REHABILITATION COUNSELOR NARRATIVES ON FACTORS AFFECTING VOCATIONAL GOAL ACQUISITION OF FEMALE IMMIGRANT CLIENTS: INCORPORATING POLICY

By

Abigail O. Akande

A Dissertation Submitted to the Faculty of the
DEPARTMENT OF DISABILITY AND PSYCHOEDUCATIONAL STUDIES
In Partial Fulfillment of the Requirements
For the Degree of

DOCTOR OF PHILOSOPHY
WITH A MAJOR IN REHABILITATION

In the Graduate College
THE UNIVERSITY OF ARIZONA

2014
As members of the Dissertation Committee, we certify that we have read the dissertation prepared by Abigail Akande, titled “Rehabilitation Counselor Narratives on Factors Affecting Vocational Goal Acquisition of Female Immigrant Clients: Incorporating Policy” and recommend that it be accepted as fulfilling the dissertation requirement for the Degree of Doctor of Philosophy.

Dr. Chih Chin Chou  Date: April 29, 2014

Dr. Linda Shaw  Date: April 29, 2014

Dr. Philip Johnson  Date: April 29, 2014

Dr. Sheila Parker  Date: April 29, 2014

Final approval and acceptance of this dissertation is contingent upon the candidate’s submission of the final copies of the dissertation to the Graduate College.

I hereby certify that I have read this dissertation prepared under my direction and recommend that it be accepted as fulfilling the dissertation requirement.

Dissertation Director: Dr. Chih Chin Chou  Date: April 29, 2014
STATEMENT BY AUTHOR

This dissertation has been submitted in partial fulfillment of the requirements for an advanced degree at the University of Arizona and is deposited in the University Library to be made available to borrowers under rules of the Library.

Brief quotations from this dissertation are allowable without special permission, provided that an accurate acknowledgement of the source is made. Requests for permission for extended quotation from or reproduction of this manuscript in whole or in part may be granted by the head of the major department or the Dean of the Graduate College when in his or her judgment the proposed use of the material is in the interests of scholarship. In all other instances, however, permission must be obtained from the author.

SIGNED: Abigail O. Akande
ACKNOWLEDGEMENTS

I extend my greatest expression of gratitude to God, who without a doubt has granted me extreme favor and blessing upon blessing throughout my doctoral career and life.

I am so grateful for the unending support of my family, who has been nothing but encouraging throughout the process of moving across the country and embarking on a journey that is travelled by few. But I have been so motivated by their love, prayers, support, and faith in my success. My parents came to this country with dreams for their children, and I hope that I have made them proud.

To my doctoral committee, Dr. Chou, Dr. Shaw, Dr. Parker, and Dr. Johnson, an assembly of great minds who have offered me support through their expertise, reassurance, advice, and genuine interest in my achievements and future. And to my advisor Dr. Chou, thank you for keeping it real, and being so approachable. When I reflect back on my time at the University of Arizona, I literally cannot believe how much I have learned and gained in knowledge and opportunity, thank you all!

I’m thankful for friends who have talked me through, prayed for me, laughed with me, and to Jodi and Connie for swinging on the vines with me.

I extend a special thanks to all of my participants; I literally couldn’t have done this without you. I’ve learned that support sometimes comes from where you don’t expect it.
# TABLE OF CONTENTS

LIST OF TABLES ........................................................................................................... 8

ABSTRACT ..................................................................................................................... 9

CHAPTER ONE - INTRODUCTION .............................................................................. 10
  Statement of the Problem ......................................................................................... 17
  Purpose of the Study ................................................................................................. 19
  Research Questions .................................................................................................. 19
  Significance of the Study .......................................................................................... 20
  Definition of Terms ................................................................................................... 22

CHAPTER TWO - REVIEW OF THE LITERATURE ................................................... 24
  Immigrants with Disabilities ..................................................................................... 24
  Familism .................................................................................................................... 26
  The Migration Experience ......................................................................................... 27
  Building Rapport and Trust ...................................................................................... 29
  Disability Policy ........................................................................................................ 30
    The Rehabilitation Act ............................................................................................ 30
    IDEA ....................................................................................................................... 31
    The Americans with Disabilities Act ....................................................................... 31
    Social Welfare and Additional Policies ................................................................. 34
    Related Legislation .............................................................................................. 36
    The Convention on the Rights of Persons with Disabilities .............................. 37
  Disability Policy in Rehabilitation Counseling Curriculum .............................. 39
  Disability Policy Implications ............................................................................... 40
Theoretical Frameworks…………………………………………………………… 41

   Schön’s Theory of Reflective Practice…………………………………… 43

Summary………………………………………………………………………… 44

CHAPTER THREE - METHODOLOGY…………………………………….. 45

Research Design……………………………………………………………… 45

Participants and Setting…………………………………………………….. 47

Data Collection Procedure………………………………………………… 50

Data Analysis………………………………………………………………….. 53

Trustworthiness……………………………………………………………… 55

Role of the Researcher……………………………………………………… 56

CHAPTER FOUR – RESULTS………………………………………………. 59

Research Question One……………………………………………………… 61

Themes from the Data………………………………………………………… 61

   Theme 1: Immigrant Status………………………………………………….. 63

   Theme 2: Level of Self-Confidence……………………………………….. 72

   Theme 3: Amount of Time………………………………………………… 74

   Theme 4: Motivating Factors…………………………………………… 76

   Theme 5: Collaboration………………………………………………….. 78

   Theme 6: Cultural Sensitivity…………………………………………… 80

   Theme 7: Rapport………………………………………………………… 83

   Theme 8: Altruism……………………………………………………….. 84

Research Question Two……………………………………………………… 85

Research Question Three………………………………………………….. 90
Reflection on Practice.................................................................90
New to Narrative.................................................................91
CHAPTER FIVE – DISCUSSION......................................................... 93
Research Question One.............................................................93
Research Question Two............................................................105
Research Question Three..........................................................108
Limitations of the Study............................................................ 109
Implications for Research and Practice..........................................111
Implications for Training............................................................ 113
Conclusion...................................................................................115
REFERENCES.............................................................................116
**LIST OF TABLES**

Table 1: Participant demographics .................................................................................. 49

Table 2: Client origin ........................................................................................................ 60

Table 3: Frequency of themes .......................................................................................... 62

Table 4: Policy in practice with female immigrant clients ............................................. 86
ABSTRACT

This dissertation examines factors affecting the service outcomes of immigrant women with disabilities who received vocational rehabilitation services, from the perspectives of their rehabilitation counselors. The participants were eight rehabilitation counselors who had received their Master’s degrees from programs accredited by the Council on Rehabilitation Education (CORE). Three counselors had Worker’s Compensation caseloads, while the other five provided return to work rehabilitation services. Counselor perspectives on client experiences were obtained through the narrative inquiry method. Eight prevailing themes arose across the stories, regarding contributing factors: immigrant status, amount of time spent providing services, level of client self-confidence, motivation, collaborative team member relationships and a strong client/counselor working alliance, counselor cultural sensitivity, the establishment of rapport, and counselor altruism. The theme of client immigrant status contained a number of related subthemes, including issues regarding acculturation, education level, legal status, refugee status, migrant femaleness, and English proficiency.

Counselor disability policy knowledge was also explored as a basis for resources and services potentially valuable to this particular client group. The counselors’ responses helped to identify a need for post-Master’s continuing education on the topic of disability legislation. The narrative process also introduced reflection on practice to the field of rehabilitation counseling, as an effective research, education, and practice method.
CHAPTER ONE

INTRODUCTION

It is estimated that 40 million people living in the United States are foreign-born, which equates to about 12.9% of the U.S. population (U.S. Census Bureau, 2010). This trend has steadily risen over the last 40 years, and represents the highest number of immigrants in the U.S. at any point in its over 200 year history (Stebleton & Eggerth, 2012). Schim, Doorenbos, and Borse (2005) labeled the circumstance of this phenomenon as the creation of a “global village” (p. 354), in which the types and quantities of cultural and ethnic groups in America have steadily increased, primarily as a result of immigration (Congress, 2005).

One important consideration for rehabilitation counselors regarding individuals who immigrate into the United States is their overall disability and health statuses. Particular attention should be paid when immigration occurs from developing countries (Dastjerdi, 2012). Individuals with disabilities comprise the largest minority group in the world (United Nations Enable, 2013). One billion people around the world have a disability and 80% of them are in developing nations (Disability Rights Fund, 2013).

Of this percentage, the majority are women who face a double stigma and additional concerns, due to the intersection of their disabilities and their gender (Shaw, Chan, & McMahon, 2012). For instance, females with disabilities are more likely to experience abuse than females without disabilities. That includes physical, emotional, financial, and sexual abuse (Banks, 2008). Globally, women with disabilities are often denied maternal or gynecological health care, because they are believed to not need it, or because it is not physically accessible to them (Disability Awareness in Action, 1996). Sexually transmitted diseases and breast and cervical cancers can go undetected for longer periods of time, resulting in higher rates of morbidity and
mortality for this group (Broussard, 2008; Disability Awareness in Action, 1996). Teenage girls with disabilities may undergo hysterectomies to promote sterility or because it is deemed easier to manage menstruation. Rehabilitation practitioners in Europe, Australia, Canada, and the U.S. have witnessed the debilitating consequences of female genital mutilation, which include impaired mobility, impaired sexual function, infertility, and increased risk of sexually transmitted disease (Disability Awareness in Action, 1996). Immigrant women with disabilities, along with their children, can arrive in the U.S. with any of these health conditions.

In addition, cultural traditions, expectations, and social determinants may force women to remain in abusive and violent relationships and living situations, of which they are at a higher risk of experiencing than non-disabled women and than non-immigrant women (Banks, 2008; Dastjerdi, 2012). This is due to any number of factors, such as fears related to being alone and facing financial instability, deportation, lack of health insurance coverage, language barriers with social service providers, lack of social support systems, cultural beliefs, and a lack of knowledge about their rights and the resources currently available to them (Banks, 2008). For instance, Liberian women in Australia, who were abused by their husbands, reported fear of notifying the authorities about their abuse. They were not only concerned about negatively impacting their husbands’ employment and educational endeavors, and attracting familial shame, but also, many of their concerns stemmed from their experiences in Liberia with a corrupt police force, where their husbands could disappear for extended periods of time (Zannettino, 2012).

