. Throughout the 1960's and 1970's the rehabilitation field was represented by the National Rehabilitation Association (NRA) (Field, 2017). Many of the educators who held office in the organization also formed the National Council on Rehabilitation Education (NCRE) and who essentially developed the guidelines for the accrediting body in rehabilitation training programs, the Council on Rehabilitation Education (CORE) (Field, 2017). According to Field (2017), not only was NRA influencing how training programs funded students and which career direction they would take, they were also essentially giving certain training programs 'permission' to continue training, leaving those with dissenting opinions out. "The whole process had the appearance of an 'exclusive' club which became readily apparent when the rumblings of the private sector arrived on the scene" in the early 1970's (Field, 2017). Eventually special interest groups of the NRA such as the American Rehabilitation Counseling Association (ARCA) and National Rehabilitation Counseling Association (NCRA) began to have differences and formed their own professional groups. It seems odd that groups that emphasize principles of inclusion for people of all kinds would experience such divisiveness.

As relationships in these groups, and others like National Association of Rehabilitation Professionals in the Private Sector (NARPPS) which eventually became the International Association of Rehabilitation Professionals (IARP), attempted unification efforts to bring the

profession together, ultimately many of these efforts failed (Leahy, Tarvydas, & Phillips, 2011; Peterson, Hautamaki, & Hershenson, 2006). Meanwhile, private rehabilitation continued to remain on the outskirts of professional unification efforts for the most part. Although, efforts continue to this day by members of NCRE, IARP, ARCA, and NRCA through a group called the Rehabilitation Counseling Coalition (RCC), later named Vocational Rehabilitation Counseling Coalition (VRCC). Despite the seeming wide ranging membership of its members, the VRCC still struggles with the same issues plaguing the past 60 years of establishing a professional identity (VRCC, 2018).

THE NEED FOR QUALITATIVE RESEARCH IN REHABILITATION COUNSELING

The issues in professional identity that call for more research on values and traits among rehabilitation counselor life care planners demand research that can dig deeper into the experience of participants. The need for research that covers a greater breadth of topics, employs more sophisticated analytical techniques, and focuses more on the people served by counselors is a fairly common theme across the profession of rehabilitation counseling (Chan, Da Silva Cardoso, & Chronister, 2009; Deutsch, et al., 2004; Mertes, 2018; Rumrill & Bellini, 2009; Rutherford-Owen & Marini, 2012). Many of the people who call to produce research refer to empirical, quantitative studies, however "qualitative research will continue to play a vital role in building our profession's [rehabilitation counseling] knowledge base" (Rumrill & Bellini, 2009, p. 290). Despite the slow growth in qualitative publication (Berrios & Lucca, 2006), there is an increased recognition of the value and natural fit of counseling with qualitative research (Hanna & Shank, 1995; Merchant, 1997; Ponterotto, 2002). Both counselors and qualitative researchers study narratives as the primary form of people's experience that take on meaning (Merchant & Dupuy, 1996), they are

trained to tolerate ambiguity and unpredictability, and they must pay attention to the underlying process and content of human interactions (Berrios & Lucca, 2006).

Within rehabilitation counseling itself, there has been a historical recognition of the need and fit of qualitative methods within the counseling literature (Hagner & Helm, 1994; Hanley-Maxwell, Al Hano, & Skivington, 2007; Szymanski, 1993). Of those studies that are qualitative in nature within rehabilitation counseling, most of those are either case studies, follow a grounded theory method, or stated no specific methodology (Hanley-Maxwell, Al Hano, & Skivington, 2007). These methods are powerful tools in describing the experiences of people with disabilities and theory development, however opportunities for other qualitative tools make them a natural fit for rehabilitation counselors (Spong, 2010). A first step in is understanding who these participants are and the context in which this study takes place.

SUMMARY

While both public and private rehabilitation counselors fall under the same umbrella of certification, the history of national policy, law, and professional relationships have changed the way private rehabilitation counselors are viewed by the rest of the field. Part of this appears to be related to suspicions of financial motivations to practice in forensic arenas, but part of it also may be a lack of understanding of who these counselors are. Along with changes in the industry that have opened up new professional opportunities for rehabilitation counselors to practice in, ultimately driven by consumer need, came divisions in the primary identity of rehabilitation counselors. As private practitioners continued to expand in their specialty areas, training programs driven by accreditation bodies and professional organizational support had not fully understood how to encourage students to enter these areas. This study on values and traits will ultimately help inform whom may be a good fit for work in the private sector.

CHAPTER II
LITERATURE REVIEW

CHAPTER OVERVIEW

Most rehabilitation counseling programs have historically been influenced by educational accreditation standards, professional organizations, and funding from the federal government to support a specific population of people with disabilities. Due to the lack of understanding in who private rehabilitation counselors, or more specifically life care planners, it remains a challenge to determine which *type* of professional would be a good fit for the work. Rehabilitation counseling has historically led the way in understanding a person's fit with their vocation. This chapter will begin with an introduction to life care planning to first help the reader understand how the private rehabilitation professional fits into the practice. This chapter will then provide an overview of Trait-Factor theory, which is now commonly known as Person-Environment (P-E) theory, to give a theoretical framework for understanding what career decision factors contribute to job satisfaction in the practice of life care planning. Specifically, it will discuss the most relevant type of P-E fit that relates to social identity called Person-Group (P-G) fit which includes values and traits relating to social groups. Given the suspicions of the influence of money on the differing values of counselors, a brief review of the role of income within P-E theory will follow. However, prior to discussing the theoretical foundations of the research question, a few comments on the philosophical assumptions of this study will be useful. These sections will help answer the two research questions, namely: how do rehabilitation counselor life care planners describe their professional identity and what values and traits do life care planners describe as important for practicing as a life care planner?

AN INTRODUCTION TO LIFE CARE PLANNING

For the reader who is not familiar with the practice of life care planning, this brief review will provide some contextual information to help understand why certain values and traits are beneficial in this work.

WHAT IS A LIFE CARE PLAN?

The origins of life care planning is largely attributed to the work of Dr. Paul Deutsch in a 1981 publication, *Damages in Tort Action* (Deutsch & Raffa, 1981). This was originally a set of guidelines for determining damages in civil litigation, which was a way to help the courts better understand the costs, as well as the experiences of people with injuries to settle health care disputes. The challenge here was that there was little holistic understanding of the long-term consequences of disability. As a result, patients were being compensated for short-term immediate needs, but their life-long care needs were often ignored, even though the consequences in later-life often left people with little money and support. The Life Care Plan was later outlined as a tool for the health care industry and by 1986 a training program was established by Dr. Deutsch to train others in the methodology of life care planning (Weed & Berens, 2012).

The life care plan itself is written in a standard format based on established categories. While there is some differentiation in how plans are written, the following standardized areas of need have been identified:

- projected evaluations,
- therapeutic modalities,
- diagnostic testing,
- wheelchair needs/accessories/maintenance,
- aids for independent functioning,
- orthotics,
- home furnishings/accessories,
- medications/supplies,

- home/facility care,
- routine medical care,
- transportation,
- health and strength maintenance,
- architectural renovations,
- potential complications,
- aggressive treatment or surgical intervention,
- orthopedic equipment needs,
- and vocational planning. (Weed & Berens, 2012, p. 6).

These comprehensive categories help establish a life-long picture of needs in a format that can be consistently used by health care professionals. Efforts are consistently made by communities of life care planners to standardize the categories of interest and methods of collecting data in order to create reliability of the plans (Sutton, Deutsch, Weed, & Berens, 2002). In other words, in order for the plan to be accurate, it needs to be done in the same way by all life care planners. If the data is good, then multiple planners should come up with the same costs, in theory anyway. Having a consistent format establishes reliability of life care plans among life care planners. However, while the structure itself works to create consistency reliability for the purposes of court admissibility, how it is used after admission is perhaps more important.

In lay terms, a life care plan is a way to identify what care a person with injuries or illnesses will need over the course of their life. If those needs can be identified and accurate costs can be established, then compensation can be given to the person to cover their life-long needs. Doing so will avoid future complications and costly medical procedures and is considered a win-win situation for, care providers, payers, as well as the person with a disability. A basic example of this is frequently experienced bed sores by people with spinal cord injuries. These bed sores, or decubitus ulcers, are perhaps the most common and costly complication of spinal cord injury, (Weed & Berens, 2012, p. 632) and lead to unnecessary emergency room visits, not to mention the

pain and suffering of patients. When adequate check-ups with providers, appropriate equipment, and education are provided to the person with a disability in advance, everyone wins.

Although this lay-definition is more practical in use, the formal definition of a life care plan is

> a dynamic document based upon published standards of practice, comprehensive assessment, data analysis and research, which provides an organized concise plan for current and future needs with associated costs, for individuals who have experienced catastrophic injury or have chronic health care needs. (Weed & Berens, 2012, p. 3)

It is the job of the life care planner to collect and organize the recommendations of the entire team of treating professionals to gain a comprehensive understanding of associated costs of a disability. It is considered dynamic because the care plan may be subject to change depending on the prognosis and outcomes of the individual. This living document can be changed and updated by the planner to reflect the needs of the evaluee. The planner begins by doing a comprehensive review of documentation to build a profile of the global care needs of the individual including medical, social, and vocational. After review of the documentation an interview takes place with the evaluee and the family, followed by contacting providers to collect general recommendations. While the life care planner does not develop the opinions of each provider, the planner must make sure that the recommendations are not merely possible, but probable and appropriate (Marini, 2012). These recommendations are based on some specific legal terminology, such as *maximum medical improvement, reasonable medical probability* and *Usual, Customary, and Reasonable (UCR)* (Busch, 2017*).* What this means is that damages will not likely be awarded if they exceed the amount of improvement beyond medical probability. As an example, a person with a brain

injury will likely make most of their improvement in the first year after injury (Weed & Berens, 2012). Beyond that point, which is individualized to each person and often somewhat ambiguous, the costs outweigh the benefits and symptoms should be treated with long-term services and not part of an acute care plan. Fortunately for the life care planner, the recommendations and responsibility to attest for the specialized needs rests on each individual provider. In this way, the life care plan itself is a collaborative effort among providers and not dependent on a single expert's opinion. However, given the inconsistency among providers relating to services and costs, it is important that the life care planner follow an established methodology and format to ensure systematic precision in their findings.

In practice, a planner is hired, often by an attorney, early on in a patient's rehabilitation process. In the best-case scenario this happens before the patient leaves an inpatient rehabilitation facility or hospital. After the patient has had an opportunity to recover to the point where a clearer view of potential outcomes and referrals to other providers has been established, a life care planner begins by performing a case intake and contacting other providers to collect their professional opinions about needs based on their specialty practice. After this the search for costs begins based on the available services within the patient's area of residence. The goal here is to figure out what the patient will actually pay, rather than base estimates on national averages or costs from hospitals outside of the individual's region. This can be a very tricky task due to the differences in cost at different facilities, differences in insurance products owned by patients, and funding from sources such as Medicare or Medicaid. One simple example used to understand the difficulty in this process is alluding to the costs of plane tickets. Costs of plane tickets can be somewhat of a mystery to consumers and as a result people pay the costs without always knowing what they are change from one moment to the next. In terms of medical treatment, even some providers will say

that costs change depending on who is paying. This can lead to contentious legal debates as to the cost of treatment and what usual, customary, and reasonable (Busch, 2017) compensation means.

While the process of life care planning has roots in the courts, the methodology of developing the life care plans began as patient-first and based on the needs of the ill or injured (Deutsch, 1994). The focus is on the patient, not the plan or cost. The development of life care planning is a response to the families need of a summary of future needs, the need for providers to communicate amongst themselves and patients about interventions, the need for a proactive approach to cost and complication management, the need for a system to break down complex concerns related to disabilities, and the need to address the individual concerns of the patient based on geographic location, personal preferences, and personal goals to make for realistic outcomes (Sutton, Deutsch, Weed, & Berens, 2002). While these are very noble motives, the life care plan that does not lead to settlement or award does not provide the adequate resources to purchase the goods and services recommended. In other words, if the plan does not follow a strict protocol, and does not support the competitive strategy of the prosecution, it may not be as strong as defense arguments. As such, other factors may be influencing the development of life care plans and be leading professionals to use them for different purposes, like doing whatever is necessary to win for people with disabilities, even if it is not sanctioned by the profession. Hence the discrepancy between the life care plan as a case management tool for the good of the patient and a litigious tool for the good of the court.

USES OF A LIFE CARE PLAN

The modern health care system is changing to require a larger emphasis on care coordination. Managed Care Organizations (MCOs) are recognizing the benefits and need to coordinate the complex care of patients in need of medical care, specifically for those who are

among the most complex and expensive (Rosenbach & Young, 2000). Traditional fee-for-service payment models are being transitioned to capitation models where providers are given a total allowance that they are allowed to charge to treat a patient (capitation), as opposed to providers continuing to charge for each service as they or the patient deem them necessary (fee-for-service). It is essentially putting a 'cap' on the total amount of money patients can use and providers can charge. Despite providers worrying that they will have to discontinue services when treatment is not complete, that they will not be able provide expensive but necessary treatments when they are needed, or that they will lose revenue by providing non-reimbursable services (Bontke, 1997), new models of care coordination are being experimented with in several states (Rosenbach & Young, 1999). The argument that life care plans can improve services and quality of life while at the same time control costs, is not unique to life care plans but an ideal for the entire health care system (Friedman, 1996; Libersky, Stepanczuk, Lester, Liao, & Lipson, 2016; Tu, 2016). While states have various experimental methods for care coordination that differ greatly, the specific uses of life care plans from a life care planning perspective is helpful to know when considering their uses.

Specific to this discussion, several of the main uses will be discussed below. However, it is important to note that concepts of life care planning have been used in workers' compensation (Weed & Berens, 2012), personal injury litigation (Weed, 2012), special needs trusts (Countiss & Deutsch, 2002), elder care planning (McCollom, 2004), mental health care (Hilligoss, 2004), facility discharge planning (Weed & Berens, 2012), government-funded vaccine injury programs (Weed, 2010), Veteran's Affairs (Weed, 2010), and structured settlement and estate planning (Weed, 2010). Additional venues for life care planning are also outlined by Albee, Gamez, and Johnson, (2017). Listed below are examples of the most common uses of life care plans.

CATASTROPHIC CASE MANAGEMENT

Part of the identity of many life care planners, and arguably all rehabilitation counselors, is that of case manager. Pomeranz, Yu, & Robinson (2014) state that "the LCP [life care plan] serves as a guide to ensure the provision of quality health care and related services throughout the lifespan of an individual with a disability" (p. 393). Pomeranz & Shaw (as cited in Pomeranz, Yu, & Robinson, 2014):

> It is first and foremost a case management tool, that involves a multidimensional, dynamic methodology based upon the actual needs of the individual and can serve as a 'roadmap' for case managers as well as an educational tool for the individual with a disability, his/her family, and services providers (2007).

While many life care planners are nurses, occupational therapists, physiatrists, or other health care professionals, not all are trained in case management and require specialized training. Additional certification is often sought by those who wish to take full advantage of the possibilities that life care plans have to offer, such as the Certified Case Manager (CCM) certification, to name only one. Rehabilitation counselors, however, are trained in case management and consider this to be a primary part of their identity (Council for Accreditation of Counseling and Related Educational Programs, 2015).

Role and function studies report that 45.2% of surveyed life care planners claim case management as a primary clinical field of practice and 39.9% are currently licensed/registered and/or certified to do so (Pomeranz, Yu, & Reid, 2010).

PEDIATRIC LIFE CARE PLANS

Pediatric life care planning deserves special mention due to the complexity and necessity of future planning. Due to the longer life expectancy of children who are injured or born with

congenital conditions, the costs associated with future care can be much greater, and more debatable.

Education can be a complicated process for parents with disabilities and the life care planner must be versed in how the system works and who pays for what. For example, depending on the state, educational costs are sometimes not included in a life care plan due to the requirement of school systems to pay for educationally-related expenses as outlined in the Individuals with Disabilities Education Act (IDEA) of 1990 (PACER, 2004). These are known as collateral sources and it is typical for defense lawyers to argue that funding that is required by law to be used for people with disabilities is not admissible as compensable damages in life care plans (Field, Johnson, Choppa, & Fountaine, 2015). In other words, if anyone with a disability can expect these services, then there shouldn't be compensation on top of what is already offered; they will end up being overcompensated for the liability.

In addition to knowledge of the education system, a life care planner must also have "a thorough knowledge of typical growth and development as well as deviation from this pattern" (Bond & Trautwein, 2011, p. 32). This knowledge is essential to predicting and preventing future challenges. This implies that case management, both during and after the plan development, is central to the identity of the life care planner. The goal for the pediatric life care planner is to act as a facilitator, advocate, educator, information clearinghouse, community resource, networker, benefit manager, service monitor, and multidisciplinary team member (Bond & Trautwein, 2011). Due to the need to consider not only the development of the child but the future working life, including schooling, the pediatric life care planner has one of the most difficult tasks of anyone in the practice.

ELDERLY LIFE CARE PLANS

With the advancement in health care technology, people are living longer than ever before. However, with a longer life expectancy comes more potential for medical complications and disability. McCollum and Zydowicz-Vierling (2010) outline the primary benefits of the life care planner in elder care. First, the life care planner "enhances individual and family education" (p. 722). As families choose the most appropriate setting for their loved ones, and ultimately how to pay for it, the life care planner practicing in this area is knowledgeable about options for ongoing services. Second, the life care planner "facilitates integration of services" (p. 724), which means they help the family consider all of the care needs of the person and support them as they make decisions about their future. The third benefit is the potential to "decrease stress" (p. 725). Clarifying costs and comprehensive needs can relieve pressure on families and individuals who are often unprepared to make decisions that were once done independently. Fourth, the life care planner "provides a continuing resource to the family through delineation of needs, rationale and outcomes for programs and services, and measurable goals for evaluation of services" (p. 725). Finally, the life care planner facilitates access to community resources.