In addition to the potential negative health experiences and conditions of immigrant women with disabilities from developing countries, this group is less likely to be formally educated, as families can regard their educations as a waste of money and resources that should be used for their male or able-bodied children (Hamzat & Seyi-Adeyemo, 2008). As a result,
literacy rates of these women are typically lower than their male counterparts (Disability Awareness in Action, 1996). This circumstance makes it more difficult for women with disabilities to earn a living, both in their native countries, and even more so in America. Those who are able to earn a living can experience financial abuse, such as theft of money and personal belongings (Banks, 2008).

Lastly, for counselors working with special populations of immigrants, such as refugees, an even more specific set of concerns are present. For this reason, it could be argued that the refugee experience should be studied separately. The issues that immigrant women with disabilities may face, like abuse, inaccessibility of resources, and unemployment are compounded for refugees with the effects of transience, and trauma as a result of war, torture, displacement, and encampment (Mosselson, 2006; Zannettino, 2012). Since the Refugee Act of 1980, an average of 60,000 refugees have settled in the U.S. each year (Mirza et al., 2013). Refugees typically arrive in the U.S. less healthy than immigrants, but they are entitled to brief supportive services, including health insurance, as a result of the humanitarian resettlement program.

In summary, immigrant women with disabilities in the U.S. face a number of challenges as a result of issues related to health, cultural differences, social and family dynamics, lack of education, abuse, and stigma. As a result, these issues may pose challenges for successful vocational rehabilitation outcomes among immigrant females with disabilities, who may experience their disabilities differently or at a greater severity than non-immigrant women with disabilities. To date, most research on immigrants with disabilities has focused on issues related to health and health disparities. Xiang, Shi, Wheeler, and Wilkins, (2010) have called for more research studying factors impacting vocational rehabilitation outcomes for this population.
While there is limited research on the topic of vocational rehabilitation and immigrants with disabilities, no research has specifically focused on female immigrants with disabilities. The existing preliminary results from a study in New Zealand studied immigrants in general and reported that low rates of employment among immigrants were a result of a lack of proficiency in English and limited access to supportive resources (Nash, Wong, & Trlin, 2006). Another study conducted by the Nationwide Children’s Hospital (2010) revealed that immigrants with disabilities experienced higher rates of employment than U.S.-born individuals with disabilities, although the former are more likely to be paid less and to be employed in physical production or cleaning jobs. Neither of these two studies has addressed the unique experiences in vocational rehabilitation services among female immigrants with disabilities. Therefore, in order to provide effective services for immigrant females with disabilities, it is important to study the factors that impact employment outcomes of immigrant women with disabilities.

One factor that is discussed in the literature and is supported by the Commission on Rehabilitation Education (CORE) is the need for a counselor’s knowledge of and ability to consider disability policy when working with rehabilitation clients (CORE Accreditation Manual, 2013; Umeasiegbe, Bishop, & Mpofu, 2013). Roach (2003) discussed the usefulness of disability policy when working specifically with immigrants, and explained that the social model has repositioned the issue of disability. Policymaking and political advocacy replace medicalized views and solutions. For example, counselors should be aware of the benefits that their clients may be eligible for, such as Supplemental Security Income (SSI), and the barriers that exist between clients and those resources, such as English proficiency, and eligibility requirements (Furtado & Theodoropoulos, 2013). Eligibility for certain services can be
complicated for foreign-born individuals, sometimes relating to length of residency in the U.S., citizenship status, refugee status, or work history (Nationwide Children’s Hospital, 2010).

In addition, emerging trends in policy such as Immigration Reform and the Affordable Care Act (ACA) can have direct effects on client services and outcomes (Caldwell & Coates, 2013). For instance, Immigration Reform might authorize a large group of individuals to work legally who currently cannot. Informal caregivers of family members with disabilities fall into this category. Immigration Reform could legitimize this informal direct care force, which would allow family caregivers to contribute economically to society and participate in the workforce. The impact of such a change would be multi-faceted, affecting client quality of care, the cost of care, and familial relationships.

Furthermore, there are several needs of people with disabilities that require the attention of advocacy efforts of rehabilitation practitioners and researchers, such as continued labors to increase societal awareness and decrease stigma across cultures, efforts to reform disability-related employment law to advance equal opportunity employment, and ensuring accessibility to healthcare (Umeasiegbu, Bishop, & Mpofu, 2013). The Empowerment Model of rehabilitation encourages an awareness and sensitivity of the legislation that directly affects clients (Sales, 2007). Rehabilitation counselors are inherently client advocates, therefore it is imperative that they have knowledge of disability legislation in order to advocate for clients, and to help clients to become empowered and advocate for themselves (Schirmer & Markuns; 2014). Playing an active role in policy is critical to the rehabilitation counseling profession.

Umeasiegbu et al. (2013) also acknowledged that disability legislation can act as an impetus for the reevaluation of rehabilitation counselor training, research, and services. They spoke specifically to the Convention on the Rights of Persons with Disabilities (CRPD), which is
an international treaty that could provide practitioners in America with knowledge about global
disability concerns that have directly affected clients who have emigrated from foreign countries.
The authors further encouraged the Council on Rehabilitation Education (CORE) to expand
rehabilitation counseling program requirements to include international disability rights and
policy, in order to promote professional development beyond practice in the United States, as
opposed to only teaching American disability policy. While CORE acknowledges disability
policy as a core area of knowledge required for Master’s degree programs in rehabilitation
counseling (CORE Accreditation Manual, 2013), there is very limited research regarding
counselor knowledge and preparedness to apply this knowledge to work with female immigrants
with disabilities.

Hennessy et al. (2006) conducted a study of 110 U.S. college students with Learning
Disabilities, Attention Deficit/Hyperactivity Disorder (AD/HD), and/or Attention Deficit
Disorder. The researchers assessed the students’ perceptions of their own employment-related
strengths and weaknesses. Six weaknesses identified by the students were directly related to the
Americans with Disabilities Act (ADA). More specifically, students felt inadequately equipped
with knowledge about their rights regarding job-related physical examinations (40%); how to
handle disability discrimination in the workplace (38%); the employment protections that the
ADA provides (38%); how to verbalize job accommodation needs with employers (37%); how to
address on-going accommodation needs (40%); and the pros and cons of disclosing disability
status with employers (45%). These post-secondary students, who also indicated self-perceptions
related to professional strength, high skill sets, and family support, reported high instances of
disability policy unawareness.
In the second phase of Hennessy et al.’s (2006) study, a focus group of students with disabilities, faculty members, student disability service providers, and rehabilitation professionals recommended that disability policy should inform rehabilitation practice, research, services, curriculum, and advocacy. The lack of policy familiarity described in this example raises questions about the levels of disability policy knowledge and application of knowledge among rehabilitation counselors who work collaboratively with their clients to identify resources, acknowledge rights related to employment, and explore the unique needs and services of immigrant populations and women. Umeasiegbu et al. (2013) stated that the awareness and application of disability policy seemed to evade rehabilitation counseling professionals and called for further research on the subject.

In order to investigate the factors contributing to the rehabilitation outcomes of female immigrants with disabilities and their experiences with policy-related services, it is important to explore counselor experiences by using a method that can capture the unique and detailed perspectives of those counselors. Of particular interest is the narrative inquiry method within qualitative research. Narrative inquiry is a form of qualitative interviewing through storytelling, which has been endorsed as a method of understanding the experiences and processes of practitioners working with people with disabilities and chronic illnesses (Abma, 1998; Patsiopoulos & Buchanan, 2011). Narrative interviewing allows for an exploration of experience that is much more in-depth than surveys or traditional interviews (Hsu & McCormick, 2011; Spears, 2004). In addition, narrative inquiry research design has a secondary benefit that may in fact improve participants’ practice by granting them opportunities to reflect on their own stories and meanings about what they encounter on a day to day basis with clients. Richardson (2012) describes the reflection process as a “feedback loop of experience” (p. 224). The method allows
for reflexivity in service provision for the purposes of promoting critical consciousness.

Therefore, the effects of the reflection process on practice are also examined in this study to
better understand whether narrative inquiry can be a valid method for improving practice among
rehabilitation counselors working with female immigrants with disabilities.

**Statement of the Problem**

There is a unique subcategory of multicultural awareness within the field of rehabilitation
counseling of which practitioners should be knowledgeable. Providing services to immigrants
with disabilities in their pursuit of employment raises a distinct set of concerns and client
experiences, which should warrant a distinct service approach and source of knowledge.
Furthermore, immigrant women with disabilities face an even more specialized set of social,
psychological, physiological, and economic issues directly related to their gender. There is no
research that investigates these particular issues for this population in rehabilitation counseling.

In addition, although disability policy is a CORE required knowledge domain within the
field of rehabilitation counseling, several studies show that the preparedness for, the perceived
importance of, and the frequency of application of this knowledge in disability service provision
are not very strong. Leahy, Chan, and Saunders (2003) conducted a survey of rehabilitation
counselors, using 5-point Likert-Scale inventories that assessed rehabilitation knowledge and
skills. On a scale of 0-4, the mean response for counselors regarding understanding current
disability legislation was 2.77; applying principles of legislation was 2.57; and being able to
educate clients about federal and state law was 2.68. However, the mean for perceived
importance of disability legislation affecting clients was 3.16. This indicated that the
rehabilitation counselors’ level of agreement with the importance of being aware of disability
policy was higher than their actual knowledge of disability policy. Likewise, in a later study by
Leahy, Chan, Sung, and Kim (2013), on a Likert-Scale of importance, being able to apply principles of rehabilitation legislation on a daily basis scored a mean of 2.26 on a scale of 0-4. The frequency of applying principles of rehabilitation legislation scored a mean of 2.32. These studies demonstrate that knowledge of disability policy among practicing rehabilitation counselors is less than their understanding of its value. But due to the quantitative nature of these studies, there is no descriptive data that provides detail about what the counselors’ disability policy knowledge was, why they perceived this knowledge to be important, or how they applied this knowledge.

There is no literature pertaining to disability policy knowledge application specifically with immigrant women with disabilities. Chan et al. (2003) conducted a survey of the training needs of rehabilitation counselors. Multicultural counseling issues and gender issues were rated at levels of 89% importance and 84% importance respectively among the participants. However, only 64% of the participants felt prepared to address multicultural counseling issues, and only 69% felt prepared to address gender issues. Chan et al. (2003) called for a need for future research to guide educational change on this topic. The current was designed to do this by assessing rehabilitation counselor perceived preparedness and importance of multicultural counseling and gender issues.

This study also sought to introduce the narrative inquiry research method as a tool to be used in research and reflection on practice with rehabilitation counselors – which has not been previously done. Researchers of vocational psychology were encouraged to utilize qualitative methods to enhance the richness of their findings and of clinical contributions (Flores et al., 2011; Nochi, 2000; Stebleton & Eggerth, 2012). Narrative storytelling in this research provided counselors with a platform from which to express their experiences in service provision with
female immigrant clients in a much more detailed manner, and also allowed opportunities for professional growth and change.

**Purpose of the Study**

The purpose of this study was to explore the experiences of rehabilitation counselors working with immigrant women with disabilities who were seeking employment. Another goal of this study was to explore the disability policy knowledge and application of knowledge of rehabilitation counselors who worked with this client group. Lastly, narrative inquiry was selected as a research design and a reflection tool for rehabilitation counselors, in order to investigate its utility as a more in-depth qualitative research method, and also to assess its usefulness as a method of reflection on practice for professional development. Overall, results of this study can serve as a resource for rehabilitation counseling educators for the purposes of curriculum enrichment, for rehabilitation counselors’ improvement in practice, and for rehabilitation researchers’ expansion in methodological proficiency.

**Research Questions**

The following questions will guide my investigation:

1) What do rehabilitation counselors perceive to be the barriers/successes for their female immigrant clients during service provision?

2) What do rehabilitation counselors know about domestic and international disability policy, and how have they applied this knowledge in their practice with immigrant women with disabilities?

3) How does the narrative inquiry method support or oppose the process of reflection on practice among rehabilitation counselors working with immigrant women with disabilities?
Significance of the Study

The American Psychological Association’s (APA) Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists discussed the need for psychologists who work with women with disabilities from ethnically diverse backgrounds to be aware of several factors regarding multicultural sensitivity and understanding, such as the individual’s meaning of disability, sources of social support, motivation and willingness to participate in treatment, differences in perspectives of those with newly acquired disabilities and those with lifelong disabilities, being perceived as too young or too old, and the idea that women of color with disabilities are members of multiple stigmatized groups (as cited in Banks, 2008 p. 185). Banks (2008) presented this information as a guide for rehabilitation psychologists working with ethnically diverse women with disabilities. In rehabilitation counseling, Lustig, Strauser, Rice, and Rucker (2002) spoke of the importance of a strong working alliance as a factor that contributes to positive rehabilitation outcomes. Blackwell, Leierer, Haupt, and Kampotsis (2003) found that a lack of education and attorney involvement could prevent return to work with rehabilitation clients. Lastly, a study on Asian Americans seeking rehabilitation services concluded that contributing factors to success for this population included counselor respect of the culture and religion, understanding of differences in job prestige between Asian Americans and European Americans, and a familistic approach to service provision. Factors that negatively affected outcomes with this group were language barriers, client unfamiliarity with service provision systems, financial problems, and fears of deportation (Chen, Jo & Donnell, 2004). These findings add to the existing literature by providing a unique perspective on the dynamics of culture, immigrant status, and gender during the provision of rehabilitation services. The information presented in this study is useful to practitioners and
educators who work with or teach about ethnically diverse populations in rehabilitation, and seek to understand the intricacies of female immigrant client pursuit of vocational rehabilitation goals.

In addition, this research sought to respond in part to the Umeasiegbu et al. (2013) paper, which highlighted a need for disability policy to provide “the opportunity for reassessment of training, research, and services in rehabilitation counseling…” (p. 69) and for “CORE standards (to) include and expand content foci on global disability rights issues and international legislation and policy” (p. 70). This research proposed to present pertinent qualitative data by inquiring into the policy-related academic and professional experiences of rehabilitation counselors, and assessing policy knowledge and application with their clients. As a result, the findings of this study can serve as groundwork for including U.S. and international disability policy in training when working with immigrant females with disabilities.

Inquiry into this topic is supported by the findings of a study where Dastjerdi (2008) sought to identify barriers and issues to health care faced by Iranian immigrants in Canada, from the perspectives of their health care providers and social workers. The author also used narrative inquiry, as well as focus groups, to explore the factors that impacted service provision with this immigrant group of clients. Three major themes arose in that study, barriers due to language and a lack of knowledge of Canadian health care, a lack of trust due to fear of disclosure, and needs for psychological supports. This study was not exclusive to the experiences of female clients nor individuals with disabilities, and the participant health care providers were all Iranian-American. This study supports one of the premises of this research, in that the immigrant experience in health service provision is worthy to be explored, and that the service providers can offer unique perspectives. Dastjerdi (2008) also discussed the importance of educating immigrant clients
about the resources available to them to “…help immigrants to be empowered and have control over their own lives” (p. 7).

Finally, this study presented a novel method of research, narrative inquiry. Narrative had never been used as a method of reflection on practice among rehabilitation counselors working with immigrant women with disabilities. This study helped to bring to light a less traditional method of qualitative research into the field of rehabilitation, by presenting data that extended the utility of the narrative inquiry method from neighboring fields into vocational rehabilitation research and practice (van der Riet et al., 2012).

**Definition of Terms**

1) Client – a consumer of rehabilitation services

2) Cultural sensitivity – as opposed to cultural competence, which suggests a sense of arrival, this term embraces an on-going awareness of and continual education on the significance of one’s cultural background during service provision

3) Developing country – an underprivileged nation that seeks economic, political, and social advancement

4) Disability - “… a social construction that is the result of interaction between physical or mental impairment and the social environment” (p. 90) (Kuehn, 2004)

5) Disability policy – Legislation that is designed to protect the human and civil rights of individuals with disabilities, and to support their full integration into society

6) Immigrant – an individual who has permanently moved from another country into the United States

7) Refugee – an individual who has been forced to leave his or her native country, for reasons of persecution, war, natural disaster, or political concerns
8) Rehabilitation counselor – “A counselor who possesses the specialized knowledge, skills, and attitudes needed to collaborate in a professional relationship with people who have disabilities to achieve their personal, social, psychological, and vocational goals” (p.67) (CORE Accreditation Manual, 2013)

9) Rehabilitation professional/practitioner – An individual who is formally trained in a field in the vocational, medical, psychosocial, and psychological rehabilitation sciences
CHAPTER TWO
LITERATURE REVIEW

In chapter two, brief background information about the uniqueness of female immigrant experiences and perspectives in health services is provided. Secondly, the implications of immigrant status and migrant femaleness on women with disabilities seeking employment, which involves the effects of the migration experience is discussed. The importance of the building of rapport with immigrant clients when providing rehabilitation services is discussed and a special inquiry into disability policy, its potential value in service provision, and its standing in the rehabilitation counseling field is performed. Related legislation that may be useful in service provision with this group of women is also discussed. Lastly, a synopsis of the various theoretical frameworks that tie in multiculturalism, immigrant experiences, and reflection on practice are presented.

Immigrants with Disabilities

A global consciousness of disability should be expected for all rehabilitation professionals. Almost every professional in rehabilitation working in the United States will meet a client or patient whose origins or familial ties are international (Schim et al., 2005). As the immigrant community continues to grow in the United States, it is reasonable to expect that rehabilitation professionals are educated on the matters of the immigrant – this includes immigrant culture, the migration experience, and disability policy.

Individual work with clients from various ethnic backgrounds is guaranteed to present a variety of experiences and perspectives. By adding in the factor of the migration experience, this group is placed even further into a specialized, yet diversified category. It would be erroneous to describe any individual or family solely in terms of the general ethnic category to which they are
ascribed (Congress, 2005). Both diversity and similarity exist within ethnic and cultural groups as much as they do outside of them. For example, a service provider might assume that two immigrant clients from Nigeria would more or less desire the same therapeutic or clinical approach. However, dependent upon the region that they are from in Nigeria, those clients can very easily be differentiated by language, religion, and custom (Akande, 2013). Conversely, the traumatic effects of a colonial history in their native country, and the type of food and music that they listen to may be some aspects of their cultures that they would have in common. Ultimately, two individuals from the same cultural group, who present with the same condition or disability, can likely have two different interpretations of disability experience, cause, and outlook. Generalizations about people based on their cultural backgrounds will not always paint a precise picture, but they can act as starting points from which disability and health professionals can engage in individualized exploration and understanding with their clients (Congress, 2005; Hampton, 2000).

Attitudes and approaches to health care and treatment are closely related to cultural affiliation (Akande, 2013). Some immigrant clients may prefer folk health care practices, while others will favor these methods in conjunction with Western practices (Congress, 2005). For instance, James et al. (2005) conducted an investigation into the Portuguese Azorean communities and their concept of “agonias.” This phenomenon refers to a cluster of symptoms that are a result of extreme stress, trauma, grief, threat, low socioeconomic status, or family distress. Studies of agonias concluded that it did not directly match any DSM-IV psychiatric diagnosis. Interestingly, the women in this study, who had experienced trauma, did not associate their symptoms with post-traumatic stress disorder, but rather with their religious beliefs. Similar findings were established in studies of Puerto Rican immigrant women, and study participants
from fishing communities in Newfoundland who were experiencing “nerves” (James et al., 2005). According to James et al. (2005), individuals with psychiatric diagnoses experience variations in symptoms that are correlated to their cultures. Also, there is an established understanding that religious and spiritual beliefs are closely connected to patients’ experiences and beliefs around pain, disability, healing, health, and death (James et al., 2005).

The World Health Organization (WHO) encourages proactive health behaviors by having overall health routinely assessed, so as to prevent illness and disability, or to at least allow for early intervention and mitigation of symptoms and illnesses (Bourne, 2009). In many developing nations, healthcare providers are typically tasked with curing illness after the fact, due to the inaccessibility of preventative healthcare services (Congress, 2005). Acute and chronic illness can often lead to disability, especially if they are not treated soon enough or effectively.

**Familism**

A critical element of the immigrant experience around health and disability practices and conceptualizations in America is the role of the family (James et al., 2005). American culture classically promotes individualism as a manner of thinking, living, pursuing goals, and decision-making (James et al., 2005). However, this view is not held in all non-Westernized cultures. Familism and collectivist views are more popular, in which the family makes decisions as a unit (Chen et al., 2004).