While all life care planners are versed in some form of financial management knowledge, elder life care planners have a unique knowledge of elder law and financial resource management (McCollum, 2004). While they are not financial advisors, the funding sources available to seniors is unique and it is essential to understand the resources available to each unique individual. This is contrasted from the specialized knowledge of pediatric development, educational resources, and vocational potentials of the pediatric specialist.

DISCHARGE PLANNING

While discharge planning is not specifically a role of the life care planner, it deserves mention here due to the increase in care coordination efforts taken on by health care providers. Initially this was a cost containment effort used by providers to encourage people to be educated about the future of their life with their condition, however care coordinators are being asked to do more than just educate patients about their conditions and responsibilities to maintain health. Discharge plans by physicians are often short-term guides related to their specific treatment, however care coordination does more to consider the holistic health of individuals and the complex needs long-term. Managed care organizations are recognizing the need to foresee the future potential of risk in a given individual and plan accordingly to avoid unnecessary suffering and expenses. While life care planners are not typically practicing within managed care networks, the principles of long-term planning and care coordination are becoming even more popular among state plans (Rosenbach & Young, 2000).

WHO ARE STAKEHOLDERS?

The previous section gave an overview of some of the areas in which life care plans are developed, however in all areas the collaborative nature of life care plans means that there are a lot of people involved in the process of care and development. This section discusses who the primary stakeholders are in the life care planning process (see figure 2, McMahon, 2018). While this list is not conclusive, it also provides highlights of some of the most common and important stakeholders in the life care planning profession.

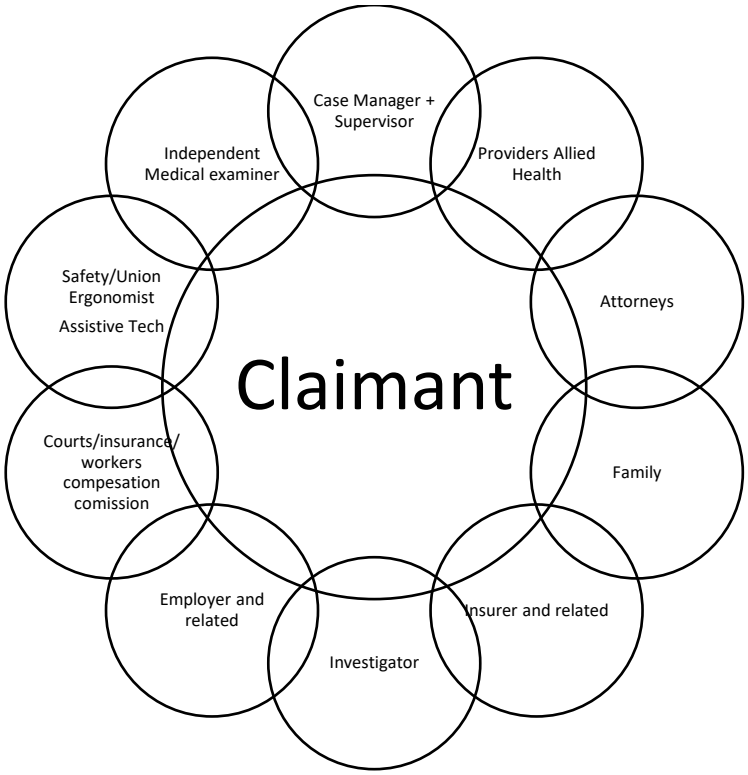

Figure 1. Stakeholders Chart

EVALUEES

The most important person in the life care plan is the person receiving services. Doctors referred to them as patients, by the life care planner refers to a them s an evaluee, not to be confused with the client who is likely the person hiring the planner for their services. Part of why life care planning can be so challenging is that the evaluee is not always able to communicate their needs, thus the planner must rely on the medical providers for a person's medical future, the evaluee's family for their social support future, and others based on the individual needs of the unique person. It can be a complex web of needs not just based on medical outcomes, but on psychosocial wellness and quality of life. In a 1999 book titled, Assessment of Rehabilitative *and* Quality of Life Issues in Litigation, the authors state that using a quality of life standard "addresses the social and leisure issues involved in life function unlike any traditional approach to life care planning (care planning

being focused historically on medical and, where, applicable, psychological needs almost to the exclusion of social, leisure, and purely intellectual/cognitive needs)" (Murphy & Williams, 1999). In this sense, the evaluee wants their whole life to heal, not just their physical body or cognitive functioning.

FAMILIES

A person who is injured or sick will need the support of the people closest to them. However, families function in different ways and are able to provide varying levels of care. Some families will request a lot of social services in order to not be responsible for the evaluee's care. Other families will rush to the person's aide and want to perform much of what could be done by professionals. Other families yet will see unfortunate circumstances of injury or illness as an opportunity to benefit financially. It is the standard position of the life care planner to not rely on family support as a supplement for professional services. This means that although a wife may be able to bathe her injured husband every day, doing so can add extra stress to the relationship. Caregiver burnout has been well documented as a stressor on families (Ybema, Kuijer, Hagedoorn, & Buunk, 2002). As a result, while the planner should consider the relationships in the family and consider their input, professional services should be used in a life care plan in order to maintain, to as close a degree possible, the same relationship that existed prior to injury or illness.

PROVIDERS OF FUTURE CARE

The roles of the individual medical providers, different types of therapists, and counselors make up the bulk of the life care plan, meaning their assessment of expected outcomes and needs based on their area of expertise is central to what services will be required over the lifespan. As an example, a physiatrist should be able to anticipate the long-term replacement schedule of a prosthetic limb, something a life care planner may know from experience but is not credentialed

to know. The life care planner defers to the medical opinion of the physician or treating therapist regarding length of service or individual need. Their role is to provide input based on their specialization and not beyond that. In many cases, a life care planner will have a background and specialized training in vocational rehabilitation and may provide expert opinion on those portions of the plan.

HIRING CLIENTS

One of the parties that has potential to have the greatest influence on the outcomes and costs of a life care plan is the person who is funding the development of the life care plan. The purpose of a lawyer hiring a life care planner is to identify and quantify care needs for the court to decide on damage compensation. There is little disagreement that people who are injured or have illness have needs, however there can be very wide, and very strong, opinions about what those needs are. They can be based not only on practical issues of availability of resources in an evaluees community, but also on philosophical values regarding how vulnerable populations should be treated. The life care planner is not hired to comment on those philosophical values, however it is possible that a lawyer could purchase a life care plan to justify their own. The role of the life care planner is to maintain their own integrity in establishing needs based on the best researched data available and the opinions of other experts. It is also their job to inform those hiring them that this ethic takes precedence over future referrals or financial gain. This is not to say that all or even most lawyers are crooked, but rather to identify the social expectation of it being so. Their role is to argue a case on behalf of their client and the planner need not and should not adjust their own objectivity based on those arguments.

INSURERS AND TAX PAYERS

In a very real sense, the cost of medical care provided by either the government or the insurance company is paid by everyone. In terms of federal support, tax dollars by the general public pay for those in our society that are most in need. In terms of insurance companies, the more a company pays out in medical services the more premiums are increased by other product owners. In this sense, everyone has a stake in the health and wellness of everyone else. Due to this role, opinions develop that can often times be expressed in terms of political views. This is not to say that they take the shape of a certain American political party, though they may, but rather to consider 'politics' in a broader sense. As a tax payer and life care planner, I may be inclined to provide the most possible services for a person because I believe that the healthy should fundamentally take care of those in need. Alternatively, I may choose to restrict funding because I fundamentally believe that a person's misfortune is not the responsibility of others. Regardless of what is right, the role of the life care planner in developing the plan is to avoid these personal judgements about right and wrong and focus on needs based on facts of established science and customs of the practice.

One of the most contentious issues related to 'who pays' for services refers to what is called collateral sourcing. States differ on how this is handled, but the basic idea is that if funding is available from other sources they should not be considered as options to reduce a care plan, such as veteran's benefits or government programs. For example, if an individual qualifies for state vocational rehabilitation services, the insurers will claim that they are not responsible for paying for vocational pursuits. "However, over the past thirty years other reform movements have focused on narrowing the scope of the collateral source rule" (Ireland & Rizzardi-Pearson, 2004). The narrowing of scope means that some juries are allowed to consider such funding sources as

social security benefits or disability income to reduce the amount of award. Some states will claim that these services are what an individual has covered when purchasing insurance and thus not allow collateral sources to be included in life care plans. Other states disagree. As a result, the political and legal differences among states can influence the outcomes of a life care plan.

LIFE CARE PLANNERS

Finally, and perhaps most importantly, life care planners have a stake in life care plans. In an important study done by Pomeranz, Yu, and Reid (2010) the roles and functions of life care planners, were assessed based on the common practices of life care planners. This study identified 21 general theme and 122 specific functions of life care planners. While it is not necessary to outline the full list here, what is important to note is that the theme of 'ethics' and 'evidence-based practice' are the themes with the most functions included in them. This potentially means that life care plans see these themes as being more useful or relevant in their work than other just based on quantity of functions.

It is the scope of this study to better understand the social influences in life care planning but given the above descriptions about outside influences it is probably safe to say that a life care planner must have integrity and a good ethical foundation if they are to maintain a healthy practice. If the life care plan is used as a tool to benefit a particular person, rather than document facts opinions based on outcomes of medical probability, then the planner has questionable ethics that are contributing to social suspicions of monetary influence.

Given the importance of the role of life care planners in this study, it would benefit us to have a better understanding of who life care planners are and how they came to be.

WHO ARE LIFE CARE PLANNERS?

Many of the pioneers of life care planning were rehabilitation counselors. People such as Paul Deutsch, Roger Weed, Tim Field, and Horace Sawyer were instrumental in establishing the practice of life care planning. The practice and development of life care planning has always been a cross-disciplinary venture, but it's initial momentum came from the rehabilitation counseling community. That is not to devalue contributions from other communities, particularly nursing. What is now the largest, life care planning organization, the International Academy of Life Care Planners (IALCP) was first incorporated in Iowa in 1996 by a nurse named Patricia McCollum. Some of its first members even shared the identity of nurse and rehabilitation counselor (Preston, 2017, p. 134)

While there is still a collaborative relationship among this group between professions, there is a smaller percentage of rehabilitation counselors today compared to their nursing colleagues. A 2010 study of the demographic makeup of life care planners showed 34% of members of the International Academy of Life Care Planning (IALCP) were rehabilitation counselors and 57.5% were practicing nurses (Pomeranz, Yu, & Reid, 2010). In that same study, other fields represented in life care planning include occupational therapists, psychologists, social workers, physiatrists, marriage and family therapists, physical therapists (Pomeranz, Yu, & Reid, 2010), and speech/language pathologists (Riddick-Grisham & Deming, 2011). Today there exists and even wider range of professional disciplines engaging in the practice as more people recognize their ability to serve as experts.

Other basic metrics that define life care planners are mean years of experience (M=11.19), Gender (Male=17%; Female83%), age (26-35=4.4%; 36-45=11.3%; 46-55=43.4%; 56-65=35.8%; over 65=5.0%), education level (bachelor's=36.8%; master's=48.9%; Phd/EdD=12.8%; MD=.8%; technical=.8%; Associates or Nursing=24.8%), and practice setting

(Owner/Independent Practice=32.2%; Sole Proprietor=48.3%; Rehab setting as employee=14.8%; Insurance Company=4%; Hospital/Rehab setting=3.4%; Corporation with Sub-Contractors=3.4%; Law Office=1.3%).

The demographics themselves are interesting, however what is more valuable to understand is the professional associations that life care planners have through organizational membership and certification. Who members associate with and how they identify themselves ultimately play a larger role in shaping the identity of how life care plans are created and used. In the next chapter we will learn not only to whom life care planners pledge their allegiance to, but the differences in the way those groups view how the life care plan is developed and what purpose it serves. These actual work products can help us understand how plans can be used to transfer both money and social goods from one person to another.

PHILOSOPHICAL FOUNDATIONS

The philosophical foundations of research play a significant role in the methodology of this study, particularly why certain methodological decisions are made with regard to how data is collected. As reported in chapter one, the social context of the data collected from participants is inseparable from their present experience. What follows is an explanation of other foundational assumptions and how they shape the collection of values and traits.

Underlying the theoretical framework is a philosophical foundation that carries certain epistemological assumptions. The purpose for this brief review is that the trait-factor theories described here have appreciated a long history of positivist thought and development, however postmodern theories are allowing for greater expansion of understanding of the human experience. While most of the research and development of the trait-factor approach, which is now known as the Person-Environment theory, have focused on objectification of traits and standardization of

job functions for the purposes of better assessments that authoritatively place people in jobs, the postmodern perspective focuses more on listening to the participant for their perspective. Positivists emphasize the concept of a passive neutral observer that then collects the data and expertly dissects it into objective parts. Postmodernist assume that both the participant and the researcher are constructing their own realities, are experts on their own experience, and are reciprocally influencing each other in every interaction. In this sense, the postmodern approach to qualitative research is a sensible way to for counselors to both conduct research and appreciate participant voice and choice regarding their own stories. It allows the participant to maintain ownership over their own experience without 'giving' it to the researcher to be manipulated.

These assumptions were alluded to earlier in chapter one in a discussion on the value of qualitative research. The qualitative methods of this study acknowledge the inseparability of my opinions and biases as the primary research tool. It also seeks to present the data as objectively as possible by describing the participant experience without unnecessary interpretation or influence. My own influence and bias cannot be removed from the process and an argument can be made that it shouldn't be. In fact, the ability to interview and glean information from participants is perhaps a strength for counselor researchers and should not be removed by relying on completely structured methodologies. The assumption driving this qualitative study then is that some influence is either unavoidable and perhaps necessary for the qualitative researcher, however pulling out data and maintain the integrity of the participant experience reduces the bias.

This study is a descriptive study of the values and traits of rehabilitation counselor life care planners. The profession and practice are deeply entrenched in questions of identity and the purpose for simply measuring one group of rehabilitation counselors is to describe the experience of that group. There is no empirical data to explain why perceptions of unethical experiences exist,

just as there is very little documented evidence to explain the development of negative perceptions of private counselors' motivations. While I have no specific goal for the study other than pure description, I do believe that meaning can be extracted from the data for the purposes of interpretation. Paraphrasing the epigraph to this text from John Steinbeck, all I wish to do is encourage understanding through description of experience.

In addition, the evolution of the trait-factor approach that later became the Person-Environment (P-E) approach did so partially based on changes from the authoritarian position of the counselor (Crites, 1981; Weinrack, 1979) to encouraging more agency and choice by the client. In other words, the counselor does not take a "test and tell" approach to diagnosis independent of the client (Chartrand, 1991), but rather like the non-directive approaches of Carl Rogers, the counselor works along-side the client to come to conclusions regarding careers together. In this same sense, the methods of the qualitative process are non-directive to allow expression, but the expressions can then be examined by the authoritative expertise of the researcher. Postmodern research acknowledges that research cannot be conducted outside of the context of the relationship between the participant and the researcher. However, once the story is recorded, it can then be examined using some more positivist assumptions. This epistemological trend both in the philosophical foundation of counseling and the nature of the counseling relationship extends to the nature of research as well with the increasing importance of qualitative methods. It is important for the reader to understand that while the qualitative assumptions that drive the methods are used to collect the data, the data is then shaped to objectively fit into the catalog of empirical research on job traits and values, which is discussed next.

PERSON-ENVIRONMENT FIT

A foundational theory for understanding the who workers are in relation to their work is called Person-Environment Fit theory, formerly Trait-Factor theory. This study argues that while certain elements of this theory have been studied, a crucial piece is missing in understanding the identity that is developed from the traits and values of workers, in this case rehabilitation counselor life care planners.

Trait-Factor Theory was the first theory of vocational counseling and is a framework to understand the self-described traits and values of life care planners. Its developer, Frank Parsons (1909), established an elementary system of matching a person's traits with workplace demands. Driven by WWI, this simplistic measure of personality was later expanded and assessments that Parsons lacked began to measure such traits as aptitudes, interest, personalities, and achievements (Kevles, 1968). An early emphasis on quantifiable traits that could be measured objectively grew with the work of Donald Patterson during the 1930's and E. G. Williamson in the 1950's (Schmitt & Growick, 1986). During the cultural shift of the 1960's new psychological advances such as the person-centered work of Carl Rogers began to deemphasize the objective and quantifiable parts of the counseling process to focus more on the personal relationship of with the client. Still, given the heavy use of assessment by the U. S. military in placing soldiers, the popularity of assessment continued with the work of Lawrence A. Pervin who in 1968 described work performance and satisfaction as a process of fit (Su, Murdock, & Rounds, 2015). Pervin saw that a person's success in a job was not only a static concept of matching them into a specific vocation, but was a complicated relationship where "people were understood to both select and shape their environments" (Su, Murdock, & Rounds, 2015, p. 82). This changed the process of job matching from a mechanical process to a counseling relationship that could not be automated. Still, given the old popularity of standardized assessment and the new counselors emphasizing the dynamic

relationship with clients, new theories were needed to understand the complexity in vocational counseling.

The concept of 'fit' is not a singular concept. P-E fit is typically broken down into several parts: Person-Job (P-J) fit, Person-Organization (P-O) fit, and Person-Group (P-G) fit (Werbel and Gilliland, 1999). Su, Murdock, and Rounds, (2015) describe these as,

> P-J fit is defined as the congruence between the demands of the job and the skills, knowledge, and abilities of job candidates and is theorized to predict candidates' job proficiency, technical understanding, and work innovations. In contrast, P-O fit refers to the compatibility of applicant's needs, goals, and values with organizational norms, values, and reward systems and predicts organizational citizenship behaviors, organizational commitment, and retention. Lastly, P-G fit entails the similarity between a person and his or her work group members in terms of their values, goals, personality, and interpersonal styles, as well as the heterogeneity of group member strengths and proficiencies, which predicts group performance and cooperation. (p. 85)

Most of the research that exists on these concepts measures P-O fit due to early interest from popular sociological theorists Emile Durkheim and Max Weber (Inkson, 2015) and some have studied the interactional effects between the concepts (Rehfuss, Gambrell, & Meyer, 2012). However, P-G fit remains empirically understudied as a concept among career counselors. For the purposes of this analysis, the relationship of interest is primarily P-G fit since group membership related to professional identity depends on the heterogeneity of group membership. As described in chapter one, heterogeneity of professional groups are essentially standardizations of scope of

practice, common codes of ethics, professional organization, and other such formal group identifiers.