The family, which can be defined as the nuclear family, or can also include the extended family, elders, members of the community, or religious leaders, makes all critical decisions collectively – including those related to health, treatment, and related services (Chen et al., 2004). In fact, the patient or client might not even have the final say in decisions about the treatment that will primarily impact him or her. This issue is important because this concept is
very different from the HIPAA-driven, confidential medical system that exists in the U.S. When servicing clients and patients from different countries, practitioners must not only be aware of these types of variations in views, but they must also acknowledge the possibility that the client or patient might accept these practices and does not regard himself or herself as voiceless, oppressed, or marginalized, and finds peace and comfort in acquiescing to cultural traditions (Mehr, 2013). This is not always the case however, and familism can have a negative impact on the individual, resulting in feelings of obligation and avoidant coping (Sayegh & Knight, 2010).

The Migration Experience

The act of immigration itself is multi-faceted and unique, and is one of the most differentiating factors between immigrants and ethnic minorities. One issue to consider is the reason or reasons why an individual or family decides to leave their home country to live in a new one. Common motives include the pursuit of economic and educational opportunities, political and religious freedom, and healthcare accessibility (Nash, Wong, & Trlin, 2006). It is crucial to note that these reasons can either make the immigration process an exciting one or a stressful one. Feelings of anxiety, fear, loss, sadness, loneliness, and anger can accompany an individual on their journey to the U.S., as they must learn to embrace probably never being able to return home or see their family members again. In addition, there may be the added stress of having to navigate the U.S. immigration system, learning a new language, acquiring a job and an affordable place to live, assimilation expectations, and facing difficulties with accessing the resources needed to approach healthcare and other needed services (Dastjerdi, 2012). Some immigrants come to the U.S. from countries that do not have supportive disability legislation in place, and do not know to expect it when they arrive in the United States (Chen et al., 2004).
Practitioner knowledge of resources, services, and legislation pertinent to this group can assist in the transition process of the immigrant client.

Some of these factors related to immigration may compound one another. For instance, a family that has fears related to deportation may resolve to socially isolate, which can in turn exacerbate loneliness or impede access to services and treatment. Likewise, an individual from a country with which the United States faces political strife, may experience insecurity, fear, and be on the receiving end of discriminatory acts. Cultural mistrust can directly impact the individual’s perceptions of Americans as a whole and the type of counselor from whom they would prefer to receive services (Amri & Bemak, 2013).

Employment bears slightly different meanings and values across cultures. For example, an immigrant man who is accustomed to being the sole wage earner in the family may take issue with accepting a lower-status position due to an acquired disability or may object to the idea of having his wife procure employment to support the family (Congress, 2005). It may also be considered demeaning to be offered public assistance of any kind. Conversely, dependent upon the immigrant’s status in the U.S., public assistance may not even be an option. There are also individuals whose academic and vocational training from their native countries are not recognized in the U.S. and they experience underemployment as a result (Chen et al., 2004). For an individual with a disability, experiencing the loss of a skill and having to be re-trained in the same discipline or having to be trained in a completely new field, can be one of the most daunting aspects of disability adjustment (Livneh & Antonak, 1997). The immigration factor multiplies that frustration. For an individual from another country, adjustment to disability is one of many adjustments to make (Congress, 2005).
For instance, financial status is a prevalent immigrant concern and directly affects whether or not and how often an individual will access health care (Chen et al, 2004; James et al., 2005; Schim et al., 2005). Disability and health status can impede an individual from working in the same capacity in the U.S. as he did in his home country, in the way that he was formally trained, or from working at all. Status Inconsistency Theory recognizes the potential of emotional distress for individuals with occupational statuses that are incongruent with their employment statuses, such as distorted self-concepts or non-gratifying social and professional interactions (Gravlee & Dressler, 2005). In other words, there is a potential for emotional stress in situations where someone is educated in a particular skill, yet is underemployed. This may be an additional source of strain within the immigrant population.

**Building Rapport and Trust**

Rehabilitation professionals must build rapport and try to establish a sense of trust with their clients from different countries, in order to begin to understand these differences in experiences and expectations (Congress, 2005). Amri and Bemak (2013) concluded that one of the main reasons that the Muslim immigrants in their study avoided mental health services was because of mistrust. Dastjerdi (2012) found that Iranian immigrants in Canada indicated a lack of trust as one of the main reasons for their dissatisfaction with the Canadian health care system. Flores, Hsieh, and Chiao (2011) discussed how important it is for career counselors to immerse themselves in local immigrant neighborhoods and communities, and to seek understanding from community leaders. These authors indicated that a key component in research and practice in career counseling with immigrants was “building egalitarian partnerships” (Flores et al., 2011, p. 330) For instance, Hampton (2000) encouraged rehabilitation counselors working with Asian
Americans and Pacific Islanders (AAPIs) to visit Buddhist temples in their communities for first hand familiarity and relationship-building.

Social capital is a concept that is measured by the existence of trusting, reciprocal relationships within a community, whose integral purpose is to ensure the growth and sustenance of that community on economic, political, and cultural levels (Adger, 2003). Social capital can be directly proportionate to a society’s measured success in the aforementioned areas. It supports a collective movement that is typically spearheaded by commonly agreed upon community leaders, who can be appointed through formal or informal processes. These community leaders would be the natural liaisons among rehabilitation and health practitioners, the people of these communities, and the legislative and political decision-makers.

**Disability Policy**

The Rehabilitation Act of 1973. This is the federal law that established the federal vocational rehabilitation, supported employment, independent living, and client assistance programs (U.S. Department of Labor, 1973). Section 21 of the Rehabilitation Act Amendments of 1992 mandated that the public rehabilitation system in the United States should be equipped to provide culturally competent services to clients of minority backgrounds, by purposefully recruiting professionals into the field from minority backgrounds (Lewis, Bethea, & Hurley, 2009; U.S. Department of Labor, 1973). The Rehabilitation Act identifies the unique needs of clients from minority ethnic groups; many of which are relevant to clients from foreign countries. However, it fails to highlight the distinctions between an individual with a disability from a minority background and an individual with a disability who has migrated from a country outside of the United States, as well as the subsequent unique differences in needs that would arise during the provision of rehabilitation services.
The Individuals with Disabilities Education Act (IDEA). This is a law that specifically ensures the special education and related services for children with disabilities, from birth until age 21 (U.S. Department of Education, 2013). This piece of legislation is of particular importance to rehabilitation counselors who work with transition students, or students with disabilities in high school who are formulating post-secondary vocational plans. Immigrants with disabilities who may have children with disabilities could benefit greatly from the knowledge of the types of resources available to their children in the public school system. This involvement with their children may inspire them to seek opportunities to advocate for their own disability rights and inquire about legislation and services that are applicable to them.

The Americans with Disabilities Act. The Americans with Disabilities Act (ADA) of 1990 is a civil rights law that is designed to protect people with disabilities and ensure that they are afforded the same rights as every other American, particularly in regard to employment (United States Department of Justice, 2013). This legislation is regarded as one of the most comprehensive laws of its kind, as it was modeled after the Civil Rights Act of 1964 and also protects the rights of individuals with disabilities to purchase goods and services, and to participate in governmental programs and services.

Historically, vocational rehabilitation has focused on the “supply-side” or the consumers by providing services to prepare and equip individuals for successfully obtaining and maintaining employment, through the lens of the medical model of health and disability (Luecking, 2008). However, policy efforts have highlighted a need to also focus on the “demand-side”, by acknowledging the mutual benefits in the vocational rehabilitation process, as well as a need to educate employers and employees/co-workers. In a study conducted by Hinton (2003) of
employed individuals with disabilities, 52% of the group indicated that their employers were out of compliance with ADA implementation in their respective workplaces.

Title I of the ADA imposed a legal obligation for employers to refrain from discriminating against employees or potential employees based on their disability (United States Department of Justice, 2013). But social stigma and discrimination are still major obstacles for individuals with disabilities in their efforts to obtain employment (Conyers & Ahrens, 2003). It is important for rehabilitation counselors to know that their clients do not need to disclose their exact diagnoses in order to obtain a reasonable accommodation, but just stating that they have a disability is sufficient under the law. The issue here is that there still exists a prevalent mindset among employers that the presence of a disability automatically discredits the value of the worker and/or their potential work performance.

Title I of the ADA does not apply to all employers (United States Department of Justice, 2013). Employers of private companies with less than fifteen employees are not held to the anti-discriminatory standard that is outlined in Title I of the ADA. Therefore, it is critical that the rehabilitation counselor keeps this in mind during the career exploration and application process. Clients with disabilities would be well-advised to think carefully about seeking employment with such small companies, unless they do not need any accommodations, the client can provide the accommodations for him or herself, or the counselor can provide accommodations within his or her agency.

It is essential for rehabilitation counselors to know that a lack of coverage under the ADA does not exempt small, private businesses from legal standards regarding discrimination and rights of the worker as a whole (United States Department of Justice, 2013). For instance, the Equal Pay Act of 1963 prohibits all employers from discriminating between men and women in
regard to pay. Also, the National Labor Relations Act of 1935 allows employees to join and form labor organizations, for the purpose of collective bargaining. Lastly, there is the Employee Retirement Income Security Act of 1974. If a small business of less than fifteen employees provides benefits to their employees, then the employer is required to provide annual summaries of these benefits to the IRS and to the employees.

These examples express how the Americans with Disabilities Act and other legislation can inform the field of rehabilitation, in regard to employer practices and knowledge, or a lack thereof. Rehabilitation counselors have an ethical responsibility to equip themselves with the knowledge to effectively inform and advocate for their clients, and to make efforts to educate employers and their staff (Commission on Rehabilitation Counselor Certification Code of Ethics, 2010). Such advocacy efforts may support the client in maintaining employment and having more positive employment experiences. This responsibility requires counselor knowledge of current implications of the ADA in the field of rehabilitation and recent case law (Conyers & Ahrens, 2003).

Rehabilitation counselor knowledge of disability policy can not only inform practice, but it can also help counselors to be able to more readily identify the ways in which policy is lacking in the support of individuals with disabilities in obtaining and maintaining competitive employment. The passing of the ADA was groundbreaking in its identification of the unique civil and human rights issues that people with disabilities face in the U.S., particularly in regard to employment. However, since the passing of the ADA in 1990, there have not been significant improvements in the rates of employment for individuals with disabilities (Bagenstos, 2004; Kulkarni & Kote, 2013; Martinez, 2013).
Social Welfare and Additional Policies. Historically, disability policy in the United States has been inclusive of welfare benefits, from the end of the Civil war until the creation of Medicare and Medicaid in 1965 (Bagenstos, 2004). The disability movement’s focus of the 1970s was to push disability out of the medical model of deficiency, sympathy, and segregation, and to shape it into a social issue to be defined by societal, cultural, and environmental constructs. However, it can be argued that the disability movement can also benefit from a system of welfare, not only for individuals who cannot work but also for those who can. Discriminatory acts, which the ADA seeks to protect people from, are not the only barrier to employment for individuals with disabilities. Work must also be made to be accessible, by ensuring supports in the areas of assistive technology, transportation, personal care, and health care.

The Patient Protection and Affordable Care Act (ACA) is a law that directly affects individuals with disabilities in a number of ways. Some of which include insurance companies no longer being able to discriminate against individuals who have preexisting conditions, expanding Medicaid to include people with disabilities, ending annual and lifetime dollar limits on health care spending, and providing accessible examination equipment (U.S. Department of Health and Human Services, 2010).

In January 2014, as part of the ACA, the Centers for Medicare and Medicaid Services issued a final rule with the purpose of ensuring that home and community-based services for individuals with disabilities receiving Medicaid would grant access to services in ways that supported the fullest possible integration of clients within their communities (U.S. Department of Health & Human Services, 2014). These services will act as substitutions for institutional care.
The Department of Health and Human Services has been in the process of establishing more of these types of community services in order to facilitate implementation.

Supplemental Security Income (SSI) benefits and Workers’ Compensation may be viable options that are worth exploring for some immigrant clients with disabilities as well. SSI is a benefit offered by the Social Security Administration that provides cash benefits to individuals with disabilities of working age (Furtado & Theodoropoulos, 2013; Social Security Administration, 2013), and satisfies the Affordable Care Act’s insurance coverage package requirements (U.S. Dept. Of Health & Human Services, 2012). It is designated for individuals of low-income status and does not have any U.S. work history requirements, as does Social Security Disability Insurance (SSDI). Before the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, and the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, virtually all legal immigrants with disabilities were eligible for SSI. However since then, only immigrants who were legally in the U.S. before 1996, refugees, individuals with adequate work histories, and individuals who were involved in the military may be eligible.

Workers’ Compensation programs provide insurance coverage and services to workers who are injured on the job, or who develop illnesses as a result of their jobs. These programs are regulated by each state, and as a result, each state will differ in the ways that it provides coverage for injured workers (Shaw & Betters, 2004). For instance in some states, illegal immigrants are eligible for Workers’ Compensation as well. Workers’ Compensation benefits for immigrant clients should be of particular interest to rehabilitation counselors within their respective states because immigrants are more often exposed to work-related injuries, disabilities, and fatalities (Gravel et al., 2009). Likewise, work-related injuries among immigrants are less often reported. Immigrants also tend to face additional barriers during the process of applying for compensation
benefits, such as lack of English literacy. Policy regulates the availability and quality of services - and it is continuously changing.

**Related Legislation.** There is also legislation that is not solely disability legislation, but is often applicable to this population and therefore useful to rehabilitation counselors. The Fair Housing Act (FHA) was established to prevent discriminatory practices against individuals seeking housing (United States Department of Justice, 2013). Women from low socioeconomic backgrounds are at greater risk of being treated unfairly or taken advantage of by landlords than men. There is also a provision that prohibits discrimination against families with children. For instance, landlords cannot deny the rental or sale of a residence to families with children or try and restrict the number of children allowed in a particular residence. The Act also protects individuals from discrimination based on disability status and outlines accessibility requirements for the purposes of ensuring that all people will have access to multi-family homes. Lastly, the Act protects people from being discriminated against based on their nationality. The Justice Department can take action against individuals who attempt to keep certain groups of people out of particular neighborhoods, because of their ethnicity.

The Family and Medical Leave Act (FMLA) allows eligible employees of covered employers to take leave from their work, in order to address personal or familial medical needs. This leave can last for a period of up to twelve weeks within a twelve month period and is unpaid, but the individual’s job is protected from dissolution during this time (United States Department of Labor, 2014). This coverage also includes military caregiver leave, in which the employee is granted twenty-six work weeks of leave to care for a family member or next of kin that was injured or disabled through military service. Lastly, he Office of Special Counsel for Immigration-Related Unfair Employment Practices is responsible for enforcing the anti-
discrimination provision of the Immigration and Naturalization Act (INA) (United States Department of Justice, 2013). Under this law, immigrants are protected from being discriminated against during the hiring and firing process, based on their ethnicity or citizenship status.

**The Convention on the Rights of Persons with Disabilities.** The Convention on the Rights of Persons with Disabilities (CRPD) is an international treaty that was adopted by the UN in December of 2006 (UN Enable, 2011). The fifty article document was developed as the first comprehensive human rights treaty of the twenty-first century and is legally binding, addressing issues related to women, standard of living, health, mobility, education, and violence against persons with disabilities internationally. The Convention did not propose to establish new rights in the United States or change existing law; however it provided guidelines and provisions to ensure that the civil rights of individuals with disabilities were being upheld and that the U.S. would have international accountability. For example, Article 6 of the CRPD discusses women with disabilities, which is already addressed in the Americans with Disabilities Act. However, the CRPD is the only international treaty with enforcement, accountability, and liability measures in place, which is especially needed in developing countries (UN Enable, 2011).

Currently, the Convention is the only United Nations treaty that solely addresses the rights of people with disabilities (Stein, 2009). Although there have been declarations, resolutions, and other documents, such as the World Programme of Action concerning Disabled Persons (1981) or the Declaration on the Rights of Disabled Persons (1995), these are not legally binding as is the Convention (UN Enable, 2011).

The Convention proposed to address issues related to women in ways that current U.S. legislation does not. Current federal U.S. law does not acknowledge women with disabilities as a distinct vulnerable population (National Council on Disability, 2008). Claims or concerns related
to both disability and gender would have to be argued with the use of case law or related theoretical frameworks. Article 6 of CRPD describes the acknowledgement of the multiple discriminations that women and girls with disabilities experience, and that governments should take action to ensure their human rights and freedoms (U.S. International Council on Disabilities, 2013). Similarly, there is no federal legislation that acknowledges the intersection of disability and childhood, outside of the school setting, and the need for protection from discrimination. This responsibility resides within state governments. This is of particular importance because the U.S. did not ratify the Convention on the Rights of the Child, which was adopted by the United Nations in 1989.

In December of 2012, the U.S. Senate failed to ratify the CRPD by a 2/3 vote, with sixty-one in favor, out of the sixty-six votes that were needed. Grassroots advocacy groups continue to educate Americans, politicians, and rehabilitation professionals about the numerous benefits that ratification of the Convention would bring, and hope that another opportunity will arise for voting in the future.

On a daily basis, rehabilitation professionals across disciplines address issues directly related to disability legislation, such as accessibility, discrimination, and special education. However, newer legislation or proposed legislation that is equally critical, such as the CRPD, is not widely known among practitioners and stakeholders (Alizadeh, 2011; Bernhard, MacEachen, & Lippel, 2010; Coole, Radford, Grant, & Terry, 2012). Yet its principles and influence are far-reaching, globally and domestically – even though it has not been ratified by the U.S. (U.S. International Council on Disabilities, 2013). It is argued that its failure in the senate in 2012 is in part a result of the marginal acknowledgement and participation in policy of rehabilitation professionals (Umeasiegbe, Bishop, & Mpofu, 2013).
United States ratification of CRPD can be useful when considering Americans who have disabilities and live abroad in the countries that have ratified the CRPD. Likewise, there are rehabilitation professionals who are educated in the U.S., with the intent to practice in foreign countries that have ratified the CRPD. This could make integration of CRPD into rehabilitation counseling curriculum useful. Some clients here in the U.S. were once residents of other countries where little to no disability services were available or accessible. One could expect that knowledge of CRPD could inform practitioners working with immigrants with disabilities from a variety of countries. This legislation, and many other international treaties, can serve as educational tools that inform the practice and service provision of professionals and residents of many countries throughout the world.

**Disability Policy in Rehabilitation Counseling Curriculum**

CORE accredited Master’s programs in Rehabilitation Counseling in the U.S. are required to provide courses within specific domains of knowledge, as identified in the Accreditation Manual for Masters Level Rehabilitation Counselor Education Programs (CORE Accreditation Manual, 2013). Knowledge domain C.1.2a, under the category of, History, systems, and philosophy of rehabilitation, specifically states that students should be able to “Integrate into one’s practice, the history and philosophy of rehabilitation, as well as the laws affecting individuals with disabilities” (CORE Accreditation Manual, 2013, p. 25). Knowledge domain C.1.3a, under Legislation related to people with disabilities, states that students should be able to “apply the principles of disability-related legislation, including the rights of people with disabilities, to the practice of rehabilitation counseling” (CORE Accreditation Manual, 2013, p. 25). Knowledge domain C.1.6a, under Informed Consumer Choice and Consumer Empowerment, states that students should be able to “Integrate into practice an awareness of
societal issues, trends, public policies, and developments, as they relate to rehabilitation” (CORE Accreditation Manual, 2013, p. 25). And knowledge domain C.1.8a, under Advocacy, states that students should be able to “Educate the public and individuals with a disability regarding the role of advocacy and rights of people with disabilities under federal and state law” (CORE Accreditation Manual, 2013, p. 26).

Disability policy education, along with the promotion of advocacy, is prevalent throughout the accreditation manual. Knowledge domain C.1.6a is of critical importance, because it starts with the Master’s degree education, but also implies the individual obligation of continuing education opportunities related to policy, so that counselors will be readily able to provide on-going, updated information, and relevant service as policy changes inevitably arise over time. Lastly, knowledge domain C.5.4.b, under Gender Issues in Counseling, states that students should be able to “Identify gender differences that can affect the rehabilitation counseling and planning processes” (CORE Accreditation Manual, 2013, p. 30). Rehabilitation counselors are expected to be equipped with the skills to be able to address concerns unique to females.

**Disability Policy Implications**

The acknowledgement of policy application as a critical component of service provision is present in fields adjacent to rehabilitation. Nash et al. (2006) identified a developing new specialization of practice within the field of social work designed to meet the needs of immigrants, refugees, and individuals seeking asylum in the United States. Practice in this specialization requires a specific knowledge base and skill set that includes cultural sensitivity and policy. Immigrants, particularly those who have left their countries under situations of duress, can experience issues related to depression, anxiety, post-traumatic stress disorder, grief
and loss, cultural and language barriers, lack of trust, and fear (Zannettino, 2012). Many of these concerns warrant engagement with primary and mental health services, which for many of the aforementioned conditions, are difficult for them to access.