With regard to Rehabilitation Counseling specifically, several identity studies are relevant. See Figure 1. First, several studies exist on the roles, functions, knowledge competency areas, or skills of counselors (Leahy, Chan, & Saunders, 2003; Leahy, Muenzen, Saunders, & Strauser, 2009) and a similar one done with life care planners (Pomeranz, Yu, & Reid, 2010). These studies have provided valuable information for the purposes of training, certification, and accreditation of counselors and programs. Results of these studies help demonstrate what abilities and skills are required to become a professional rehabilitation counselor and many of the identity debates have surrounded these studies. These studies have also been used as justification for unifying the profession under the umbrella of the American Counseling Association, a move considered by some to be a stripping of a disability/vocation-focused identity. These two studies can be categorized as studies of P-J fit because of their interest in abilities, skills, and knowledge domains.

Recognizing the need to focus more on counselors' perspectives on the profession, not specifically on job tasks, Fleming, Phillips, Manninen-Luse, Irizarry, and Hylton, (2011) asked counseling students specifically about their views on their professional identity. Based on previous literature that explained rehabilitation counseling identity as split into two parts, surveys asked students which group they primarily identified with, mainly counselors with the specialty of working with people with disabilities on vocational issues or whether they were more clearly a discipline separate from the counseling profession. These studies emphasized the cultural orientation of counselors as if the profession were a single organization inquiring about their

citizenship behaviors and is categorized here as P-O fit. What remains are no known studies on P-G fit.

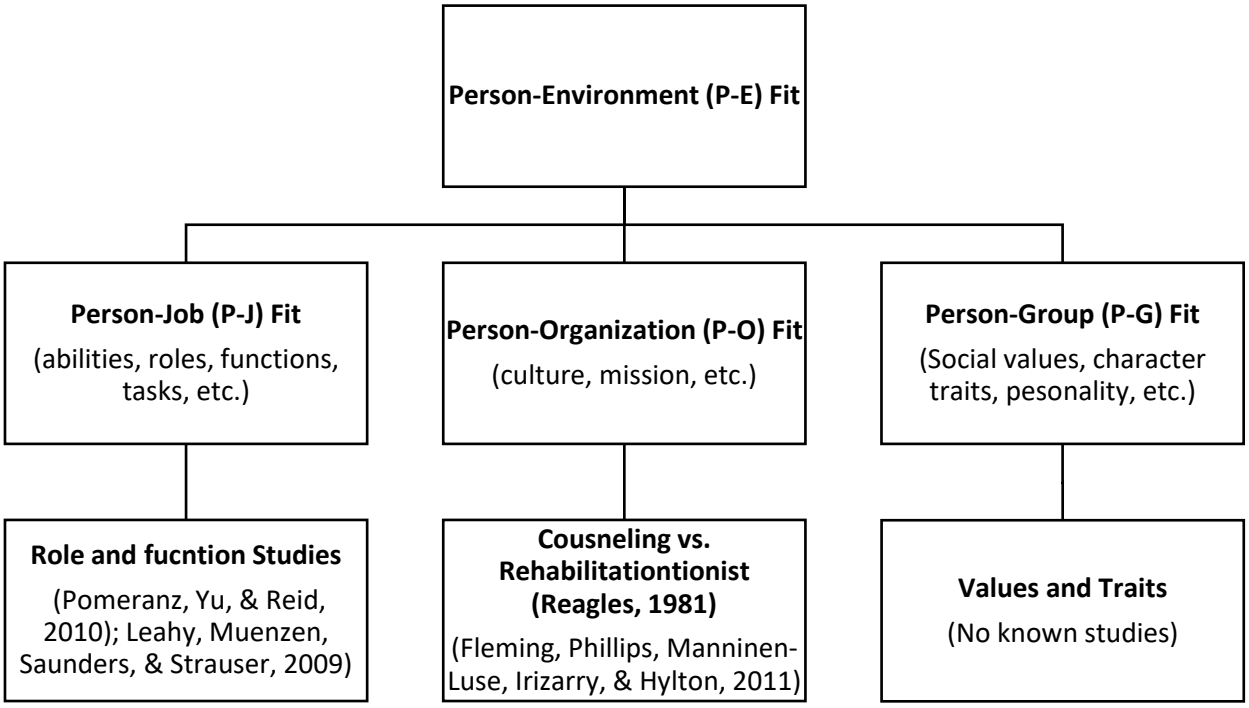

Figure 2. Rehabilitation Counselor's Professional Identity Fit

P-G FIT

P-G fit relates to the way an individual fits within their social working group. In the counseling world, new counselors enter the field and are often influenced by the people they meet, assess their inclusion to different working groups based on comparison of themselves and the group, and then decide on a career path. This rough sketch of the process does not do justice to what elements the individual considers when evaluating likeness and interest in group participation.

In order to understand the different kinds of considerations that go into P-G fit, it is first helpful to understand two concepts: supplementary and complementary fit. Supplementary fit occurs when "a person supplements, embellishes, or possesses characteristics which are similar to

other individual in the environment" (Muchinsky & Monahan, 1987, p. 269). Complementary fit occurs when a "weakness or need of the environment is offset by the strength of the individual, and vice versa" (Muchinsky & Monahan, p. 271). In other words, a person might find sameness with other members (supplementary) or fills a need that the group does not possess (complementary). According to Seong and Kristof-Brown (2012), supplementary fit relates more to shared values or traits with the group and complementary fit relates more to abilities that the group benefits from. While this has been the subject of some debate, the three concepts of P-G value fit, P-G trait fit, and P-G ability fit remain generally consistent across research efforts.

In Seong and Kristof-Brown (2012), these three concepts were tested as individual predictors of overall group fit. Interestingly, prior research on social identity theory suggests that values-based fit is more predictive of overall fit than trait-based fit (Kristof-Brown et al., 2005). Abilities-based fit is even less predictive of individual attitudes to group fit because it is a more performance-based measure, which means people maintain membership to a group in this way if they are able to perform the tasks. While all three of these measures are important for P-G fit, one would expect the topic of identity to be more related to values and personality than ability. Based on this research, if counselors in both the public and private group claim their identity to be that of a rehabilitation counselor, then one would expect them to have similar values. Since the ethical code of the rehabilitation counselor is based on a set of values and there are claims that private counselors are unethical, then one might expect to observe a different set of values. Said differently, if rehabilitation counselor life care planners describe a different set of values, then perhaps personal identity differences are more salient than role and function studies of the field would suggest. (Pomeranz, Yu, & Reid, 2010; Muenzen, Saunders, & Strauser, 2009).

VALUES AND TRAITS

The term values describes a wide range of definitions among career theorists. In fact, fourteen of the seventeen major career theories include values as an important consideration in career satisfaction (Patton & McMahon, 2006). Despite the recognition of the importance of value considerations in career satisfaction, career interest has gotten the bulk of the attention in career theories (Brown & Crace, 1996). Part of the reason for this may be that one of the initial theorists to develop a strong value model, Donald Super, believed that work values are not directly observable (Dunning, 2010). Instead, career values 'show themselves' through behaviors as individuals attempt to meet psychological and physical needs (Super, 1995). In this sense, career values are more fundamental than career interests and thus more significant in their affect on career satisfaction. Super operationally defines work values as "goals or objectives sought through engagement in work" (Super, 1973; Super & Sverko, 1995). In other words, values are expressed based on the actual work duties that one performs.

The reason that values play such an important role in vocation and career is that they represent a more stable construct that is foundationally based on human needs. Thinking of Maslow's hierarchy of needs, Bluestein (2006) theorizes that work serves some essential functions including survival and social connection (Dunning, 2010). In this sense, compensation for work meet the basic needs of food, water, safety, security, etc. and social connection meets the needs of belongingness, love, and esteem. Dunning (2010) describes several studies demonstrating that social connection is important to people of all ages. What is important to emphasize is that values play a fundamental role in guiding the vocational decisions based on the needs of people. In the context of this study, one of the value statements about rehabilitation life care planners is that profiting from people with disabilities implies that these counselors are profiting beyond the basic

needs as described by Maslow of food, water, safety, and security. The goal for this study will be to understand the values of rehabilitation counselor life care planners, particularly about how values shape their professional identity and fit with the larger profession of rehabilitation counseling.

In terms of both values and traits, one of the most popular models for understanding how they connect people is John Holland's theory of types. In this theory there are six personality types: Realistic, Investigative, Artistic, Social, Enterprising, and Conventional. All people have a primary type which shows up more prominently in their personality and career choices, as well as both secondary types that are less prominent but still represent the values and traits of the individual. All workers represent some combination of these main types and all jobs are best suited for some combination of these characteristics making this a version of P-E theory.

As an example, most counselors have 'Social' as their primary type. The social type according to Sharf (2006) expresses values of altruism and have traits of being talkative, particularly about social relationships. However, counselors may vary greatly in their secondary types such as being Investigative and valuing scientific endeavors or being Artistic and valuing creativity and emotional expression.

Interestingly, the primary occupational tool in use today which describes the primary values and trait profiles is the O*Net. It is developed and maintained by the U.S. Department of Labor and provides profile data based on Holland's theory. The Holland code for Rehabilitation Counselor is Social-Investigative demonstrating a trait profile based on frequent communication with others and extensive mental problem-solving. They also give a profile of values of Relationships, Achievement, and Support. It is unclear how these traits and values were

established and how well they represent the value and trait profile of rehabilitation counselors across the profession.

INCOME AS A FACTOR OF CAREER CHOICE

While it may seem out of place to describe a single factor of career choice like income, it is helpful to understand the function of money as a transaction for services, as well as how it affects people's choice in a particular career. As cited earlier, Bluestein (2006) describes one of the core functions of work as meeting the needs of survival, meaning income serves a primary purpose in career decisions and ultimately professional identity. Several studies describe financial considerations as an important factor in job satisfaction. Cable and DeRue (2002) began some initial research to weigh out factors related to career satisfaction. They found that *needs-supplies* **(**N-S; i.e., rewards returned for services) was perceived as more important to employees than *person-organization* fit (P-O; i.e., congruence between personal values and organizational culture) and *demands-abilities* fit (D-A; i.e., congruence between skills and job demands (Cable & DeRue, 2002). However, other studies rank P-O as most important when N-S or D-A is low (Resick, et al., 2007) and that proactive personalities positively relate to career satisfaction, but only with high P-O and D-A fit. Finally, in a study of over 450 counselors, Rehfuss, Gambrell, & Meyer (2012) concluded that P-O and N-S were the only significant predicting factors related to career satisfaction. In other words, evidence suggests that payment in return for services is a primary concern for workers, except in jobs were compensation is lower, then congruence between organizational values and personal values becomes more important. If this is true, one would expect counselors who believe compensation is inadequate would emphasize the importance of fit between personal values and organizational culture. On the other hand it could be argued that those who believe their compensation is adequate for the services rendered are less reluctant to

discuss the importance of money. It may be the case that counselors who report a higher income are more comfortable discussing financial matters.

In the current context of this study, this makes sense that private rehabilitation counselors whose compensation needs are being met may report job satisfaction in terms of adequate income. It also would make sense that counselors who are lower on the rehabilitation counselor pay continuum would consider value and ethical considerations to be more important when considering their job satisfaction. Although no data is available on the importance of money based on differing occupations, it seems reasonable to suggest that it is possible that those in private practices whose job security depends on their ability to manage money, while those who are salaried may not spend as much time having to think about money or their income because it comes in at a steady rate. Also interesting, the Rehfuss, Gambrell, and Meyer (2012) hypothesized that all three types of job fit would be interrelated and significantly impacting one another. *Demands-Abilities* is the concepts that is most related to historical conceptions of job fit and is used in many standardized applications of job matching is not reported as being most important to job-satisfied workers.

SUMMARY

Given the historical expansion of the practice of rehabilitation counseling and the need for people with disabilities to involved in legal disputes over paying for long term care, the rehabilitation counselor is a natural fit for the practice of life care planning. Some studies have attempted to show this by describing the roles and function of the work, but they have neglected to describe the type of character traits and values that would be ideal for this work. Chapter one gave a description of why qualitative analysis is an ideal method for analyzing these values and traits, however the approach to assessing career fit between employees and their jobs has largely been driven by quantitative assessments that rest on positivist assumptions. As a result, the Person-

Environment Fit theories in the field of rehabilitation counseling and life care planning has missed investigating social group factors that play a central role in career satisfaction. Also, given the importance of the role that income has played among private rehabilitation counselors, an overview of the role of income was also included. These factors have contributed to a lack of understanding of the traits and values of rehabilitation counselor life care planners, and ultimately contributed to the identity challenges of the field.

CHAPTER III
METHODOLOGY

OVERVIEW

This chapter describes the design of the study and the methods used to collect and analyze data. The purpose of this study is to identify values and traits to assess the P-G fit of counselors in the specialty practice of life care planning. In order to do this, a specific qualitative methodology is described. The value of qualitative research comes through methodological rigor and the establishment of trustworthiness. While previous chapters have discussed some of the foundations of qualitative research, the role of the researcher, and my personal approach to the project, this chapter will focus solely on the methodological practices of conducting the research project.

PARTICIPANT SELECTION

The sample participants are rehabilitation counselor life care planners who are 1.) members of the International Association of Rehabilitation Professionals (IARP), particularly the life care planning section titled the International Academy of Life Care Planners (IALPC). 2.) The participants have graduated from a master's level rehabilitation counseling program accredited by the Council On Rehabilitation Education (CORE) or the Counsel for Accreditation of Counseling and Related Educational Programs (CACREP) and are a Certified Rehabilitation Counselor (CRC). The criteria to identify life care planner is two-fold. Either the participant is 1.) a certified life care planner (CLCP) or 2.) they have been practicing as a life care planner for over 15 years. A significant number of the population of life care planners began practicing near the inception of the practice prior to certification in 1996, which establishes credibility within the field and among other life care planners. These were chosen as the only other exclusionary criteria in order to gather the people with the most experience and the widest range of demographic attributes.

Following Institutional Review Board (IRB) approval and permission from the International Association of Rehabilitation Professionals (IARP) to conduct research with their members, I began contacting members to invite them to participate. Several colleagues knew that I was working on a research project and had volunteered to participate, so I had emailed them to request an interview time during the conference. Given relationships already established with other members of the target organization, the primary method for gathering participants was using a snowball sample. I began letting people know during conversation that I was engaging in a research project and gave them the opportunity to email me if they were interested in participating. They were also made aware that I was seeking other participants and that they could direct others to contact me via email with interest. As it turned out, the best method for finding the most participants was to find one person who had a significant network and who also garnered respect from peers. This person was able to help with the collection of participants. Much of acquiring participants happened while at the conference research site where I was able to accept participants in person. Several of them had talked to someone who had previously interviewed and they approached me stating that they would be willing to be interviewed.

There was a total of eight participants with demographic data represented in Table 1 (See Appendix B for the collection tool). Interestingly the demographics of the sample were not representative of the life care planners as a whole, however this may be to some advantage for the present study. Compared to a 2010 study of the roles and functions of life care planners that also included demographic information, the participants of the present study were of greater experience and more advanced age than the general population of life care planners (Pomeranz, Yu, & Reid, 2010). The benefit to the present study is that the additional experience and time in the field of the counselors may provide greater insight into what values and traits are the most desirable.

Additionally, the relative balance of representation of plaintiff and defense case ratio provides some range of traits and values based on who hires them.

Table 1. Demographic of Participants

ID	Age	Years in Practice	Employment Status *	Plaintiff/defense case ratio
Erica	46	25	Self-employed	50/50
Lauren	37	13	Employed by firm	70/30
Luke	70	40	Self-employed	50/50
Janet	61	38	Self-employed	60/40
Johann	57	24	Self-employed	10/90
May	55	20	Employed/ Self-employed	50/50
Elaine	63	38	Self-employed	50/50
Diane	63	36	Self-employed	75/25

Note. *Within the role of life care planner most participants consult as self-employed, however some hold other positions which are undisclosed to protect identity.

SITE SELECTION

Rehabilitation Counselor Life care planners come from all over the country, however they gather annually at a conference put on by the International Association of Rehabilitation Professionals (IARP). This made it an ideal place to conduct as many of the initial interviews as possible. While some were willing to devote time during the conference, others were not available during this time. Given the nature of snowball sampling, it took the initial participants some time to invite others to participate, so some interviews took place via phone following the conference. Also, this is a valuable time for the community to network, earn continuing education credits, and consult with colleagues, so some requested following up via telephone following the conference. Of the eight participants, three were interviewed in-person and five were contacted telephonically. Participants were given the option to interview in a private location of their choosing, however all

in-person participants chose to find a semi-quiet space near the conference location. Some even commented on appreciating the visibility of research being conducted and preferred the public exposure to research over their anonymity. For those interviews that happened over the phone, all interviews were conducted from my private residence where recording quality and privacy could be assured.

DATA COLLECTION

The study was not considered to be of a 'sensitive nature' by the Institutional Review Board of the University of Iowa, so participants were not required to provide written consent. Verbal consent was attained after describing the study to the participants (See Appendix D), the length of time it would likely take, and how confidentiality would be maintained during the study. I explained these items and began recording to collect their verbal consent on record.

The data was recorded using the free software program called Audacity on a Microsoft windows 10 system. A Yeti Blue USB microphone was attached to collect sound and the files were subsequently saved into an encrypted partition using Veracrypt software. A handheld digital recorder was also used as a backup device in case of technical difficulties with the main recording devices, however the recording was deleted once I confirmed that the file was successfully saved in the encrypted partition. Essentially I would save the file as soon as the interview was complete and delete the digital recording on the handheld device to ensure security.

The interview was conducted using a semi-structured interview (See Appendix A) (Bogden & Biklen, 2007) and is a common method used in qualitative analysis (Stevens, 2014). Following verbal consent, I was able to collect demographic information to ensure suitability for the study, which will be shown in the following chapter. The list of questions in Appendix A provided me guidance as a means to focus the interview, however I wanted the participants to have the freedom

to respond in whatever manner they wanted. While a structured interview has the advantage of increasing trustworthiness within the group, semi-structured interviews allows for more probing into the internal processes of the individual. In this study, it allowed the participants more flexibility to navigate toward those topics of interest. With flexibility comes concern over quality (Roulston, 2010), however quality criteria outlined by Kvale (1996) was used to ensure richness in the data. For example, Kvale (1996) describes the quality of an interview coming from the extent to which the interviewer speaks only to ask simply, open questions and then probe for clarification (p. 145). The interview itself should be "self-communicating" or not requiring additional description or explanation (Kvale, 1996, p. 145).

The semi-structured interview questions used in this study were written to allow the participants to not only tell about their traits and values, but to show them as well. As Super (1995) states about career values, they show themselves through behavior and are not simply a catalogue list of words to be shared. For this reason, the questions were few and open. As an example, asking someone about motivating factors for getting into life care planning helped establish values used in decision-making when entering the field. While some participants stated that it was a way to help people or create social change, others 'showed' that it was more of a natural extension of their current work, a supplement to their practice that created more job security. These answers came out of selectively attuning to details in the participant's answers to the initial questions.

Two other significant questions asked about a person's identity as a professional (see question three and four in Appendix A). The first asked about what goes into their view about their identity as a rehabilitation counselor or life care planner. This was intended to begin guiding the participant toward self-reflection of their own qualities as a professional and led to discussions of behaviors and life events that motivated them to move into the field. The second question asked

them to think of a metaphor that describes their work, which helped think about a greater range of qualities that are helpful in a successful life care planning career. For example, Erica stated that her life care planning practice reminded her of the Hemmingway novel, The Old Man and The Sea. In that book, the main character travels out to sea alone in a small boat, catches a great fish, which is then eaten all away as it is dragged home. She used this to describe the loneliness of working alone at times, the hostile environment, and the need to retain an illogical amount of hope and optimism at times. Using a question that requires more creative interpretation provided some of the most rich and interesting responses. I generally avoided great amounts of interpretation of the meaning of the metphors in order to allow the content of the participants words to not be taken too much out of context. In hindsight, more questions allowing the participants to allow the participants to attach their own meaning to the metaphor like who they identify with in the metaphor and why could provide some very interesting results. However,while some participants were able to easily respond to these questions, others required more follow-up, perhaps indicating that a mix of questions requiring conventional fact-based answer and others that require creative interpretation is best. Regardless,t the questions used in this study were written so that the responses were not guided in anyway and that the responses were purer to the participants experience. This was simply a strategic choice to allow the participant words to speak for themselves, however the development of more creative questioning could be interesting.

DATA STORAGE

Audio recording of the data was collected using my own personal computer and an external microphone. The recordings are stored under a 256-bit encrypted partition of the hard drive which are unmounted when not in use. The software to encrypt the data is an open-source program called Veracrypt and ensures that data cannot be accessed even if the laptop is stolen, as long as the

partition is unmounted. Using this software means that the data is behind a double-lock, one password to access the Windows operating system environment and another to access the files themselves.

CONFIDENTIALITY

Most counselors are likely familiar with the idea that deep and honest opinions are difficult, if not impossible, to share without trust in the researcher and the research process. The qualitative process of collecting rich descriptions then requires deep and meaningful disclosure of personal opinions. In order to do this, confidentiality must be assured to the participant. As an initial step, Institutional Review Board (IRB) approval was acquired prior to any data collection to ensure that the anticipated methods provide the adequate protections to participants (See Appendix C and D).

An initial protection is to deidentify participants using unique identifiers such as false names or a number. As a professional preference, some of the humanity of participants can be maintained by using a false name instead of a number. I kept a record to which false names were associated with the correct ones, so a spreadsheet was made with names, identifiers, and contact information. The reason this connection must be maintained is for the process of member checking, which will be described below. This data, like all of the rest, was kept under password protection and 256-bit encryption which provides dual password protection. The encrypted volume was maintained on my personal computer in a separate partition using as separate password for security purposes.

DATA ANALYSIS

Data analysis for this project began following the advice of Charmaz (2014), “let your research problem shape the methods you choose” (p. 27). As such, following the first interview

and the initial analysis of the data I was able to better adjust questions and coding strategy based on the success of gathering rich data. Both the questions asked to the participant during interviews and the coding techniques below are tools to establish underlying meaning. Just as a counselor may reflect on their use of specific language, body posture, formal assessment, and the environment in determining therapeutic benefit to the client, so too the qualitative researcher continually adjusted in order to gather the 'best' data. With that said, while the tools changed, the methodology of coding processes remained consistent.

What that meant in this case was that the transcription software tools and recording device were on the same personal computer, so I was able to begin the first of several cycles of data analysis by listening to the recording and beginning transcription. While none of the transcription was completed in this manner, it gave an opportunity to adjust the questions and the strategies used to glean information from the participants. As an example, one of the questions asked the participants to describe their work using a metaphor, however it was a question unlike the others and the first participant had a difficult time with it. So, in order to help the participant think of another way to answer the question, I asked the next participant if there was a particular movie, song, piece of writing, or work of art that came to mind when thinking about her work.

One of the goals of analysis for this project was to become as intimately familiar with the data as possible in order to encourage deeper analysis. I eventually worked through each transcript several times with a specific intention each time. The first cycle was the interview itself and the second was the above described initial review. The important thing to note about the initial review was the intention to avoid bias in future interviews, meaning I paid particular attention to the potential for confirmation bias, or the tendency to lead future participants toward answers that would be similar to emerging categories established by the first participants. To protect against

this, I not only focused each cycle on a specific task to help stay on track with a particular objective, but also kept a journal to help 'filter' biases out of the project. At the very least, biases were brought to light during the journaling process that helped me maintain objectivity. A good example of this came up during the interview with Luke. It became clear through the first interviews that one of the most obvious themes emerging was the tendency of a life care planner to be a teacher, trainer, or some sort of educator, however Luke did not talk specifically about educating in the same language as others. He did talk about being a salesman of ideas, which in many ways is similar to the ideas of educating. As I went into the following interviews, there was a tendency to want to talk about ways in which other participants discussed these ideas of sharing information, but it was important to allow the interviewees to not have these ideas 'planted' into their minds to taint their personal views of their own or ideal traits of others.

It was mentioned above that the first cycle was the interview, the second was listening to the recordings of the interviews. The next cycle was the transcription process itself, which I did personally in order to further acquaint myself with the data. By the time I began to code the transcripts, I had already been through the material three times. What follows is a description of the coding procedures as outlined by Saldaña (2009). The reference to the cycles of analysis and what Saldaña refers to as "coding cycles" are essentially separate passes through the raw data in order to familiarize and move deeper into the content. While both serve the same function, they can be seen as separate processes, cycles of analysis and cycles of coding. This can potentially be confusing, but to clarify, by the time I began with the first coding cycle, this was actually the fourth time I had been through the raw data. What follows is a description of the coding cycles. By the time the coding was complete I had been through the data a total of six times with a different focus

each time, essentially to comb the data for different types of content. The initial coding was not done until all the transcription process was complete.

Saldaña's first cycle methods are considered "fairly simple and direct" (2009, p. 45). Organizing the data into meaningful chunks, stanzas, and selecting a coding method are part of the first cycle. What he refers to as Attribute Coding was a simple collection of participant demographics in this study. It was an opportunity to see if there were any major themes in age, level of experience, or other category relative to the content. It was particularly important for this project to see if there are different traits relating to generational age differences or advocacy orientation given the context of the development of the practice. This initial process was more an organizational tool and another layer of reflection rather than an interpretation of meaning. The following coding methods require more analytical skill to synthesize the data for the purposes of extracting meaning from the participant and understanding emerging themes.

The second coding cycle began with In Vivo coding of each transcript in order to start pulling out meaning, but also to avoid biasing future analysis with my own language. The hope was that by using the participants own language, it would provide more justification for the established themes to follow. As Saldaña (2009) writes, it allows the study to "prioritize and honor the participant's voice" (p. 74). Again, the goal here was to simply describe what the participant actually said before introducing my own interpretation.

Following In Vivo Coding was Descriptive Coding, which was the first time I began to describe the participant's meaning while also keeping in mind the goal of the study to find traits and values in the material. For example, both Johann and Diane discussed getting into the practice of life care planning at a time when they had growing families and the need to provide for them. So, descriptions of 'provider' and 'independent' were used to describe some of the traits and

'financial security' described a value. Sometimes these descriptor words were describing a single word or phrase and other times it was used to describe as much as the paragraph in order to provide context in which certain traits or values came up. This was important to understand what the participant was saying relative to the context of the rest of the interview, as well as the development of the field which will be discussed in following chapters.

The next cycle of coding combined two other coding strategies. Values coding, or capturing "a participant's values, attitudes, and beliefs" about "oneself, another person, thing, or idea" (Saldaña, 2009, p. 89), and Holistic Coding, or 'chunk' the data into larger blocks of meaning or content. Values Coding was important for hopefully obvious reasons, but the way in which it was used was a bit different. The purpose of this study is to describe the global values of an individual, but many of the values that arise during conversation are very specific to individual people, things, or ideas. As an example, one participant described the occasional lawyer as being 'so perverse that they just enjoy tying you in knots like a pretzel for the fun of it" and the need to have "backbone" to cope with those situations. This was used as a value judgement toward the occasional occupational hazard and would later become evidence to describe a personal value of staying grounded in the humanity of the rehabilitation process, but it needed to be identified as a value judgement first. Holistic Coding is used to capture meaning out of large portions of text, often as a time-saving tool or to understand the broad topic of the text, however in this context it was helpful as a way to pause after several passes through the text and reflect on the 'big picture.' After taking a very detailed look at small portions of text and intricate meanings, it was an opportunity to step out of my frame of reference and make sure nothing was missed. The reason this was done in conjunction with Values Coding was because it was the last of the detailed coding

of individual transcripts before combining codes into themes between participants and it gave the opportunity to reflect on the interview itself as a single unit.

The final process in coding was to combine each participant's codes together to establish common themes among all participants. This was done by weighting the established codes from each participant based on frequency and salience. The outcome of this process can be seen in Table 3 in the following chapter. While frequency refers to how often the trait or value was mentioned, the salience refers to the importance or stress that was placed on that specific idea. For example, a common theme that arose at very key and emphasized times was the importance on having high levels of intelligence and performance in certain areas. This was not mentioned often, but when it was mentioned, it was done with reluctance and poignancy. When frequency and salience were taken into account, established themes were made by making a shortened list based on the frequency of codes, then those codes were given a one through three score to show the salience of that particular code for that participant. What this looked like was taking all of the codes for traits from each participant and grouping them together in a spreadsheet. This list was then reduced to a list of 20 codes.

Next, I established a weight score for each of the 20 codes for each participant. Once this was done for all participants and looked like a matrix of scores, which were then used to establish a shorter list of themes based on which codes appeared to be the most salient among all participants. In some cases, a simplified word to describe the theme was used and sub themes were established based on similarities among the trait or value. As an example, the way participants talked about money differed among them, but they all described some sort of financial awareness. In May's case, it was responsible to establish reasonable costs in a care plan that are not only reasonable for the person with a disability but also are responsible in a larger social sense,

presumably since ultimately all people somehow absorb the costs of medical care used by individuals. In other cases, the need to address the value of one's work was about putting a dollar amount on services based on free market principles, such as higher fees being a representation of the credibility of the profession in Luke's case. Ultimately, what came out was a list of traits and another of values that describe what the participants discussed during interviews.

ESTABLISHING TRUSTWORTHINESS

POSITION STATEMENT: REFLECTIONS ON SELF AS A RESEARCH TOOL

According to commonly held qualitative methods, the researcher is the "*primary instrument for data collection and analysis* [italics in original]" (Merriam & Tisdell, 2016), meaning my personal perspective is not something to be removed from the data analysis but to be understood as intersecting with it. This is different than viewing the scientist as a developer of empirical results devoid of any influence during the research process. Therefore, it is useful to understand how I came to the questions that drive this study and how I intend to approach them. The goal then is to build trust in the reader that the research results come from the participants and not from preconceived notions or biases of the researcher.

The impetus for this study begins from personal experience and listening to the stories of others. Being heavily invested in the rehabilitation counseling and life care planning communities I read professional opinions in academic journals, attend presentations of experts in the field, and hear stories from people entering the field. I learn about who they are, who they want to be, and what career options are available to them. While much of what we learn about our profession comes from formal writings or presentations, there is a significant difference between what people are willing to write in a textbook and what they will tell you over dinner. These dinner conversations have made me curious about what counselors think outside of academia and the

forces that guide decisions unknown to the decision-maker. They have led me to investigate the informal opinions of counselors because they lead to a different understanding of a person's views.

During the first year of my master's program I was given a textbook from two well-known authors in the rehabilitation counseling field and asked to read about the history of the field. The challenge was that while the book described the field one way, I was hearing other anecdotal messages from professionals in the field. I was also regularly introduced to guest speakers working in the general rehabilitation counseling community which introduced us to different career options. Through this I was learning that formal writing and informal explanations were both essential to a fuller explanation. Both were very informative and helpful in developing my own sense of direction, but I was still left with a feeling that I didn't fully understand exactly what the field had to offer. At first I thought I was perhaps a just a restless soul, but during the first year of my doctoral program I was introduced to the idea that there has been confusion among counselors for years and that current changes have reinvigorated the debate about identity (Stebnicki, 2009). Consequently, identity conflict means that students are not feeling a strong sense of unified identity as they leave training and enter work (Fleming, Phillips, Manninen-Luse, Irizarry, Hylton, 2011).

As I continued to learn about the identity struggles, I began to expand my search to the far reaches of the field to understand the scope of professional options available to students and I came upon a group that has been around for decades but was only given a tertiary explanation in texts. Perhaps it was a chapter at the end of a book (Rubin & Roessler, 2008; Shaw & Betters, 2004), if at all, or a comment about "some other group" mentioned in a master's course. I started to read books about the world of private rehabilitation counseling and gained a qualitative understanding of what clients they serve, where funding sources come from, what lifestyles they live, and what values they hold. What I learned is that there is a world of 'public rehab' and 'private rehab,' and

they are not the same. As I assimilated to this professional culture I started to grow some sense about how they were different, but I didn't understand what exactly made them so. I knew that public counselors often worked for the state or federal Veteran's Administration system and that government money paid both for their services and their salaries. I knew that there were others who worked in the community who were technically private for-profit or non-profits companies who served people with disabilities, who's paychecks mostly trickled down from state health departments or county funding in the form of waivers (Riddick-Grisham & Demming, 2009), and who shared the same general ethic of 'advocacy for the underdog mentality. What I also learned was that the 'other people' worked in private businesses but often they worked for themselves and were paid either by insurance or through legal fees. Also, the overwhelmingly common statement that accompanied explanations of life in the private sector of rehab is that 'they can make a lot of money.' It always struck me as a strange way of describing a career path as both alluring and disgusting at the same time. Something about the way it was being described was both discouraging and enticing.

I began to explore the world of private rehabilitation counseling by asking myself how the money makes a difference. Many of the people who work in private rehabilitation either work for themselves as sole-proprietors or limited liability corporations (LLC) as business owners, as opposed to employees of the state. The emphasis on self-employment means more managing money and paying attention to revenue. In some sense there is a political divide between those who are comfortable with the capitalist system of competition driving excellence and the potential to be rewarded for that excellence by profit making. Then there are those who believe that an economic system is only good insofar as it meets the needs of all people and a collective distribution of goods and services is superior. It is Adam Smith versus Karl Marx. It is Republican

versus Democrat. It is Good versus Evil. It is the polarization that plagues the times as the marking of American social life. Despite role and function studies describing the common core functions of rehabilitation counselors across the spectrum of career paths (Leahy et al., 2009), there was still a sense that somehow money and its effect on improving the lives and overall social status of people with disabilities made the difference.

Life care planning is a practice that was born in the legal system by rehabilitation counselors and nurses. Due to the legal requirement of having the most current, scientific, and expert advice (*Daubert v. Dow Merrill Pharmaceutical, 1993*, *General Electric v. Joiner, 1997; Kumho Tire Company v. Carmichael, 1999)*, counselors who hold this expert status can consequently charge for it. As a result, life care planners are considered to be some of the highest earners in the field and are a perfect candidate for a study on the values and traits that make them successful and satisfied in their work with people with disabilities.

As I will show later, it is not just their income that is a source of contention but what they do to get it. Having expert knowledge and being compensated for that does not seem to be related to the identity challenges of the field. Rather it seems to be those who, whether they have knowledge or not, are willing to shape their professional opinions to the highest bidder, known as a 'hired gun' (Dunn, 2017). The legal system is full of stories of 'experts' using assessments and "professional opinions" to help lawyers win cases and make money, rather than being guided by an ethic of supporting objectivity, justice, fairness, and equality. Much of the field of rehabilitation counseling seems to live by the ethic that our social system disadvantages people with disabilities and therefore advocacy to promote the social status of people with disabilities is central to the rehabilitation counseling identity (Bruyere, 2000; Kyong Jeon, 2014; Waldmann & Blackwell, 2010). Those who work for an insurance company doing vocational assessment or life care

planning, which are sometimes used to deny insurance claims, are seen as essentially on the wrong team. Again, despite a scope of practice and code of ethics that claims the role of the life care planner is to use objective and factual information free from bias, the concern is that it simply doesn't happen, and their high earnings are a reflection of that. Whether a counselor's motivations for engaging in certain type of work is known or not, the suspicion exists.