Nash et al. (2006) presented findings from a 2001 study in New Zealand, where local non-governmental organizations (NGOs) working with refugees were surveyed to identify the strengths of their program. These NGOs identified the following strengths: accessibility (free services, translators), centrality (one-stop services), specialization (by gender and ethnicity), appropriateness, education, safety (particularly for abused women and children), advocacy, and practicality (provided material needs). Interestingly, more than half of the NGOs surveyed identified that recent changes to their organizations, both positive and negative, were a result of policy changes in New Zealand. The NGOs vocalized a need for a more holistic approach to immigration and resettlement policy, as well as a need to address the lack of New Zealand employers that wanted to hire refugees. Policy directly impacts services, and research studies like these can be used by practitioners and researchers to advocate for their clients and inform policymakers.

**Theoretical Frameworks**

There are several theoretical frameworks that support the rationale for this research. The biopsychosocial model describes the interaction between the physical, psychological, and social factors that holistically elucidate the experiences of an individual with a disability or chronic illness (Covic, Adamson, Spencer, & Howe, 2003). This framework illuminates the essentiality of a multidisciplinary approach to treatment, as well as highlights the intricate and reciprocal dynamics within the many facets of an individual’s life. As rehabilitation professionals work with clients on one area of their lives, such as employment, they must also acknowledge other
areas. Family, religion, and socioeconomic status are just a few examples of the aspects of a person’s life that can directly affect rehabilitation outcomes. For example, Stebleton and Eggerth (2012) discussed a holistic approach to occupational health psychology that encompasses the work environment, the individual, and the interaction between work and family.

This research is also framed within a socio-political context of disability, which connects it to Mike Oliver’s Social Oppression Theory (Simarasl, 2012). In this context and investigation, social oppression theory postulates that societal perceptions and the subsequent socio-political responses to these perceptions cause the oppression of individuals with disabilities and individuals who are immigrants (Sandys, 1998). The attitudes toward disability and immigration status lead to disadvantage and the inadequate availability of services and legislation, rather than those statuses themselves. Steering away from the medical model, social oppression theory acknowledges the need for a joint approach of social and political intervention (Oliver, 1998). Individuals with disabilities are oppressed by not being able to fully participate in society (Simarasl, 2012). Barriers, discrimination, and exclusion exist within social services, the public physical environment, and within people’s personal prejudices. Hence it is a macro or political issue, as well as a societal and social one.

Feminist migration research has shed a new light on feminist theory that has resulted in a theoretical framework that highlights the impact of employment, political dynamics, and economic trends on the international labor migration patterns of women (Silvey, 2004). It also brings attention to the fact that migration is not always a result of an empowered move for a better life, but also forced displacement of asylum-seeking refugees. Feminist Migration Theory encapsulates the gendered patterns and dynamics in migration, and the social and labor market hierarchies that are directly connected to being female. Immigrant women receive lesser quality
positions than men, are paid less than men, and are regarded as more exploitable (Nawyn, 2010). They also become stereotyped for certain job functions, such as domestic care, light manufacturing, and service industries. For example, Silvey (2004) presented a study of Mexican women factory workers, who were regarded as “cheap” and “docile.” These impressions were linked to the high rates of murder and rape among this group of women. Conversely, some women experience greater levels of responsibility and independence through work that result in higher levels of self-esteem, respect, and gratitude from family members (Al-Sharmani, 2010). Overall, the experience of the migrating woman is unique, and can be marginalizing or emancipating (Al-Sharmani, 2010). These theories help to highlight some of the experiences of the clients of the counselors that were interviewed. They also support the argument for the distinctiveness of the experiences of immigrant women with disabilities and the subsequent approach to providing them with services.

**Schön’s Theory of Reflective Practice.** Donald Schön’s Theory of Reflective Practice posits that practitioners “reshape their approaches and develop wisdom and artistry” through the processes of reflection in practice or action and reflection on practice or action (Mishna & Bogo, 2007, p. 531; Oandasan & Reeves, 2005; Schön, 1983). Schön explained that artistry is an inherent component of all professions, defined as an exercise of intelligence. In professional practice, there is an art to the processes of framing a problem, implementing a solution, and also improvisation (Schön, 1987). He argued that school curricula in general might need to deviate from the traditions of education for practice and integrate a reflective practicum. Schön used the example of the changes in medical education by incorporating programs to address the psychosocial effects of illness, versus just those that are biotechnical. The art of reflecting provides opportunities for a deeper understanding of client and counselor, through “publicly
testing private attributions, surfacing negative judgments, and revealing confusions or dilemmas…” (Schön, 1987, p. 302).

Reflection in practice is the act of applying knowledge and theory from past and current experiences to address challenging issues with clients in the moment, while reflection on practice occurs after client interaction, for the purpose of developing new understanding from that situation. This deliberation provides teachable experiences for improved practice. In my research, I was particularly interested in the concept of reflection on practice through narrative inquiry. Reflection on practice is becoming more popular in the fields of social work, health, and education, yet is still elusive in the field of rehabilitation counseling.

Summary

Rehabilitation professionals working with immigrant clients can only benefit by maintaining awareness of cultural diversity and the specific ways in which being a female immigrant with a disability can affect engagement in services. Familism, the effects of migration, and a lack of rapport represent some of the personal and interpersonal dynamics present in the counseling relationship.

Disability policies and resources, such as The Americans with Disabilities Act, Supplemental Security Income, and Workers’ Compensation are just a few examples of the legislation and programs in place to address the unique circumstances that immigrant women with disabilities face. And CRPD is a current opportunity for a global improvement of the conditions of the world’s most marginalized group. As advocates, researchers, students, educators, and practitioners, rehabilitation counselors can play lead roles in the development and implementation of policy that can improve services and standards of living for rehabilitation clients and educational programs for rehabilitation students.
CHAPTER THREE
METHODOLOGY

Research Design

Chapter Three encompasses the design of this qualitative research study. It is divided into the following parts: Research Design, Participants and Setting, Data Collection Procedures, and Data Analysis. In order to investigate the knowledge and implementation of policy among rehabilitation counselors working with female immigrant clients, the following research questions guided the course of this study:

1) What do rehabilitation counselors perceive to be the barriers/successes for their female immigrant clients during service provision?

2) What do rehabilitation counselors know about domestic and international disability policy, and how have they applied this knowledge in their practice with immigrant women with disabilities?

3) How does the narrative inquiry method support or oppose the process of reflection on practice among rehabilitation counselors working with immigrant women with disabilities?

In order to carry out this investigation, a narrative inquiry interview process was employed with seven Master’s level rehabilitation counselors, and one PhD level rehabilitation counselor. Narrative is ideally executed among a small number of participants (Bell, 2002; Bernhard, 2010; Mohamad, 2006; Nochi, 2000; Stebleton, 2012). It is a popular form of research used in the fields of education and health (Creswell, 2009; Reissman & Speedy, 2007; van der Riet, Dedkhard, & Srithong, 2012), but is scant in the field of rehabilitation counseling.
Narrative Inquiry can be categorized under the postmodern, interpretivist qualitative approach that supports the social constructivist paradigm, which acknowledges an individual’s personal, situational, and relative outlook and experience (Keddell, 2009; Patsiopoulos & Buchanan, 2011; Pavlenko, 2002; Richardson, 2012). A person’s story, the way that he or she uses language and his or her accompanying emotions provide a distinctive evidence and position on a particular phenomenon, with more detail and richness than a quantitative approach (Patsiopoulos & Buchanan, 2011; van der Riet et al., 2012). Narrative research posits itself on the notion that the told story acts as a gateway into an underlying story, experience, or consciousness of which the participant is often unaware (Bell, 2002). Patsiopolous and Buchanan (2011) deduced that narratives “provide important information useful to gaining some understanding of the systemic underpinnings of counseling practice” (p. 302). Narrative is regarded as an approach to self-compassion and self-care that has assisted counselors in establishing more realistic expectations, setting boundaries, and self-correction.

Narrative storytelling can also help the counselor participant to become aware of his or her clients’ strengths, weaknesses, and struggles, as well as the counselor’s own strengths, beliefs, biases, and areas in which he or she may fall short. This enhanced cognizance positions counselors to access appropriate resources needed to support the individuals that they are servicing. The introspective process of narration can also cultivate an ethic of professionalism among counselors. This particular insight has been credited as relevant to vocational psychologists, because of their professional task of helping people discover life purpose and meaningful activity — specifically related to work (Richardson, 2012). This same credit should be granted to rehabilitation counselors. Narrative inquiry is a valued approach for this study because of the richness and detail of the interviews, its potential to elucidate underlying or subconscious
thoughts or ideas, its ability to highlight practitioner strengths and weaknesses, and its value as an educational and practical tool for counselors to utilize in rehabilitation practice.

**Participants and Setting**

The participants for this study consisted of eight female rehabilitation counselors who graduated from CORE accredited rehabilitation counseling Master’s programs, with one participant also holding a PhD in rehabilitation counseling. The counselors all spoke, read, and wrote fluently in English. They were all actively employed in state, non-profit, or private rehabilitation agencies and had provided services to immigrant women with disabilities for at least three months. In order to recruit participants, I sent a recruitment email to former and present colleagues, students, and professors within the rehabilitation counseling field. Through network sampling, some of these individuals then forwarded the email to additional students, colleagues, and co-workers. I also posted the message in the all member forum in the community section of the International Association for Rehabilitation Professionals’ website, which reached a potential of 2,400 rehabilitation professionals. All prospective participants who responded were sent a screening questionnaire to determine their eligibility for the study, with the use of exclusionary criteria. In order to be eligible to participate in this study, all prospective participants must 1) have been capable of speaking, reading, and writing in English; 2) have received a Master’s degree in rehabilitation counseling from a CORE accredited program; 3) not have retired more than five years ago; and 4) have provided vocational rehabilitation services to at least one immigrant woman with disabilities over the course of at least three months.

All eligible prospective participants were invited to participate in the study and to schedule an interview date and time. Eight out of nine of those who were eligible followed
through with the interview. All participants were emailed the consent form at least one day before the scheduled interview, and asked to sign it, scan it, and email it back.

Participants were located in various cities throughout the United States, and worked for agencies that provided a myriad of rehabilitation services. Participants were also varied by ethnicity, the number of years employed after receipt of their degrees in Rehabilitation Counseling, the type of rehabilitation services they provided, and their countries of birth. One interview took place in person, in a private study room at the University of Arizona Main Library. Three interviews took place over Skype with video, and 4 interviews took place over Skype’s phone feature (with no video). All participants and I were in private locations each time. Table 1 provides demographic information about each participant.
<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Job Title/Work Functions</th>
<th>Agency Type</th>
<th>Work Location Region</th>
<th>Birthplace</th>
<th>Year obtained Master’s</th>
<th>Interview Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>f</td>
<td>White</td>
<td>VR Counselor</td>
<td>State VR Agency</td>
<td>SW</td>
<td>USA</td>
<td>2012</td>
<td>In person</td>
</tr>
<tr>
<td>B</td>
<td>f</td>
<td>Hispanic</td>
<td>VR Counselor</td>
<td>State VR Agency</td>
<td>SE</td>
<td>USA</td>
<td>2013</td>
<td>Skype video</td>
</tr>
<tr>
<td>C</td>
<td>f</td>
<td>African American</td>
<td>Rehabilitation Supervisor</td>
<td>State VR Agency</td>
<td>W</td>
<td>USA</td>
<td>2006</td>
<td>Skype phone</td>
</tr>
<tr>
<td>D</td>
<td>f</td>
<td>White</td>
<td>Mental Health Social Worker</td>
<td>Non Profit</td>
<td>W</td>
<td>USA</td>
<td>2011</td>
<td>Skype phone</td>
</tr>
<tr>
<td>E</td>
<td>f</td>
<td>Hispanic</td>
<td>Bilingual RC, Voc Expert, Life Care Planner, &amp; Adjunct Faculty</td>
<td>Private for Profit</td>
<td>NW</td>
<td>Foreign - Born</td>
<td>1993 (PhD in 2007)</td>
<td>Skype video</td>
</tr>
<tr>
<td>F</td>
<td>f</td>
<td>White</td>
<td>Owns WC business providing VR services</td>
<td>Private for Profit</td>
<td>MW</td>
<td>USA</td>
<td>1991</td>
<td>Skype phone</td>
</tr>
<tr>
<td>H</td>
<td>f</td>
<td>Hispanic</td>
<td>Return to Work services</td>
<td>Private for Profit</td>
<td>W</td>
<td>USA</td>
<td>1991</td>
<td>Skype phone</td>
</tr>
</tbody>
</table>
Data Collection Procedure

A narrative protocol endorsed by Jovchelovitch and Bauer (2000) was utilized, which consisted of five stages: Preparation, Initiation, Narration, Questioning, and concluding talk. The pre-phase was Preparation. During this time, I developed a preliminary understanding of the topic of investigation by researching domestic and international disability policy, related legislation that impacts individuals with disabilities, CORE accreditation requirements for rehabilitation counseling Master’s programs, rehabilitation counseling fields of practice that are associated with policy and legislation, the prevalence of narrative inquiry in rehabilitation counseling research and practice, and the use of reflection as a tool in rehabilitation counseling research and practice. This information coupled with my own interests formed the exmanent questions, which were the issues and interests fueling the research, in my own words. These were different from the immanent issues, which were the themes, accounts, and significances that were uniquely uttered during the narrations of the participants.

The first phase of narrative inquiry was Initiation, which involved the process of consenting and explaining the context of the research. Each interview began with a review of the research consent form, which had previously been read and signed by the participant, including requesting permission to contact the participant at a later date for member-checking. I then provided each participant with an opportunity to ask any questions about the consenting and research processes. I described the format of the interview as narrative inquiry - “uninterrupted storytelling” (Jovchelovitch & Bauer, 2000, p. 6). I explained to participants that I would provide a series of prompts or questions and encouraged them to respond in a storytelling format, with a beginning, middle, and end, and to be as detailed as possible. I explained that there was no such notion as too much information.
In accordance with Jovchelovitch and Bauer (2000), the following rules in order for the narrations to be able to sustain themselves were invoked: 1) the initial topic needed to be of relevance and significance to the participant; 2) the initial topic needed to be broad, so as to encourage a long, detailed story, and 3) as the researcher, I did not introduce any specific dates, names, places, or the participants’ interest in the topic – as this information was left to be introduced by the participants.

The second phase was the main narration, which was not interrupted until the participant had clearly indicated an ending to their story, such as with a long pause or by asking me a question. The following questions were used during initiation and the main narration, along with occasional prompts for participants who needed assistance with responding:

1) Initial topic: I’m interested in your work providing vocational rehabilitation services to female immigrants with disabilities. Tell me about your experiences with this population.

2) What have been some mitigating issues/factors in the lives of these women that have prevented them from meeting their goals or led to successful outcomes? (prompt: How might some of these issues have been unique to being female immigrants?)

3) Describe your knowledge of and experiences with the application of domestic and international disability policy in your work. (prompt: What do you know about disability policy (domestic and international) Discuss a time(s) when your knowledge of disability policy enhanced your service provision with immigrant women, such as the ADA, the Fair Housing Act, or Rehab Act?)

4) From where did you obtain your knowledge about disability policy? (prompt: Are you a member of any professional rehabilitation organizations?)
During the screening component of the recruitment phase, some of the participants identified specific countries where their clients immigrated from, most of which were developing countries. During initiation, I reminded the participants of those aforementioned countries and asked them to speak about experiences with those clients. During narration I did not speak, but rather provided evidence of active listening, such as nodding and other non-verbal encouragement to continue talking (during Skype interviews only), and paralinguistic utterances of “I see,” “ok,” or “hmm.” Lastly, I probed for additional information when the narrative clearly ended, by asking “Is there anything else that you would add or that you think would be relevant information?”

The third phase was the questioning phase. Attentive listening and note-taking during phase two became crucial during this phase, because here is where my exmanent questions were translated into immanent questions. Using the language and wording of the participants, I asked questions to address any gaps or unanswered research questions, and to confirm preliminary themes in the data. Three rules were upheld during the questioning phase: 1) I did not ask questions about personal opinions, positionality, causes, or reasons. Neither did I ask “why?” questions. Narrative inquiry typically encouraged the natural elucidation of this information, without probing; 2) my questions only referred to topics mentioned in the story or those related to the study, but by using the participants’ words; and 3) I did not highlight any contradictions in the participants’ stories, so as to discourage rationalization (Jovchelovitch & Bauer 2000).

Lastly, the fourth phase was concluding talk. This marked the formal end of the interview and the audio recorder was turned off. For some participants, the setting became more relaxed and small-talk ensued. This was the time to ask any “why” questions. When concluding talk ended, I immediately took notes on pertinent comments, while they were fresh in my memory.
Some interviewees did not participate in concluding talk, and the conversation ended directly after the formal interview ended.

The narratives in this research were presented as a negotiation between storytelling and questioning. The narratives presented diversity in depth and breadth of participant experiences, while specific questions helped to elucidate similarities and differences across interviews, as well as fill in gaps in information. The completely uninterrupted narrative storytelling that does not require additional prompts or questions is considered an “ideal-typical procedure” that will not always be exactly adhered to (Jovchelovitch & Bauer 2000, p. 8). This depends on the experience and interpersonal skills of the researcher, the topic of research, and the perceptions, memory, and personalities of the participants.

After each interview, I made an entry into my reflective journal, recording all personal impressions of the interviews, questions, concerns, noted themes, biases, and emotions. It was useful for documenting patterns in the data, connections to theory, answers to research questions, strengths and weaknesses of the study, and directions for future research (Saldaña, 2009). All audio-recorded interviews were professionally transcribed by either a company transcription company in Tucson, AZ or an internet-based transcription company.

**Data Analysis**

Upon electronic receipt of the interview transcriptions, I reviewed each and read along with the audio recordings in order to ensure accuracy and make necessary corrections. I then double-spaced the transcripts in Microsoft Word and printed them. I employed manual analysis of the transcribed narratives through thematic coding, using manila folders and colored pens for organizing and categorization (Glesne, 2011). I allowed the codes to emerge naturally in the research, rather than use predetermined codes (Creswell, 2009). Through this process, I searched
for categories, themes, and patterns within and between every story. All analysis and coding was completed independently, writing directly on the printed transcripts. Most coding in qualitative research is completed solely by the researcher, unless it is a large study (Saldaña, 2009).

By “themeing the data,” I read each interview line by line, and noted possible codes in the margins that described overarching themes (Saldaña, 2009). I also engaged in simultaneous coding, where one piece of qualitative datum fell under more than one theme. I then typed codes into a Microsoft Word document that served as my electronic codebook. Subsequently, I arranged the codes into categories and subcategories, merged categories where possible, and pulled codes apart where necessary. As codes developed, they were applied to subsequent transcriptions, adding and subtracting codes as themes grew or disappeared between transcripts. New codes from later interviews were applied to interviews that were previously analyzed. The coding process occurred in two cycles. During the second cycle, I engaged in the process of pattern coding, which helped to group the existing codes into a smaller number of codes (Saldaña, 2009). I then analyzed my reflective journal and field notes in the same manner.

I created a codebook, as a glossary of codes that I developed during the coding process. The purpose of the codebook was to assist with consistency and adherence to the research questions. The types of codes that I looked for in this study addressed participant perspectives on the unique experiences of immigrant females with disabilities seeking employment, participant knowledge of disability policy, participant insight through the narrative process, and emergent and related ideas, responses, and reactions that were unanticipated. Glesne (2011) described the construction of the codebook as “highly personal” (p. 197) or unique to the researcher.

Upon completion of analysis and coding, I engaged in focusing strategies to help construct the written results and discussion. The main strategy involved writing about one major
category or concept at a time, which then allowed me to reflect on how each one connected or was interwoven with another, along with its overall significance (Saldaña, 2009). My secondary approach was to choose any additional themes which were not necessarily the most prevalent, however offered noteworthy contributions to the discussion. I included this strategy as a secondary approach, so as not to inadvertently omit a critical theme that was not as predominant as the others.

**Trustworthiness**

All transcriptions were proofread for accuracy, by listening to the audio recordings while reading the corresponding transcripts. During coding, I constantly reviewed codes and their definitions for accuracy and to eliminate redundancy. Data was triangulated through interviews, maintaining a field log, taking notes during the interviews, and checking in with participants at the ends of the interviews to verify information, address questions, and support initial themes. Follow-up calls were required for three participants, in order to clarify misunderstandings or questions within the transcripts.