In full disclosure, I am a certified life care planner, I sit on the International Academy of Life Care Planning board, and I associate with life care planners regularly. If I were reading this I would automatically suspect collusion and bias. If I were a life care planner I would be nervous about what might be said about 'my people.' I would suspect that in some way I am using my high educational status and veil of scientific objectivity to prove that life care planners are good-hearted people who are just better than everyone else. I would be suspicious of 'confirmation bias,' the idea that the data will end up proving what I already believe to be true. I admit, I am both an optimist and cynic at the same time. I believe there is more in common among life care planners and the rest of the rehabilitation field than there is different, an opinion also held by others within the practice (Robinson, 2014; Weed, 2014). I also believe that all science has the potential for error. Scientists and researchers are people and if they are guided by the ethics of ego and vice, the data will reflect that. If bad data or bad process are introduced to even the purest system of inquiry, the whole thing is tainted. Or, "garbage in, garbage out" as the saying goes. What I hope to do in this study is to argue that this problem exists, but the methods have the potential to reduce the amount of bias as much as possible. While I am to be considered the primary instrument of the study which cannot be removed from it, it is the rigor of the qualitative research process, constant reflection on the self as a research tool, that instills confidence in the reader that biases are controlled for as much as possible. The hope is that the outcomes are the truest possible

representation of the feelings from the participants. However, the purpose of this initial commentary on my background is to build trust in the process and my intentions as a researcher. I recognize the need for trust in the tools of scientific inquiry, which in this case is me.

I will do my best to be transparent about my process of discovery. I will do my best to acknowledge the influence that my personal and professional identity has on the way the data is represented. The question in the back of my mind will be, "How does who I am affect this process?" (Hill, Glaser, & Harden, 1998). This feminist mantra acknowledges that whether as a counselor or a researcher I am a powerful tool in the discovery of truth. It also acknowledges that this power can be abused. Knowing full well that my biases and perceptions on the profession of rehabilitation, the practice of life care planning, and the research process have the potential to skew and slant, I hope to establish a transparency that instills confidence in the data. This is my commitment to the study, to the profession I value, and to my own integrity. May my decisions be wise and my heart be open.

BRACKETING

The description of the impetus and motivations of the project was given in order to build some of this trust in my process and intent. This is often referred to in qualitative research as *reflexivity*. It is the critical self-reflection that builds trust with the reader that I had engaged in the scientific process of discovery, not necessarily an agenda involving ulterior motives. Reflexivity is essentially a term referring to the position of the researcher and the tool for maintaining this position is called *bracketing.* "Bracketing is a method used by some researchers to mitigate the potential deleterious effects of unacknowledged preconceptions related to the research and thereby to increase the rigor of the project" (Tufford & Newman, 2010). This was perhaps the most

difficult part of the study due to both the design choices and potential for personal bias given my position as a life care planner and private practitioner.

The practice of bracketing was a challenge in several ways. First, if the primary tool for extracting deeper meaning from the participants is myself as the researcher, a more probing, unstructured, interview would have been a good choice. The reason for choosing a semi-structured interview was to avoid biasing the participants to answer in a certain way. Due to my prior understanding of who life care planners were and what they do for their work, I came in with certain expectations about their responses. As will become apparent in the results section, the role of the educator is a primary part of the life care planner's identity. Even before the interviews I had suspected that this would be a primary theme when asking life care planners to describe what qualities made the ideal practitioner. However, as I progressed through the interviews the theme of education came up in unexpected ways and I was interested in asking additional questions such as, "in what ways are life care planners educators." However, my choice to follow my script was done in an effort to reduce bias by leading them to the theme that I expected to see. What I saw as more valuable was letting the participants venture their on their own to reflect their own believes and language without suggestion from me. However, without the ability to probed deeper into themes that seemed valuable and to develop, a deeper analysis of the interviews was essential.

There was another challenge related to the balance between remaining objective in my questioning and accepting and stating my bias in order to develop a deeper understanding with the participants. The process of analysis requires interpretation of the participants ideas which is a somewhat subjective position. The following chapter will dive a little deeper into my subjective process during the analysis of the results, but it is important to state here that certain decisions were made remain objective while others were made to acknowledge my own subjectivity. For

example, rehabilitation counselors are often trained to place individual into jobs based on their best qualities. This is known as having a strengths-based approach to counseling. It is not simply a process of accurately describing traits or values without connotation. It is sometimes taking a client's negative view of their abilities and providing positive feedback that can be used in their work identity, or turning a dysphemism into a euphemism. The challenge I had in this project was that I was making efforts to remain unbiased and let the participants speak for themselves, but during analysis I would sometimes err on the side of euphemism in order to provide outcomes that can practically be used by educators. One could argue that this skews the results by not taking a more critical lens, but it can also be seen as mimicking the participants view of the 'best' qualities of the life care planner, not the worst. This does leave room for the questions about financial motives of private rehabilitation counselor somewhat open for judgement by readers, but I chose this method because I believed that by erring on the side of positive connotations, it would help comfort the participants and encourage more openness in their answers, as well as provide more future benefit to the field. The pros outweighed the cons.

OTHER METHODS OF TRUSTWORTHINESS

Merriam and Tisdell (2016) list strategies for promoting credibility in the qualitative process (p. 259). Some of these strategies have already been described but not named as customary qualitative methods.

The above section outlining coding practices was written to outline the process of engagement with the data. This document serves as an audit trail, or a "detailed account of the methods, procedures, and decision points in carrying out the study" (Merriam & Tisdell, 2016, p. 259). The dissertation process serves as a peer review process, or "discussion with colleagues regarding the process of study, the congruency of emerging findings with the raw data, and

tentative interpretations" (Merriam & Tisdell, 2016, p. 259). These methods encourage trustworthiness in the project, but there are a few more that need mention.

Another practice to encourage correct interpretation is *member checking*. During the coding process, I analyzed the transcript for the participant's meaning. This was then introduced back to the participant to make sure that the correct meaning was interpreted. In this study, I emailed the coded transcript and interpretations back to the participant to allow them the opportunity to correct or clarify intended meaning (See Appendix E and F). This was in the form of a copy of the transcript, a list of traits and values pulled from the transcript, and a narrative description of those traits and values. The narrative report was essentially used to as other questions to clarify or to confirm that I interpret correctly what the participant is 'showing' me through their past actions or current beliefs. While many of the narratives have identifying information, here is a sample of one of them to give the reader an idea of what those looked like.

> [life care planning] takes a constant willingness to learn and build knowledge. Both with evaluees and as a professional, there is a need to be not only a consumer of information but a creator of it as well. You spoke of your work like it is a puzzle that has never been solved. Your job is to investigate this new territory in a methodical way as a means to discovery. In order to do this you need to be fiercely independent, decisive, and tenacious.

The important part of member checking is to help establish credibility, which is the qualitative counterpart to quantitative internal validity (Koch, 1994).

Another method used to encourage credibility was triangulation or using multiple sources of data, such as interviews and documents. This study intends to only analyze interviews, which

can be considered a limitation of the study. However, in developing chapters one and two, several texts were used to understand the nature of the study. These will be used in the following chapters to display results and discuss their implications. As a reminder, in order to understand P-G fit, the individual responses of the participants need to be understood within the larger community group within which they work. While these are not going to be analyzed in the same way the transcripts will, they may be considered contributions to the trustworthiness of the outcomes. Specifically, if the reader is convinced that the problem stated in chapters one exists, then the outcomes selectively screened for in the transcripts represent real and meaningful social practices relating to rehabilitation counseling and life care planning.

A fourth method for encouraging quality analysis was the use of a research journal. This was primarily used for analytic memos, or reflections on the "coding process and code choices; how the process of inquiry is taking shape; and the emergent patterns, categories and subcategories, themes, and concepts in your data" (Saldaña, 2009, p. 32). These are brief organizing notes that encourage qualitative researchers to reflexively think about the project on a deeper level. The journal was also used as a place to keep field notes, or observational notes kept about the responses of participants. The use of analytic memos, field notes, and free-writing helped to organize and clarify the data, as well as keep the primary research tool, my own thinking process, 'sharp and clean.'

SUMMARY

The methods described in this chapter are intended to show the design of the study and how the data was handled to promote credibility. The methods of site and participant selection were chosen to encourage the most salient responses from members of this group who are possibly the most credible sources of value and trait information. The a semi-structured interview was

chosen to allow participants to explore their own thoughts about what makes an ideal life care planner with as little influence from the researcher as possible. While more rich description is possible through a probing analysis of their thoughts, additional layers of analysis were chosen to extract as much meaning from their transcripts to compensate for this. By using these 'cycles of analysis,' thematic meaning could be extracted from the participants responses. In other words, the goal was to remain as objective as possible during the interviews to reduce influencing their answers, then use qualitative tools to extract a deeper meaning. What follows are the results of the analysis.

CHAPTER IV
RESULTS

OVERVIEW

This study seeks to answer two questions. First, it is an seeks to understand how life care planners describe their professional identity and second, it seeks to describe what values and traits life care planners see as important for practicing as a life care planning. The results in this chapter describe the more specific question of what traits and values are described as important for life care planning, however from those results a more general summary of the professional identity of the life care planner can be described. Not only will they be described to best understand the nuances of meaning, but they will include some context for the development of those traits. As was stated earlier, career fit is a process of both being influenced by and shaping a job, so understanding a worker's satisfaction in terms of how those traits and values may influence the profession in the future is essential to predicting satisfaction. In order to understand these traits within the theoretical framework of P-G fit, it will be important to understand how these traits and values look within social groups. Lastly, results indicate that a sensitivity toward income and money is an integral part of both the traits and values, however it may perhaps be misunderstood by those not practicing in this area.

TRAITS

For the sake of clarity, a final list of traits and values is listed in Table 2. It is important to know that these traits and values are not in any particular order of importance or hierarchy. They are listed in the present order in a way that was a natural result of the analysis process. No special care was taken to prioritize these themes.

Table 2. Final List of Results: Traits and Values of Rehabilitation Counselor Life Care Planners

Traits	Values
differentiation	recognizing humanity
educator/performer	integrity
intellectual excellence	objectivity
detail oriented	freedom in work
financial awareness	social and financial responsibility

DIFFERENTIATION

The term differentiation is borrowed from family therapy theorist Murry Bowen. Within the family system, Bowen describes differentiation as the degree to which a family member can balance a) emotional and intellectual functioning and b) intimacy and autonomy in relationships (Bowen, 1975). While he developed this theory to describe family functioning, it has been extended by theorists to explain other kinds of relationships. The Bowen Center for the study of family states that this dynamic can be extended to other social groups. They describe the well differentiated person as someone who "recognizes his realistic dependence on others, but he can stay calm and clear headed enough in the face of conflict, criticism, and rejection to distinguish thinking rooted in a careful assessment of the facts from thinking clouded by emotionality, (The Bowen Center for the Study of Family, 2019). What this means in the life care planning context is that the high pressures of adversarial questioning may lead to accepting positions that favor a particular side or simply losing the ability to maintain one's own position on a topic. Those who are susceptible to persuasion may lack the ability to maintain confidence in their own position when being questioned about the quality and validity of their own work products. Or what is worse, may simply be paid to say whatever is asked of them by legal counsel regardless of its accuracy or effect. In the current context it was described as the trait of "not being easily influenced by others", as being "tough-skinned," as being "confident," and as being "resilient."

The idea of being differentiated in life care planning primarily came when discussing forensic settings. Janet stated the life care planner must have a "little more backbone" to deal with lawyers who seem to "enjoy tying you in knots like a pretzel for the fun of it." She also mentioned that when working for some lawyers, there can be the temptation to say what the lawyer desires instead of what the facts of the case state. This situation requires the honesty to act on one's own beliefs and that whatever payment received for services is not worth selling your integrity, especially when it is "rare to find an insurance company or an attorney or a customer to be loyal enough to sell your soul to."

Luke was another participant who talked about this same theme but in different terms. Coming from an entrepreneurial business and counseling background, he talked about the different nature of relationships in the forensic setting. Using language that more closely represents that of psychological combat or competition, he told stories of opposing lawyers using fear and strategic manipulation to put him in a place where he was "emotional, unstable [and] not feeling confident." He stated that counselors need "confidence in yourself so you don't let people beat you up because you are going to get beat up." With the term differentiation in mind, he was commenting on the need to perform despite adversity and, perhaps just as important, is the need to be resilient when failure inevitably happens.

All of the participants mentioned this theme in some way, that the ability to not be intimidated, to be confident, or emotionally secure in one's self is an essential theme for life care planners working in forensics. This often came along with an assertiveness during the interview that was not shy about correcting my misunderstandings or stating that they did not understand a particular part of a question. The goal seemed to be accuracy and not just agreeing with an other's idea. Another way to think of differentiation is that individuals are able to maintain the ability to

listen to legal questions and respond as clearly as possible so as not to be misrepresented, even when the questioning gets difficult. As Diane stated nicely, "you have to do it [engage with others] anyway even if you're terrified."

EDUCATOR/PERFORMER

Another major theme that all of the participants either made a special point to mention or continually alluded to was the idea of the life care planner being an educator. However, it did not carry to connotation of being a private tutor simply sharing intellectual content, but more of an orator who crafts their material and performs it for people. Erica brought this up in the context of standing trial and sharing information about the plight of people with disabilities to correct misinformation about the real consequences of disability. "I have a captive audience… and when they are in that jury box they have to listen." In another context, Luke talked about teaching as selling ideas to juries, to attorneys, to doctors, and to families. In this sense, the way a person carries themselves and represents their work to others is what builds trust to believe with they have to say. When asked about what metaphor he would use to describe his work as a life care planner, he mentioned the movie Cool Hand Luke. This metaphor represents likens his work as a life care planner to the smooth talker who resists authority and convention. Along with the concept of differentiation, it explains how he views himself as someone who stands up for the 'little guy,' the social undervalued, by "looking cool." It is an image focused view of how to influence people by getting them to buy into the idea that what he has to say has value and he will say it to anyone, even the powerful authorities.

To others the idea of performance was not as strong, but they still came from a background of lecture style teaching or public speaking. There was also comment on how being able to debate the quality of ideas or a position was an important quality. Elaine mentioned that while life care

planners are not advocates for a particular person, "we advocate for a position…. You're advocating for the right thing." She followed this up with, "It's not like an attorney in court that you, you know, advocate for a position you don't think is right even." What she is referring to here is establishing future medical needs of a person with a disability and sharing those with attorneys and the courts in a way that helps them understand that the needs are based on research. However, what she was doing is verbally affirming the research that she had done to come up with her information, which she then has to present in a way that others can learn from.

Both May and Johann talked about their work as a service to the court, that life care planning at its foundation is providing the court with information that can be used to make better, more informed decisions. In this sense, trial is about getting good information to the decision-makers. Interestingly, both of these participants made mention that what they are attempting to teach is "the truth." It came out in very different contexts, but both mentioned that they in some way are trying to find the most accurate and correct information and to share those truths with others. While this comes from much private research, an essential component of this is also being able to share those truths publicly in a way that resonates with the audience.

Being an educator on disability has been a tenant of the practice since the early days (Weed & Field, 2014). What is perhaps unique from other areas of counseling is the comfort and effectiveness with teaching to larger audiences without the privilege of asking questions. Some parts of the legal process require a person to thoroughly explain ideas without the ability to check understanding, as in most counseling contexts where a more conversational style is used. In these settings, it is important that the life care planner be able 'monologue' about their ideas.

DESIRES INTELLECTUAL EXCELLENCE

All of the participants in this study discussed the idea of excellence in some way, particularly the idea that intelligence or the use of information was tied to success in the field. A desire to do the job well, to the best of one's ability, and to the highest of standards is necessary. There were not a lot of times during the interviews that participants stated explicitly that life care planners need to be *the best* at what they do, but the way in which they discussed the practice of life care planning suggests the need to be driven toward excellence. Erica talked about being obsessive about details. Janet talked about being bored with other jobs because they didn't provide the appropriate challenge. May talked about needing "a desire to get into the weeds of the kinds of level of detail and precision you need for forensic work and so they're [trainees] probably not a good fit for this area of practice. This suggests more than just satisfactory work, but 'the best' work. Elaine mentioned, "I'm not trying to be smart here… you do have to have a certain intellectual level." While she did not specifically say what that 'certain level' is, I suspect that her coy beginning suggests that she was somewhat reluctant to brag about her own abilities and yet acknowledges that some level of excellence is necessary.

Over and over again I heard that "this field is not for everybody," and while that does not specifically exclude people on any particular grounds, through the interviews I got the sense that it is essential to be driven, almost obsessively, to fact-finding and precision with information. It requires a sharp mind and the ability to share what's in it with others clearly and effectively. It was not uncommon to hear people talk about loving the "hunt" for information or the "puzzle" of developing a plan. What is more, that hunt is even more challenging than other types of reporting or documenting disability need. May called life care planning work "case management on

steroids," meaning "it is something that we do anyway but it's an intensification and enhancement of that."

The impression I kept getting from this group was that many people enter the field, but only those with a certain skill-set survive. "I have seen people get into this who have very limited educational skills who have been salesman before they became life care planners and they tend not to last," said Erica. While there is need to have a specific skill-set, I believe those skills are developed by people whose character strives to always be better or to excel at what they do. As I began this project I was somewhat curious to know if egotism and arrogance would arise as character traits, however what I saw more often was a "humility," as Diane put it. It takes humility to fail and try again to do better the next time.

When talking with Erica about why a person would engage in such work, she said this.

> The attorney walks away with a giant fee. The client walks away with, if successful, at least enough money to cover their future expenses, right. They know they are not going to get their leg back, but they know there is going to be some monetary consequence of it. They both walk with that and you just walk having, really just having done your job and gotten beaten up.

Although this comment is a bit bleak in-an-of-itself, what I think she was really saying is that the seeming futility of the work comes from the idea that

> If there aren't people like us willing to go in, people informed about disability, willing to go in and talk about this group of people who have suffered, who have been advocated for very little over the history of this country… there has to be somebody to do it.

May made reference to the song *Keep on, Keepin' On* by Curtis Mayfield and Janet called rehabilitation "the precious gift of hope." The sense that I got from these people was that part of their desire to excel was the recognition of the need for hope for people with disabilities. That is not to say that egotism and other negative traits do not exist, but they were not reported in this group. Of course the possibility that ulterior motives for excellence exist, but they did not present themselves in my reading of the data. What did was that being more informed, research, and intellectually capable means better success for both the client, the planner, and ultimately the community.

DETAIL ORIENTED

A life care plan can live or die as a reliable court document by small details. During the interviews it became very clear that attention to very minute detail is an important quality of the successful life care planner. Lauren mentioned that it is not simply the detail of writing a consistent report, but beginning with medical record review, it is important for the life care planner to carefully review records to spot areas for future need. A rehabilitation counselor is trained to know the future implications of the work-life of a person with a disability, which will likely not be part of the medical record. In this context, the life care planner will be looking for details about the disability that will affect the evaluee's future. As a better summarized by Johann, "as a rehab counselor you are trained to be an active listener and attention to small details can have impacts on folks lives and the world of work… so even if I'm not always able to conduct my own interview

of the claimant I am reading depositions and other experts' interview with that person." According to Johann's referral base, which is primarily from defense attorneys, he may not have the ability to interview the person with the disability, but it is essential for him to understand the needs of the person by what is written in other reports.

One of the strongest proponents of how the level of detail is important was May. Not only did she state how important it was to be very particular, but she emphasized the importance of seeing small inconsistencies and having the persistence to put in the work to justify them. The ideal life care planner has a "willingness to really dive into getting further information about something. Um those kinds of individuals are very precise in how they report things, not just vague general responses." She did not give any specific examples of the level of details required, but her language of "systematic," "comprehensive," "preventative," "persistence," and "ability to conceptualize" all spoke to the need to be aware of not only the holistic needs of a person over time, but the need for organization to be able to address the very specific needs of that individual.

While not everyone used the word 'detail,' it came out in different ways, such as the need to be data driven and methodical. Life care planning in a forensic setting is highly dependent on being objective and scientific given the standards of the federal rules of evidence (Weed & Field, 2014), meaning conclusions must be founded on the best scientific facts known at the time and in a manner consistent with the profession. So, it is incumbent on the life care planner to pay attention to facts, stay abreast with the latest science in their community, and be very accurate and specific about reporting that data. Diane stated, "I've learned what things to double check or triple check" in reports. Also, even if it is not the legal process that scrutinizes the details, Johann stated that "if they actually ever see the life care plan, the family could take that and use that as a blueprint of the rest of this individual's life, that it be spot on." In this sense, providing good detailed

information is not only essential for the plan's utility to the court, but it if it is to have any value to the person with a disability and their caretakers, it must also have sufficient and accurate information for them as well.

FINANCIAL AWARENESS

Several of the participants show an awareness of finances or an interest in business. Many life care planners are self-employed and manage all aspects of their practice, including managing the business. Not all participants discussed this as something that they particularly enjoy, many discussed it as a motivating factor in deciding to get into the work. Both Luke and Elaine both talked about parents who worked as business men and women who encouraged them to be considerate of the personal income that a career provides. Elaine, who has a parent business executive, stated that "my mother always said I was never going to make any money because I always wanted to just help people." After starting her own business and investing "a ton of money and time to go through that [life care planning training] program" she was able to establish her own caseload. It was unclear whether she learned this on her own or from her family, but in talking about her formal higher education training she said, "no one teaches you that." Yet survival as a sole practitioner required a certain amount of financial management that she was willing to engage in.

In Luke's case, he commented that he wanted to be an entrepreneur even during his early training as a counselor. He came from a family of entrepreneurs and has an undergraduate in business and economics. Throughout his interview he frequently used words like "sell" and "market" to describe the constant need to be acquiring referrals. He spoke about valuing his services as being an important part of managing his image, meaning the cost of his services were not simply a spreadsheet comparing expenses to revenues but rather they were a reflection of free-

market ideas of value be exactly what someone is willing to pay for them. It is also a reflection on the profession, meaning he believed that people in the rehabilitation field are as qualified as others in the medical field and should be compensated as such, however that begins with valuing ones own services in comparable ways instead of asking others to see our value first. He states, "you're offering a service just like a physician is an it's a different part and it's important that you hold your own… be respectful of what you're worth and not diminish yourself."

May also brought a unique perspective to financial awareness. A common concern in the forensic setting is providing objective and truthful information, rather than saying what a hiring client is wanting. While rehabilitation counselors are trained to be advocates for people with disabilities (CRCC, 2014), an awareness of "valuing responsibility and cost effectiveness" in life care planning is an important quality. The terms 'usual, customary, and reasonable' are used in references to the cost of medical services and it behooves the life care planner to consider this, she says. I believe what she was referring to was not only the cost to defendants or payments to plaintiffs but an awareness of how those costs affect the larger economy for which we all participate.

Johann and Diane also talked about money being a motivating factor for them, but it was more in terms of personal financial survival. Both were taking into consideration their families as they made early career decisions and stated that going into the field of private-forensic rehabilitation, including life care planning, is a way to simply get the bills paid. For Johann, he was drawn, in part, to rehabilitation by available scholarships and as he made a shift from public to private rehab it was at least partially motivated by slight increases in pay. However, what was most interesting about this was not the decisions that he made based on the finance but the language he would use to describe his career progression. He said he got into life care planning to

"diversify," his services, a term more commonly used in investing than in rehabilitation. Like Luke he talked about the value of his services. "I feel like a valuable service is being provided" when objective reports are provided to the court. Diane talked about "supporting" herself by doing forensic work and how she "almost starved to death" before she got into it. What was interesting about her was her discussion about being motivated by people with disabilities needing financial relief as well.

VALUES

RECOGNIZING HUMANITY

The foremost value expressed by all of the participants was the importance of recognizing the humanity in people with disabilities. This comes as no surprise given the values expressed in the CRC code of ethics (CRCC, 2014). Several participants echoed the Hippocratic Oath, 'do no harm,' which is also stated directly in the CRC code of ethics preamble (CRCC, 2014, p. 1). What was even more common was a general sense of supporting humans, who in some cases have been forgotten and in other cases have joined a whole class of people who generally seem to be treated as inhuman.

For example, Erica said this.

> The vast majority of people who I would see… were VA caseloads [and] there was not the pro veteran sentiment that exists today. Their military career was interrupted and we kinda started over and they were resilient and they were open to new experiences and they were, um, they were strong and they were proud of what they had done. I mean, it just didn't get any better than that.

Here she is describing working for a group of people who were underrepresented and disadvantaged and loving the opportunity to do that professionally. While this example relates more strongly to her earlier vocational career, throughout her interview it was clear that her current life care planning work greatly reflects her desire to give a voice to people who wouldn't normally have one in a system that disadvantages certain people. She ended her interview with this statement.

> For the vast majority of the people who I've worked with for 25 years, when they come to my office, this is the first lawsuit they've ever filed. They almost always say, I really did not want to file this lawsuit, but I couldn't get anybody to respond to me. People have lost their house, their car, their families. They've lost their way of navigating in the world.

Through examples like these, it is clear that she empathizes with the evaluee and even though, in some cases, she may be working on the defense side to review a life care plan, she still seeks to inject a component of the very real human component into the practice of life care planning.

Another example of working to acknowledge the life of people comes from Luke who talks about the unfairness of certain industries and how they treat people. He states,

> The insurance industry doesn't believe in doing testing. They don't want to spend the money. They just want to shoot from the hip and give an opinion of something. That's not the way to evaluate somebody. *It's a person's life!* [italics added to represent emphasis expressed]

Other areas of his interview told stories of giving voice to others who have a harder time speaking up for themselves, especially in environments where power hierarchies discourage insubordination. The humanity that he describes comes from the voice that individuals are not able to express for themselves and altering a social system that doesn't allow personal choice.

The idea of autonomy of choice is highly reflective of rehabilitation counselling values and was express by other participants. May specifically acknowledges the importance of "valuing people regardless of their circumstances… to recognize the humanity within that person." This statement directly acknowledges the main theme of recognizing the humanity within a person, but recognition is not a valuable service provided to the individual. What is valuable is the life care plan, which May calls a "tool" to remove "barriers" of different kinds, particularly communication barriers, but also "physical," "attitudinal," and "systemic" barriers. The life care plan, and the process for developing it is a way to help a person communicate their needs in a legal setting in ways that they may not have the training or skills to do.

So, as a life care planner, one of the values express in these ways is to provide information about the real and substantial needs an individual has, to provide them with a voice, to respect their autonomy as an individual human, and to do so in an environment that may have a tendency to simply quantify those needs in monetary terms.

INTEGRITY

The value of integrity came out in several different ways. It was demonstrated as valuing one's self as a professional and the value of the professional work in relation to other professions, such as doctors or lawyers. It also was discussed in terms of motivation to engage in the work and the intrinsic rewards for doing so. Said differently, some value doing the work for the psychological value of doing it for its own good and for the good of the community. Integrity is

also demonstrated by the intellectual curiosity and the desire for personal achievement for its own sake, to become one's best self. In lay terms, integrity is the 'uprightness of character' and doing the work for the 'right' reasons. While this was directly expressed by several participants, it was often demonstrated through description of why or how someone works the way they do.

First, as an example of the direct expression of integrity, May specifically stated it when talking about not being influenced by others to think or act in a certain way (described more thoroughly above in the discussion of differentiation). In this same context of not selling opinions to lawyers who sometimes try to pressure a life care planner to develop opinions favoring them, Janet also commented that integrity means not selling one's self.

Regarding demonstrated integrity, Elaine talked about a time at a previous job when she worked for a state agency and she had a supervisor who was not attuned to the quality of work coming out of his office. "He had no idea what I actually did from day to day. He would sign off on everything I did but he had no clue." Due to this lack of awareness she told of an ethical conflict she was a part of where a client was denied services and he was non-supportive during the process. Despite the lack of support from superiors, Elaine stated, "I stood up for myself each and every time" during ethics appeals. In essence, she knew the rules and knew that the work she was doing was of high quality, but also ethical and fair. "You have to be willing to fight for what you believe is right," she said. This sentiment was echoed throughout her interview where she continually stated that she would work hard to do what is right, albeit with the flexibility to change her mind if she is convinced otherwise.

Diane echoed similar ideas about maintaining a belief in the quality of one's own work despite the doubts of others. She talked about other professionals who would put down certain professions as not being qualified or trained appropriately to do life care planning due to the type

of training received. However, even though other life care planners cast doubt on her credentials and qualifications during depositions, Diane states that one must maintain the belief that their work is valuable in a way that others do not. For example, when talking about the silliness of "turf wars" among professionals who believe that they have a 'right' to do the work over others she said, "I always laugh to myself" about those "interesting battles." In her own work, she has not been credentialed because she has been doing life care planning since before certification even existed, however "not having the CLCP [certified life care planner] has never hindered me in my work." What she is describing is an integrity in her work regardless of those who question her ability, motivations, and credentials.

Integrity is important to life care planners, particularly because of the suspicions of people becoming "hired guns" (Vierling, 2003). Although some of the participants work explicitly in the forensic setting, everyone told stories of what their idea of 'the right way to work is' for them. What this means is that nobody had the attitude of, "I just do what I'm told." Given the individuality, independence, and autonomy that many life care planners have as a personality trait, it is no surprise that all of them develop their own meaning or purpose for how to do the work right. As stated in the introduction, while there are people who apparently enter the expert witness field to make money, even life care planning, none of the participants seemed to fall into this category and the integrity from which they work is an important part of that.

OBJECTIVITY

One of the stronger value themes was objectivity. Given the pressures coming from many different directions in life care planning, participants reported it is important to actively work to maintain a non-biased perspective. Perhaps the strongest proponent of the objectivity is Johann.

> You know, that objectivity is a really big deal to me because I see so many plans that are not, that are really padded, or are cut to such bare bones that either one's not really realistic. Being as accurate and objective as possible to where the family, if they actually ever see the life care plan, the family could take that and use that as a blueprint for the rest of this individual's life, that it be spot on.

At the beginning of the interview Johann stated that he does somewhere around 90% defense work and given these statements about fairness to all parties, to me he sounds as if part of his role is providing a check and balance to "unrealistic" future care. It seems objectivity offers an "appropriateness" to dramatically slimmed or padded plans.

May also gave a description of objectivity in terms of "responsibility and cost effectiveness." Throughout her interview she spoke about advocacy for people with disabilities in terms of having the tools to overcome barriers. Outside of her role as a life care planner, she talked about working at the state level to build a system that is fairer for people with disabilities. However, even though the way she talked about people with disabilities shows some level of sympathy with the systemic injustices people with disabilities face, she acknowledges that life care planning requires acknowledgement that it is part of a larger economy and political landscape that affects all people. Therefore, there is a responsibility on the life care planner to improve the system for all people by "valuing determining the truth and telling the truth," she said. While that does come along with the need to acknowledge the value of all people, as well as the historical context of a society that has not done that, being "able to go forward understanding that it's worthwhile trying to make life as good as possible in a cost effective manner for everybody" requires an objective lens to view a life care plan through.

This value of objectivity is strongly linked to the traits of differentiation and the desire to not be influenced by personal biases or others' pressures. Luke says, "You don't want to be swayed." Elaine says, "I think you have to be willing to look at all sides." Avoiding the intimidation of difficult lawyers means that a life care planner will not say one thing during one trial and the opposite during the next. Not only does this provide credibility to the life care planner and secure future work, but it also is more than just a self-serving desire to look good to a referral source but it means something bigger. It was linked to other values, something like fairness, justice, and personal strength. It was linked to ideas of truth and honesty, concepts that came up in several ways that have already been described above, but that, I believe, are linked to the idea of objectivity in the life care planner.

FREEDOM IN WORK

Several participants talked about the need for freedom and independence in the work that they do. This was in part a desire to work in a way that suited that particular person outside of the constraints of a larger restrictive system, but it also came with a belief that a system can be done better. Rehabilitation counselors work to build autonomy in their clients and throughout the interviews it seemed as if the counselors themselves had a desire to be as autonomous as possible, to practice the independence that they preach. Luke talked about enjoying driving alone around the state to visit worksites for insurance rehabilitation. Erica told of herself as an "ego-centric" young counselor who was learning alongside clients in ways that were not just and "academic exercise." These were not the only ones, and certainly the fact that many of the participants were self-employed or the owners of a company is testament to a preference to be autonomous in their work.

Several people talked about enjoying the variety in the work that is afforded by private rehabilitation practices. Both Johann and Erica stated that they didn't see themselves as mental health counselors because of the need to have this variety. Talking about mental health counseling, Johann stated,

> You're kindof seeing the same diagnoses all of the time and each individual is different, I understand, but you're primarily working with the same kind of people with the same diagnosis over and over, anxiety or depression or whatever it is. Same scenario, different folks. With rehab, every time you get a new file it's pretty much a new scenario.

He is speaking of a 'freshness' of the work when it includes not only the variety of cases coming in, but the ability to learn and grow from them as he works on the case. Later in his interview he talked more about private rehabilitation, including life care planning, as "not being constrained by other rules or governing bodies… to be able to have some control over when you schedule appointments rather than, you know, you had to be there during office hours."

Interestingly, even though the autonomy and freedom this type of work affords is a benefit, several people talked about the lonely parts of the job. It was exclusively in a negative context because many people claimed, for example, that research is lonely, but it also affords the ability to spend large amounts of time in the research process, which can be both lonely and satisfying. Diane states, "in some ways I like it, you know, being alone. I've got all my data, I've got my computer and my mind just goes." Janet explained that she "could spend a day and a half researching all the different things that a registered nurse could do in the world of work and how much they make and what the labor market outlook is and that thrills my heart." This idea was

echoed throughout the interviews, that the loneliness of the job was not always particularly lonely, but the independence in the right doses also brings the mental space to do the arduous research necessary for a quality life care plan. Even though the solitude can be seen as challenging by those who are more extroverted, the way the participants spoke about it seemed to come with a bit of excitement, almost as if working alone by one's own choosing is a gift and not a punishment.

SOCIAL AND FINANCIAL RESPONSIBILITY

The value of social and financial responsibility has been alluded to already, suggesting it is conceptually linked to other values. However, it is worth mentioning given the emphasis on the concept of responsibility. Financial awareness was mentioned as a trait and more directly relates to simply being aware of 'money matters' relating to disability. However, being aware of financial matters and treating them with respect and care are two different things. As we have seen from people like May, being "cost effective" means that care is taken to suggest expenses in a life care plan that exceed reasonable and justifiable needs. There can be a tendency to see rehabilitation experts as having similar motivations as lawyers, namely that they do what they can to benefit the person with the disability. However, the person with a disability is not a client and the life care plan is not designed to benefit them alone. It is designed as a container of information that is founded in factual evidence, based on scientific data, and free from motive or bias.

Participants would talk about this in different ways, but often it was talked about with a sense that while advocacy is important, seeing the needs and rights of one individual class of people is secondary to principles of liberty and justice for all. I specifically asked about advocacy to several people because of the emphasis of advocacy in the CRCC code of ethics and its potential contradictions with the idea of objectivity as method of non-favoritism toward a specific part of the legal process. What came out was something that sounded like 'higher ideals' of social and

financial responsibility. This is perhaps one of the more complicated and convoluted themed values here and require further explanation.

May spent time talking about both the need to support and value people with disabilities and their families. However, as a life care planner her role becomes more complicated because she does not serve them, but she is in service to a system that serves everyone. This is not in some idealistic sense, but data and information used in one case may be used as precedent in other cases and may affect many people to come. So when she uses the term "cost effectiveness," I believe she is referring to not just the need to be fair in a single case but to be fair for the sake of our healthcare economy and for our social ideals upheld by decision-makers. Diane echoed the idea that each person's work affects others in other places and at other times when she said, "What I know I've learned from people like you and what I learn from your case will benefit the people coming down the road."

Many of the participants I interviewed were quite experienced and it is possible that along with this experience comes a maturity acknowledging the interconnectedness of people and the effects of decisions. Several people, like Johann and Janet, stated that their work was a service to another industry, but what I heard was that their work was not simply a career, a way to make an income for themselves or their family, but it was also a duty to their community that came with a responsibility given the weight of their role. With sometimes millions of dollars at stake and the valuable lives of people who have suffered greatly due to 'acts of God' or the 'accidents of man,' the need for life care planners to see beyond their simple duties was apparent through these interactions.

SUMMARY OF RESULTS

To bring these results into perspective, the rehabilitation counselor life care planner is someone who enjoys being autonomous and making their own choices. They enjoys data, information, and research, sometimes spending large amounts of time sifting through copious amounts of data for small details that make a big difference in the final product of the life care plan. This minutia and level of detail requires a patience and persistence. Not only does the life care planner need this ability to work alone and maintain high standards with their own work, they also benefit from working well with others. To have the personality that can coordinate with other providers to find information means they are able to listen and learn from other professionals, then integrate that into a simplified plan. They is also an educator who is comfortable not only building the written record, but who can clearly recount and explain what the plan is. What is more, they must also be willing to handle criticism and feedback about the quality of both themself as a professional as well as his work product. As such, having the emotional and intellectual capability to persist in the job despite the adversarial environment is not just a skill, but it is also an almost blind optimism or hope in the potential benefit of the life care plan. This patience, persistence, independence, and fortitude extends to a savviness with the world of not only counseling, but medicine, law, and business as well.

I couldn't help but think as I was listening to the stories of these participants, that many of them talk about their careers as sometimes lonely and almost always solitary that they were somehow like Homer's Odysseus on an epic journey, an independent Odyssey to serve people with disabilities in a novel and important way. The life care planners were doing a job that was not being done prior and it required courage to engage with the unknown, but also an inclination toward excitement about doing work that nobody else was doing. They seemed to have a comfort

with being on the cutting edge and, because of the novelty, it came with the necessity of maintaining integrity and a moral compass to remain objective and responsible with their motives.

CHAPTER V
DISCUSSION

OVERVIEW

The results of this study are descriptive and report the outcomes of the qualitative interviews in terms of self-report traits and values of life care planners. The previous chapter described the results of stated and demonstrated traits and values of life care planners, however what is missing is an understanding of what those traits mean in terms of Person-Group culture of the field of Rehabilitation Counseling. The organizational culture of the profession comes with a history that both affects and is reflected by the practice areas within it. What follows is a discussion of the results within the context of the 'group' of rehabilitation counselors. It will also discuss the usefulness of the data in terms of career counseling potential life care planners. Limitations and future directions for research will also be included.

P-G CULTURAL CONTEXT

As was stated in previous chapters, P-G fit refers to the compatibility of the individual's characteristics with the culture of the organization, or in this case the profession as a whole. Another way of framing this is the identity of the individual and it's fit with the profession. The first chapter included a brief discussion of the development of private rehabilitation counseling as a service to the community and within the professional organizational context. Despite several studies on other types of employment fit (Pomeranz, Yu, & Reid, 2010); Leahy, Muenzen, Saunders, & Strauser, 2009; Fleming, Phillips, Manninen-Luse, Irizarry, & Hylton, 2011), namely Person-Job fit (abilities, roles, functions, tasks, etc.) and Person-Organization fit, there seems to be differences between public and private rehabilitation counseling. In order to understand the development of differences in the practice of private and public rehabilitation, which subsequently

led to the practice of life care planning later on, a bit more context for the history of the profession is in order.

Development of Group Culture Among Public and Private Rehabilitation

Rehabilitation counseling, unlike other areas of health care, was primarily formed as a public service provided by government funding. The federal government has been providing funds to training programs through the Rehabilitation Service Administration for rehabilitation counselors to provide services to Americas most vulnerable populations since 1954 (Rubin & Roessler, 2008, p. 33). However, it wasn't always this way. The modern historical beginnings of rehabilitation is generally attributed to the passing of the Soldiers' Rehabilitation Act of 1918 and the Smith-Fess act of 1920. These were generally efforts to support soldiers returning from the first world war and were limited to certain types of disabilities, excluding intellectual and emotional disabilities. These were essentially vocational rehabilitation efforts in practice and focused both on a medical model, addressing specific conditions as a deficit and efforts to overcome them, and the psychometric model, using a person's intellectual, personality, and interest traits to match them to work. Following the second world war, public rehabilitation expanded rehabilitation efforts to include intellectual and emotional disabilities. At this time, vocational rehabilitation counseling practices were essentially "authoritative in nature, with elements of consumer choice subjugated to professional judgement" (Dunn, 2017, p. 92). This authoritative method of providing services subjugated consumer choice to professional judgement of providers.

While this advocacy was taking place to provide expanded services to American citizen, the insurance field also began to see the value of effective rehabilitation interventions. In 1943, Liberty Mutual Insurance Company opened a rehabilitation center to treat policy holders (Lewin,

Tamseur, and Sink, 1979; Matkin, 1980). In other clinics, rehabilitation nurses were hired to coordinate medical services to avoid duplication of services and provide follow-up services (Rausch, 1985). "It became increasingly clear, however, that medical management services did not always result in reemployment" (Rausch, 1985). This spurred the need to include vocational management services as well. Not only did this provide much needed services to policy holders, but it made financial sense as well. If claimants could return to gainful employment quickly, they could provide an income for their family and require less benefit from the insurance agency. As time went on, many insurance companies began to see the cost-saving value of effective rehabilitation and by the early 1960's a number of insurance companies had followed suit providing in-house rehabilitation services that included vocational elements.

While these changes were affecting the labor force and private industry, the social activism of the 1960's and 1970's created a public atmosphere more heavily influenced by the advocacy of individual rights. The Rehabilitation Act of 1973 expanded the service provisions even further to all people with disabilities and created an atmosphere that prioritized those with the most significant disabilities in public rehabilitation settings. The affect this had on services was that those with few or less severe disabilities could apply for public services but were not seen as a primary obligation of the state. It was around this time that "proprietary [private] rehabilitation became prominent for the first time to meet the needs of those who might have been served by the pre-1973 rehabilitation service model" (Dunn, 2017, p. 93). Not only did the insurance industry begin to see the value of returning injured workers to employment, but services were becoming more scarce given the high need and the low number of individuals accepted for public support.

As the public sector of rehabilitation counseling continued to serve individuals with the most severe disabilities, and continues to do so to this day, the way that they did so was quite

different. While state rehabilitation agencies served more complex disabilities that demanded more complex supports, the insurance model incentivized individuals to return to work quickly. The public rehabilitation system essentially adopted a model of train-then-place, which focused on building the abilities of an individual to work before they went to work, as opposed to the insurance model which would place a person in a job, then train them to work in it. These philosophical differences changed the way services were provided given the different incentives. Cost efficiency was not a priority for public rehabilitation and focused more on maximization of potential, and also viewed more as an entitlement from the state, while private rehabilitation providers were not bound by demands to provide services and served people based on the possibility of returning to work. It is also important to note that while mandatory rehabilitation services became in vouge during the late 1970's and 1980's through the worker's compensation system in most states, rehabilitation became available based on worker's choice rather than the prerogative of the insurance company, essentially maintaining the spirit of consumer choice in the rehabilitation model (Dunn, 2017).

During the late 1970's and through the 1980's the goals of rehabilitation and tools used to rehabilitation people with disabilities were essentially the same; to get people employed. However, how this happened was different. The disability community criticized the use of psychometric assessment due to poor validity and lack of standardization, essentially stating the obvious severity of the disability and leaving people in a position to be denied services or placed in sheltered workshops for long periods of time while they waited to find an employer. In addition, high caseloads, the length of time to establish eligibility, and the emphasis on retraining in these workshop settings made public rehabilitation a less desirable option for rehabilitation services (Rausch, 1985). As time went on, industry viewed this model as not effective for the successful

and rapid return to work model that they sought and pursued private providers for services. While private industry was still using psychometric testing, on-the-job assessment, and trait-factor based theories for placing individuals in jobs, public rehabilitation continued to follow demands of their consumers and legislative mandates to rely more on observation of work activity. These differences served to create a larger rift between those who were accepted by public and private rehabilitation providers.

As the practices continued with their separate clientele, the effects of policy played a role in how services were provided. The public sector was funded primarily by federal mandates with monies filtering through the Rehabilitation Services Administration and were supported by several professional organizations that favored the services of public rehabilitation. The private sector was essentially following state mandates on rehabilitation services provided by worker's compensation laws, which depended to a larger extent on individual state's view on the necessity of an injured worker returning to work. While the notion of worker protections dates far back into the 1800's and harkens to changes caused by the industrial revolution globally, most of the compensation provided was for medical care related to a specific injury and not on holistic rehabilitation based on future earnings and quality of life. Counselors in the rehabilitation field continued to work with this philosophy in mind, however it appears that policy changes were much more influenced by the individual state's economies than on social welfare.

TRAITS AND VALUES IN THE CONTEXT OF HISTORY

As a result of this history, it is perhaps easier to understand how the group culture of the respective public and private industries acquire different professional cultures. It is difficult to know whether the people working in these fields at the time shaped the field or were formed by the necessities of their environment. What is easier to know is that for those who are going into

the field or training others, certain traits and values lead to more satisfaction in a person's career choice. While there is likely some overlap among traits such as 'recognizing humanity' and social responsibility, those who entertain a career in private rehab will be well served to by a desire to find more freedom to make decisions in their jobs, to view the world through and objective and scientific lens, enjoy intellectual challenges, be detail oriented, and be able to manage finances. The person will be well served by being comfortable with others who think like a business person, talk like a teacher, debate like a lawyer, and feel like a counselor. Given the need to expand services to people with disabilities in new areas that have yet to be discovered, private rehabilitation professionals may think more like an entrepreneur in that they are seeking new ideas, methods, and models to provide service that compete with others for the most effective solutions. They may be more comfortable with objective psychometric assessment, data science, and authoritative expertise. Along with more freedom in work comes risk of not having a consistent income or stream of referrals. So someone who is financially aware and responsible not only for their clients and people with disabilities, but also for their own self-survival will likely do better in private rehabilitation. Also, within the specific practice of life care planning, the person who is inclined to be interested in the medical aspects of disability will likely find life care planning a better fit that those who are more attracted to the psychological aspects of the profession.

FINANCIAL NEEDS AWARENESS ON P-G FIT

Special mention was made on income as a factor in career decision, particularly given the suspicions of financial self-interest among forensic counselors and the high earning potential. While this study did not specifically investigate the financial motivations of rehabilitation counselor life care planners, it was interesting to hear how people talked about their financial interests. Some discussed having parents who were entrepreneurs or had careers in the business

world. One participant commented on being teased by a parent about choosing profession more because it was a good fit with her desire to match her abilities and strengths rather than provide her a significant income. Two participants stated that that they specifically were drawn to private rehabilitation, and subsequently the practice of life care planning, because of the increase in income. As an interesting aside, these same two participants were the only two that stated that at the time that they made the decision to seek out a higher-paying job, they also had young families with children they were responsible for. One participant stated that she prefers doing medical case management to spend more time with her clients, but she does the forensics because it pays just enough to stay in practice.

What is perhaps even more enlightening is presence of *financial awareness* as a main theme-trait. This was included as a major theme for two reasons. First, given the suspicions about financial and ethical motivations of life care planners (Dunn, 2017; Field, 2017; Vierling, 2003), I specifically did not ask questions about money, income, or other aspects of professional finances. I was curious to know however, and surprised to see, the ways in which people did talk about the topic, particularly the variety and frequency of it. Although these participants did show an interest, a savviness, and awareness of the role of money in the practice of life care planning and rehabilitation counseling, it seemed to be for quite a variety of reasons, mostly related to the wellbeing of the counselor themselves, the profession, and the larger community. Secondly, if people did discuss money during interviews, I was curious to know how the results compared to other research on income as a factor in career choice. In other words, based on how people talked about finances, does it affect their career satisfaction. Results seem to be consistent with Rehfuss, Gambrell, and Meyer (2012) where because adequate compensation is provided, money matters. However, what we see here is that it matters because to the self-employed professional, it must

matter for practical reasons. It also matters to people like May for reasons of social responsibility and to others like Diane and Luke for family standards. In terms of traits, it seems that those who think about managing money more will likely be more satisfied in this field, simply because the field requires it. As Bluestein (2006) describes, because it is a required by the field, those who are able to meet the needs of the private profession in terms of trait disposition will likely meet the need of survival.

The results of this study were qualitatively inconsistent with the research described earlier. What I would have expected from those who were working in lower-paying counseling jobs is to give more emphasis on doing the job for the for the match between their abilities and the job demands and the fit between their desire to do social good and a profession that allows for an outlet of that personal expression. Instead, I met a group that talked openly about the demands of the job and their ability to meet them with their own skills (demands-abilities fit) in terms of the detailed work required to do life care planning. I also met a group who discussed very openly about the value of their services and the need to be both financially aware and financially responsible, (i.e., Needs-supplies fit). What was less emphasized was the fit between personal values and organizational values, perhaps because there was a greater emphasis on independence from organizational and professional culture and many are self-employed.

It is entirely possible, maybe even probable, that appearing more humble and caring and less driven specifically by greed and excess did not come up in the interviews because of a social desirability bias, or wanting to appear the best possible light. It is a limitation of this type of research. I make mention of this here because while the context for which the study took place brought up these suspicions, this study was not designed to refute those claims, but it does give some data on the intentions of this group. Likewise, even though I've claimed that these results

seem inconsistent with previous studies, it should be mentioned that this is not meant to offer contradictory evidence, simply because the study was not designed to do that. This is a descriptive study that seeks to describe the traits and values, as well as give insight into the self-expressed identity of rehabilitation counselor life care planners, not a study of their motivations or decision-making.

IMPLICATIONS OF THE STUDY

This study has several implications. First, it may be useful for rehabilitation counseling students to self-assess their personal traits and values relative to those who practice life care planning. It may also serve as a primer for other educators who are less familiar with the practice of forensic rehabilitation and life care planning. Given the historical trends of educational programs acquiring and maintaining grant funding for students interested in seeking a course in public rehabilitation settings, somewhat of a bias has been established in the guidance of students in the field of rehabilitation counseling. Anecdotally, as this study was conducted and I would engage other younger professionals in conversation about the study and their professional goals, it was stated that they knew very little about life care planning and other forensic aspects of the rehabilitation counseling profession. This study can hopefully shed light on that historical trend and provide information for students and educators to be more informed about the career options of future counselors.

As stated several times throughout this document, the differences in practice settings and 'types' of people who engage in rehabilitation counseling has to some degree contributed to confusion about the identity of what rehabilitation counselors do. Much has been said about the identity of rehabilitation counselors and the consequences of the confusion (Dunn, 2017; Irons, 1989; Mpofu, 2000; Patterson, 1957; Stebnicki, 2009; Tarvydas & Leahy, 1993). The hope of this

study is that it plays some small part in accurately describing the traits and values of the rehabilitation counselor life care planner. It is worth some comment that what looks like confidence and integrity in the value of one's services to one person may look like arrogance and greed to another. I did my best in the study to avoid euphemism and dysphemism and focus on simple description. My own biases of knowing and valuing the group of life care planners that I've come to enjoy naturally pushes me in the direction of positive attribution. Also, being trained as a strengths-based counselor probably also encourages more positive attributions. However, I did my best to maintain and objective lens despite being inclined toward positive attribution. While it may perhaps benefit the field to focus on positive identity attribution, I chose to do my best to be scientifically objective in order to build integrity in the data and descriptions of the participants themselves.

This data can also be used as something of a cross-reference to the values espoused in the CRCC Code of Ethics (CRCC, 2017). The six values there describe the foundations of the principles that drive the ethical code. Mostly, the majority of the CRCC values were expressed throughout the interviews, with a few caveats. In terms of "ensuring integrity of all professional relationships," there was an emphasis on the life care planner ensuring the integrity of themselves in front of difficult lawyers, however it was also mentioned as an expression of the integrity of the person with a disability even in cases when hired as a defense witness. In terms of "acting to alleviate personal distress and suffering," life care planners do not work to alleviate distress and suffering directly. What several of the participants stated was that their job is to inform the courts about the future needs of the individual in a way that is accurate. The life care plan is a tool or vehicle to alleviate the personal distress and suffering indirectly for the person with a disability. However, like all tools, it can be abused or not used wisely, so the life care planner establishes

equal focus on justice and fairness in the system than solely on the individual through objective use of scientific data. In this sense, the alleviation of pain and suffering is less direct than in the traditional counseling relationship.

Lastly, "appreciating the diversity of human experience and culture" is something that was mentioned less. However, one participant did make extended mention of the types of people who end up using life care plans, e.g., the agrarian workers, truck drivers, and people who do manual labor. With these caveats in mind, the values expressed by participants were very similar to those expressed in the CRCC code of ethics giving further evidence that perhaps the identity of private rehabilitation counselors is more similar than different to others in the profession.

LIMITATIONS

The intention of this study is to describe the values and traits of rehabilitation counselor life care planners and further understand the identity of this group. As such, a simple descriptive design was appropriate for this study. However, simplicity also means it can miss subtle nuance and underappreciate the complexity of the human experience. This can also reduce some of the credibility of the study. Several limitations of this study do just that.

Regarding the sample, the snowball sample was essentially a matter of convenience in establishing a willing group of participants. As discussed previously, a sample representative of a wider demographic range using 'maximum variation sampling' would have been preferable (Merriam & Tisdell, 2016, p. 96) and an initial attempt at this was made. In this method, potential participants are given a demographic survey and are selected based on the most equal distribution of the given population. The advantage of this method is that it has the potential to reach the widest range of experience of the questions of interest. However, this method can make saturation harder to reach given the number of willing participants and logistical constraints of the study. It

became clear that thematic saturation would be the most beneficial priority guiding the number of participants and the range within demographic categories. Also, it might have been possible to use the maximum variation method, however due to the time allowed for the study and the number of willing participants, the snowball sampling method was deemed the most appropriate. Second, a larger sample size would have been preferable but was not possible given the above constraints.

An important concept in qualitative research is saturation, meaning enough information is gathered that no new information is coming from the data. In this study I made the strategic decision to increase the types of analysis to pull more information out of the data instead of interviewing a larger sample of life care planners. To use a metaphor, I was casting a deeper net instead of a wider one. This was mostly because the ability to gain additional participants was limited. In order to decrease the effects of this limitation, additional coding methods and 'rounds of analysis' were used. As a result, I chose to use additional analysis techniques instead of continuing to acquire participants until saturation was sufficiently reached within each interview, meaning no new information was coming out. Another way of saying this is that greater saturation within each participation was reached as opposed to greater saturation among life care planners was reached.

Another factor that could be seen as a limitation was my own interest in remaining objective, despite my own acknowledgement of being the primary tool of analysis. I often confronted the desire to be objective and let the data speak for itself to reduce the amount of bias instead of acknowledging my positionality as a researcher and bracket my bias. Although this positionality and bracketing are essential to qualitative analysis, I often erred on the side of objectivity instead of discussing my bracketed thoughts. The reason was not an attempt at

obfuscation but to meet the expectations of the community of life care planners, which tends to appreciate objectivity and lack of bias in research.

An additional limitation to data collection was the reluctance of life care planners to participate in research. I can only speculate to the reasons why this might be, but one possible reason is that while life care planners are ardent consumers of research as empirical foundations for their claims as expert witnesses, the process and value of developing research is less obvious. Also, the time it takes to participate in research can take them away from their primary professional objectives, particularly at conferences when much of the practical goals include continuing their own education to stay abreast of practice and maintain certification. More willingness or interest in participation may have provided a greater sample, better generalizability, and more credibility to the data.

The results of this study are not meant to be inferential or generalizable to a larger population and do not reflect the whole of the population of rehabilitation counselor life care planners. It is a descriptive snapshot aggregating the self-report experiences of these eight counselors. Despite the limitations of sample size, and the potential social desirability bias, the results should be taken at face value. However, I argue that the sample design and research questions accounts for this bias. Specifically, understanding the self-report traits and values of people who are satisfied in their career, which is assumed by the length of their practices, is sufficient to use the data for the purpose of career counseling. In other words, in the strengths-based search for career values and traits it is important to emphasis the positive aspects of a person and job which then has the potential to increase future satisfaction. One could argue that it would be unethical, i.e., *increasing* personal distress and suffering as stated in the CRCC code of ethics

(2017), to advocate for job fit based on personal weakness or negative aspects of a job. So, even a positively-skewed bias in the data is ok in this case.

FUTURE RESEARCH DIRECTIONS

This research adds to other studies on rehabilitation counselor identity and to the body of literature on the specific traits and values of people practicing in specific settings within that field. This my provide a comprehensive description of private rehabilitation counselors. This data can be useful for two reasons. First, it can help educators identify and guide students toward practices that fit their specific work values and traits. Second, for those in the field who may need or desire a career change for a variety of reasons, this can help them make more informed decision, effectively increasing their chances at job satisfaction.

This study also spent a significant amount of time explaining the context from which life care planning was developed from the rehabilitation counseling perspective. It also discussed some of the underlying cultural context of the profession of rehabilitation counseling. Given the small sample of a specific practicing group, it was not possible to discuss identity issues from multiple perspectives within the greater field of rehabilitation counseling. The perspective of this single group was merely included here to provide relevant context to the results. What could be valuable is a qualitative inquiry of a wider group of private rehabilitation counselor regarding the professional identity, particularly how it developed over time.

It is also possible that what prevents educators from guiding students toward certain areas of the field, as well as transitioning to these areas in mid-career, is misconceptions about the role of money in private rehabilitation counseling. It is possible that fears, misconceptions, and misunderstandings may be contributing to beliefs that certain areas of the practice do fit within the primary identity of rehabilitation counseling. This study did not specifically focus on the role of

money for a very specific reason. Not specifically asking about it allowed the participants to include the role of money only if they believed it was important enough to be a primary theme in their practices. However, a more overt look at the role of money could be beneficial for clarifying issues about the ethical management of money and the role of income.

Lastly, this study became interesting to me as I experienced some dissonance between what I experienced with this group of life care planners and what I was hearing and reading about them. What I read and heard was that working at a cross-section between law and medicine is too dissimilar to counseling and is thus not the work of a counselor. I also read that given the potential for high earnings, at least compared to other counseling positions, that those entering the field are doing it for the money. Along with that claim came the connotation that it was not a noble or honorable direction to go for counseling students. Future studies regarding the motivations of forensic rehabilitation counselors may shed light on the truth or falsity of this public discourse. Future studies on the potential distrust of other practitioners within the field may also shed light on whether there is truth to desire for financial gain or whether there is perhaps some misunderstandings, jealousy, or feelings of shame among professionals. It is only speculation at this point, but just as counseling rests on the assumption that individuals can be rehabilitated to higher degrees of functioning and greater coherent identity, I believe that future research on the sources of this conflict may provide the profession with a more coherent identity.

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APPENDIX A

Guided Interview Potential Questions that Answer Research Questions

How do rehabilitation counselor life care planners describe their professional identity?

1. How did you get into life care planning?
2. What were motivating factors for getting into life care planning?
3. Do you identify more as a rehabilitation counselor or a life care planner? What goes into that view?
4. Can you think of a metaphor that describes you work as a life care planner?

What values and traits do life care planners describe as important for practicing as a life care planner?

5. Describe what makes a good life care planner?
6. Describe the values that make a good life care planner?

a. Do most life care planners live by those values?

7. Rehabilitation counseling values, according to the CRCC code of ethics are: Respecting human rights and dignity

a. Ensuring the integrity of all professional relationships
b. Acting to alleviate personal distress and suffering
c. Enhancing the quality of professional knowledge and its application to increase professional and personal effectiveness
d. Appreciating the diversity of human experience and culture
e. Advocating for the fair and adequate provision of services

Are there parts of the practice of life care planning that challenge these values?

APPENDIX B

Demographic Questionnaire

Demographic Questionnaire

1.) Years of experience: _____

2.) Age: _____

3.) Employment status (eg. Self-employment, employee of organization, etc.):

_____

4.) Percentage of cases related to defense or plaintiff (suggesting advocacy orientation):

_____

5.) Other relevant certifications: _____

APPENDIX C

IRB Approval Memo

IRB ID #: 201808823

To: Aaron Mertes

From: IRB-02 DHHS Registration # IRB00000100,
Univ of Iowa, DHHS Federalwide Assurance # FWA00003007

Re: Rehabilitation Counselor Life Care Planner Identity

Approval Date: 10/23/18

Next IRB Approval Due Before: N/A

Type of Application:	**Type of Application Review:**	**Approved for Populations:**
☐ New Project	☐ Full Board:	☐ Children
☐ Continuing Review	Meeting Date:	☐ Prisoners
☒ Modification	☐ Expedited	☐ Pregnant Women, Fetuses, Neonates
	☒ Exempt	

Source of Support: College of Education Research Fund

This approval has been electronically signed by IRB Chair:
Janet Karen Williams, PHD
10/23/18 1718

IRB Approval: IRB approval indicates that this project meets the regulatory requirements for the protection of human subjects. IRB approval does not absolve the principal investigator from complying with other institutional, collegiate, or departmental policies or procedures.

Agency Notification: If this is a New Project or Continuing Review application and the project is funded by an external government or non-profit agency, the original HHS 310 form, "Protection of Human Subjects Assurance Identification/IRB Certification/Declaration of Exemption," has been forwarded to the UI Division of Sponsored Programs, 100 Gilmore Hall, for appropriate action. You will receive a signed copy from Sponsored Programs.

Recruitment/Consent: Your IRB application has been approved for recruitment of subjects not to exceed the number indicated on your application form. If you are using written informed consent, the IRB-approved and stamped Informed Consent Document(s) are attached. Please make copies from the attached "masters" for subjects to sign when agreeing to participate. The original signed Informed Consent Document should be placed in your research files. A copy of the Informed Consent Document should be given to the subject. (A copy of the *signed* Informed Consent Document should be given to the subject if your Consent contains a HIPAA authorization section.) If hospital/clinic patients are being enrolled, a copy of the IRB approved Record of Consent form should be placed in the subject's electronic medical record.

Continuing Review: Federal regulations require that the IRB re-approve research projects at intervals appropriate to the degree of risk, but no less than once per year. This process is called "continuing review." Continuing review for non-exempt research is required to occur as long as the research remains active for long-term follow-up of research subjects, even when the research is permanently closed to enrollment of new subjects and all subjects have completed all research-related interventions and to occur when the remaining research activities are limited to collection of private identifiable information. Your project "expires" at 12:01 AM on the date indicated on the preceding page ("Next IRB Approval Due on or Before"). You must obtain your next IRB approval of this project on or before that expiration date. You are responsible for submitting a Continuing Review application in sufficient time for approval before the expiration date, however the HSO will send a reminder notice approximately 60 and 30 days prior to the expiration date.

Modifications: Any change in this research project or materials must be submitted on a Modification application to the IRB for prior review and approval, except when a change is necessary to eliminate apparent immediate hazards to subjects. The investigator is required to promptly notify the IRB of any changes made without IRB approval to eliminate apparent immediate hazards to subjects using the Modification/Update Form. Modifications requiring the prior review and approval of the IRB include but are not limited to: changing the protocol or study procedures, changing investigators or funding sources, changing the Informed Consent Document, increasing the anticipated total number of subjects from what was originally approved, or adding any new materials (e.g., letters to subjects, ads, questionnaires).

Unanticipated Problems Involving Risks: You must promptly report to the IRB any serious and/or unexpected adverse experience, as defined in the UI Investigator's Guide, and any other unanticipated problems involving risks to subjects or others. The Reportable Events Form (REF) should be used for reporting to the IRB.

Audits/Record-Keeping: Your research records may be audited at any time during or after the implementation of your project. Federal and University policies require that all research records be maintained for a period of three (3) years following the close of the research project. For research that involves drugs or devices seeking FDA approval, the research records must be kept for a period of three years after the FDA has taken final action on the marketing application.

Additional Information: Complete information regarding research involving human subjects at The University of Iowa is available in the "Investigator's Guide to Human Subjects Research." Research investigators are expected to comply with these policies and procedures, and to be familiar with the University's Federalwide Assurance, the Belmont Report, 45CFR46, and other applicable regulations prior to conducting the research. These documents and IRB application and related forms are available on the Human Subjects Office website or are available by calling 335-6564.

APPENDIX D

Informed Consent Document

INFORMED CONSENT DOCUMENT

Project Title: **Rehabilitation Counselor Life Care Planner Identity**

Principal Investigator: Aaron Mertes

Research Team Contact: **Aaron Mertes**
aaron-mertes@uiowa.edu
218-831-0371

Dr. John S. Wadsworth
john-s-wadsworth@uiowa.edu
319-335-5246

N338 Lindquist Center
240 South Madison Street
Iowa City, IA 52242

This consent form describes the research study to help you decide if you want to participate. This form provides important information about what you will be asked to do during the study, about the risks and benefits of the study, and about your rights as a research subject.

- If you have any questions about or do not understand something in this form, you should ask the research team for more information.
- You should discuss your participation with anyone you choose such as family or friends.
- Do not agree to participate in this study unless the research team has answered your questions and you decide that you want to be part of this study.

WHAT IS THE PURPOSE OF THIS STUDY?

This is a research study. We are inviting you to participate in this research study because you are a rehabilitation counselor who practices life care planning, you hold CRC (Certified Rehabilitation Counselor) certification and CLCP (Certified Life Care Planner) certification and you have authored at least one life care plan/year for the last 5 years.

The purpose of this research study is to explore how rehabilitation counselors practicing life care planning view their professional identity. Specifically, what values and traits do life care planners describe as important for practicing as a life care planner?

HOW MANY PEOPLE WILL PARTICIPATE?

Approximately 15 people will take part in this study based at the University of Iowa.

HOW LONG WILL I BE IN THIS STUDY?

If you agree to take part in this study, your involvement will last for approximately one hour at the time of the interview. Also, you will receive a future email from the research team with a summary of your responses asking you to verify that we have understood your responses accurately. This email and response should take you approximately 15 to 20 minutes to complete.

WHAT WILL HAPPEN DURING THIS STUDY?

During this study you will be asked to complete an informal, face-to-face interview with the researcher about you as a life care planning professional. You will first be asked five demographic questions such as: years of experience, age, employment status, orientation to plaintiff or defense, and relevant certifications. You will also be asked questions such as: "What were your motivating factors for getting into life care planning?" and "Describe what makes a good life care planner?" The interview will last about an hour and you are free to end the interview at any time with no explanation or repercussions. If you wish or if it is more convenient for you, the interview may also take place via telephone.

Within a month after your interview, the research team will begin reviewing and coding our conversation into themes. Once that is finished, we will send you a copy of the transcript of our conversation, as well as the coding summary, to ensure the accuracy of our understanding. This will be an opportunity to correct or clarify any of the results based on your intended meaning. We will ask that you approve of these results via a response email. This is a standard procedure in this kind of research to ensure confidence in the researcher's conclusions.

AUDIO/VIDEO RECORDING OR PHOTOGRAPHS

One aspect of this study involves making audio recordings of you during the interview. These audio recordings will be used to create transcripts that will then be analyzed. Only members of the research team will have access to the recordings. Once the analysis is complete, all of the audio recordings will be destroyed. Due to the importance of the audio recording to get accurate transcripts for qualitative analysis, should you wish to decline being recorded, you will not be able to participate in this study.

WHAT ARE THE RISKS OF THIS STUDY?

There are no foreseeable risks to participating in this study. However, there may be other unknown risks, or risks that we did not anticipate, associated with being in this study.

WHAT ARE THE BENEFITS OF THIS STUDY?

We don't know if you will benefit from being in this study.

However, we hope that, in the future, other people might benefit from this study because the knowledge gained from this study could help rehabilitation counseling training programs better prepare graduate students for careers. The information gathered in this study also has potential to change attitudes among rehabilitation counselors regarding private practices.

WILL IT COST ME ANYTHING TO BE IN THIS STUDY?

You will not have any costs for being in this research study.

WILL I BE PAID FOR PARTICIPATING?

You will not be paid for being in this research study.

WHO IS FUNDING THIS STUDY?

The University and the research team are receiving no payments from other agencies, organizations, or companies to conduct this research study.

WHAT ABOUT CONFIDENTIALITY?

We will keep your participation in this research study confidential to the extent permitted by law. However, it is possible that other people such as those indicated below may become aware of your participation in this study and may inspect and copy records pertaining to this research. Some of these records could contain information that personally identifies you.

- federal government regulatory agencies,
- auditing departments of the University of Iowa, and
- the University of Iowa Institutional Review Board (a committee that reviews and approves research studies)

To help protect your confidentiality, we will assign a unique identifying number to your data instead of using your name. This number will be linked to your name but will be stored separately from the rest of the data. All hard copy records will be scanned and stored in encrypted folders on the researcher's password protected laptop. Additionally, all of the electronic data from this study will be stored in encrypted folders to ensure that if the laptop is ever lost or stolen, there is no way for another person to access the information. If we write a report or article about this study or share the study data set with others, we will do so in such a way that you cannot be directly identified.

IS BEING IN THIS STUDY VOLUNTARY?

Taking part in this research study is completely voluntary. You may choose not to take part at all. If you decide to be in this study, you may stop participating at any time. If you decide not to be in this study, or if you stop participating at any time, you won't be penalized or lose any benefits for which you otherwise qualify.

WHAT IF I HAVE QUESTIONS?

We encourage you to ask questions. If you have any questions about the research study itself, please contact:

Aaron Mertes
aaron-mertes@uiowa.edu
218-831-0371

If you experience a research-related injury, please contact

Dr. John S. Wadsworth
john-s-wadsworth@uiowa.edu
319-335-5246

If you have questions, concerns, or complaints about your rights as a research subject or about research related injury, please contact the Human Subjects Office, 105 Hardin Library for the Health Sciences, 600 Newton Rd, The University of Iowa, Iowa City, IA 52242-1098, (319) 335-6564, or e-mail irb@uiowa.edu. General information about being a research subject can be found by clicking "Info for Public" on the Human Subjects Office web site, http://hso.research.uiowa.edu/. To offer input about your experiences as a research subject or to speak to someone other than the research staff, call the Human Subjects Office at the number above.

If you agree to be in the study, please verbally consent. I will also begin recording and ask that you verbally consent as part of the documented interview.

If you do not wish to be in the study, please tell me now or at any time.

Thank you very much for your consideration of this study.

APPENDIX E

Member Checking Follow-Up Email

Hi [participant name],

Thank you again for taking the time to interview with me. I've done my analysis on our discussion and as part of the qualitative research process it is customary to perform what researchers call 'member checks.' This helps ensure that the data pulled from our interview reflects your opinions or stories accurately. In this case I am interested in the traits and values of rehabilitation counselor life care planners.

I've attached a document to this email that summarizes a couple things: 1.) a narrative summary of my analysis and 2.) a list of traits and values that I've pulled out from our conversation. What I would like you to do is read through the attached document and verify the accuracy of my analysis. We can either set up a time to discuss the findings, you may call me at your convenience, or you can make changes to the document and return via email. You may change, edit, add, delete, etc. anything that you think is wrong or inaccurate. This will then conclude your participation in this study.

Thank you again for your help with this. I am trying to get this out with enough time before the holidays for you to respond, but I will follow up after Christmas if I don't hear back.

Happy Holidays!

APPENDIX F

Member Check Summary Template

Do you have a preferred pseudonym that you would like me to use to preserve your anonymity? (I can make one up if you wish): Enter name here: Ex. Alex, Julie, etc.

Interview Summary:

Click or tap here to enter text. (written here is a summary of topics discussed in the interview)

Analysis Summary:

Click or tap here to enter text. (written her is a summary of my analysis of the interview)

List of Traits and Values:

Traits	Values