Reflexivity is critical in qualitative, feminist research (Creswell, 2009; Glesne, 2011; Ortlipp, 2008). In order to cultivate and maintain my own self-awareness of potential biases, experiences, emotions, culture, theoretical commitments, and positionality throughout the research process, I kept a reflective field log. I made an entry into the log immediately after every interview, where I documented my thoughts, perspectives, concerns, questions, and any other subjective material that had the potential to influence my perception or interpretation of the data and to encourage transparency. This act of reflection, allowed me the opportunity to more accurately and more objectively interpret the results of my inquiry with participants (Glesne, 2011). It also assisted with opening my mind to receive new thoughts and ideas. For instance,
self-reflection during the research process helped me to identify a need to slightly modify the methodology, specifically by making the initial topic more specific and by providing the participants with examples of disability policy in order to enhance their ability to answer the question (Ortlipp, 2008). Also, some participants presented ideas and practices that were contrary to my own. Writing down and reviewing those differences helped me to remain aware of them and also how I worded and presented my findings.

Taking notes during the interview provided additional support, as it allowed me to take notes on participant comments and actions, as well as my feelings and thoughts in the moment, without having to remember them later. I documented participant phrases that stood out to me because of their relevance to my research questions, a possible theme, or other significance. I also made notes on topics that required further inquiry on my part, for the completion of the narrative.

To address issues of dependability, which is the qualitative equivalent of reliability, I have described my data collection and analysis procedures in a detailed manner that would support efforts for replication (Saldaña, 2009). Lastly, debriefing with my academic advisor created the opportunity for objective assessment of writings and relation of the data to the research questions and theoretical framework, through proofreading and questioning from a fresher perspective (Creswell, 2009).

Role of the Researcher

As a certified rehabilitation counselor, who is the daughter of immigrants, I had a particular interest in immigrant issues regarding disability status. I am also aware of some of the views that immigrants can have regarding gender and toward disability. Over the course of my career, I have worked with immigrants and with women, and have seen how these statuses can
affect vocational rehabilitation outcomes. As a public health minor, I have taken courses in Sociocultural and Behavioral Aspects of Public Health, Public Health Policy and Management, and Women and Child Health Policy and became increasingly aware of the implications of intersectionality and the importance of practitioner awareness and advocacy. I have a specific interest in policy-related advocacy efforts and have recognized through research and practice that rehabilitation counselors as a whole do not tend to engage in these types of efforts. I was interested in shedding light on possible ways that policy could support this specific population of clients, for the purposes of increasing engagement and enhancing multicultural rehabilitation counseling. Lastly, I have a great appreciation for the richness of qualitative research and believe in the value that narrative inquiry can add to research, education, and practice in rehabilitation counseling.

In regard to my positionality in this research, my first generation background influenced my view that immigrants and females face culture-related disparities that negatively impact social interactions, particularly if the individual also has a disability. I entered this research with an expectation to find evidence of these views. This positionality also allowed to me to relate on some levels with some of the clients discussed in the participant stories, as either commonalities in experiences or my own memories of my parents or family members having those experiences. Also, based on my own Master’s education and clinical experience, I expected to find that the rehabilitation counselors in this study were not abundantly aware of relevant disability policy or how to apply it in practice with immigrant clients. I also expected that counselors who worked in WC would be generally more knowledgeable of disability policy. In order to account for my bias and expectations, in addition to journaling, I checked in with each participant at the end of every
interview to ask questions for clarification, understanding, and verification of preliminary data
codes.
CHAPTER FOUR

RESULTS

The purpose of this study was to explore the unique experiences of rehabilitation counselors providing services to immigrant women with disabilities who were seeking employment, in terms of the factors that impacted clients’ employment outcomes. A secondary function of this study was to assess the disability policy knowledge of the counselors, and whether their policy knowledge informed their service provision with this client group. Lastly, this research investigated the utility of narrative inquiry as a qualitative methodology in rehabilitation counseling research. This method has been used infrequently in rehabilitation counseling, in comparison to other fields, such as social work, health, and education.

This chapter reports the responses of seven Master’s-level counselors and one PhD-level rehabilitation counselor who had provided vocational rehabilitation services to immigrant women over the course of at least three months. I completed and audio-recorded a total of eight interviews, at which point data saturation was reached. Interviews ranged in length from 29 minutes to 74 minutes, dependent upon the participants’ memories, their abilities to answer the questions, and the number of clients or groups of clients that they discussed. For the purposes of confidentiality, the actual names of the participants and their clients do not appear in this manuscript.

Three participants recalled a large number of female clients with disabilities for whom they had provided services and preferred to speak of those experiences collectively, by grouping the service provision experiences by the clients’ countries of origin. These stories tended to contain more descriptive summaries and generalizations about client experiences. The remaining five participants spoke of specific clients with whom they had worked, ranging from one female
immigrant to eight female immigrants. These stories provided more specific, individualized client information. The clients were immigrants from a variety of countries and regions named by the participants. Table 2 provides a list of the countries and regions represented by clients as described by their corresponding counselors.

Table 2: Client origin

<table>
<thead>
<tr>
<th>Participant</th>
<th>Client Countries &amp; Regions of Origin</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Mexico, Jordan, and Russia</td>
</tr>
<tr>
<td>B</td>
<td>Haiti, Cuba, Venezuela, and Jamaica</td>
</tr>
<tr>
<td>C</td>
<td>Mexico, Afghanistan, and Ethiopia</td>
</tr>
<tr>
<td>D</td>
<td>El Salvador</td>
</tr>
<tr>
<td>E</td>
<td>Mexico, Portugal, and Latin America</td>
</tr>
<tr>
<td>F</td>
<td>Mexico, Somalia, Vietnam, the Philippines, Latin America, and Guatemala</td>
</tr>
<tr>
<td>G</td>
<td>Bosnia and Herzegovina, the Bahamas, Ghana, Brazil, Sierra Leone, Haiti</td>
</tr>
<tr>
<td>H</td>
<td>Mexico and Latin America</td>
</tr>
</tbody>
</table>
Research Question One: What do rehabilitation counselors perceive to be the barriers/successes for their female immigrant clients during service provision?

Themes from the Data

The following themes represent factors that were most prevalent in the research and also ideas that arose less frequently, but provided unique insight and topics for discussion. Table 3 provides an overview of the frequency of these themes, which includes direct references, phrases, words, and examples from the interviews where the theme was mentioned as being a factor affecting the vocational service outcomes of the clients. Magnitude coding is a method of quantitizing qualitative data, for the purposes of intensity or frequency analysis (Saldaña, 2009).
# Table 3: Frequency of themes

<table>
<thead>
<tr>
<th>Theme</th>
<th>Frequency: total number of times theme mentioned in all interviews</th>
<th>Number of participants who mentioned the theme n = 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Immigrant Status</td>
<td>137</td>
<td>8</td>
</tr>
<tr>
<td>a. Acculturation</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>b. Refugee Status</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>c. Legal Status</td>
<td>13</td>
<td>6</td>
</tr>
<tr>
<td>d. Education Level</td>
<td>15</td>
<td>7</td>
</tr>
<tr>
<td>e. Migrant Femaleness</td>
<td>36</td>
<td>8</td>
</tr>
<tr>
<td>f. English Proficiency</td>
<td>58</td>
<td>8</td>
</tr>
<tr>
<td>2. Level of Self-Confidence</td>
<td>26</td>
<td>7</td>
</tr>
<tr>
<td>3. Amount of Time</td>
<td>29</td>
<td>7</td>
</tr>
<tr>
<td>4. Motivating Factors</td>
<td>38</td>
<td>8</td>
</tr>
<tr>
<td>5. Collaboration</td>
<td>42</td>
<td>8</td>
</tr>
<tr>
<td>6. Cultural Sensitivity</td>
<td>46</td>
<td>7</td>
</tr>
<tr>
<td>7. Rapport Building</td>
<td>24</td>
<td>7</td>
</tr>
<tr>
<td>8. Altruism</td>
<td>5</td>
<td>2</td>
</tr>
</tbody>
</table>
Theme 1 - Immigrant Status. The counselors reported that immigrant status contributed the most to whether or not a client was successful in obtaining vocational goals and that special consideration should be taken into account when providing services to immigrant clients. This was the most prevalent theme throughout all of the data. Counselors interviewed provided information on a variety of instances in which a client’s status as an immigrant contributed to the barriers experienced in their pursuit of their vocational goals, in ways that were unique from other clients on their caseloads. The following subthemes are examples of counselor perspectives on the issues faced by immigrant women with disabilities seeking vocational services.

Subtheme 1a. - Acculturation. Issues regarding acculturation were brought up five times during the interviews. In this study, participants discussed client difficulties with or resistance to adaptation to American culture and customs. This lack of assimilation and differing views around disability service provision was caused by the newness of being in America and a lack of trust. Participants reported that the challenges with acculturation related issues negatively affected engagement in services by decreasing treatment compliance, and decreasing client engagement in services and appointments. This ultimately led to a decrease in the achievement of vocational goals.

<Participant C>: “So, it really gave me a flavor for kind of race and ethnicity and internationality and being able to incorporate those things and to come up with a plan for employment. So, I was really, really thankful the (the psychiatrist) gave me some good things to try, which included referring her to...
believe it was an Ethiopian support group for just being more around folks that were of her nationality, because she hadn’t.”

<Participant B>: “Also adjustment issues. Just getting used to a new culture here. It's been my experience that a lot of people who come to south Florida have a little bit less of the issue of adjustment, because there's a lot of people who speak Spanish and are out there, same culture. They still do have a hard time adjusting to the American way of life and what they were normally able to do in their country, it's not something that's very doable here. From employment to resources to anything, everything, it's just completely different. I think that's why it makes it a little bit harder for them to adjust to everything; to new stressors, to finding how to feed their children, how to feed themselves. It's just hard.”

Subtheme 1b. - Refugee Status. Counselors described difficulties with service provision to refugees 10 times. They spoke of how these immigrants who were granted asylum in the United States had experienced trauma, stress, depression, fear, and anxiety. This was due to separation from family members, violence, war, political turmoil, and persecution in their home countries. Counselors acknowledged a need to approach these clients with sensitivity and patience.

<Participant E>: “They're coming for different reasons. The ones that are coming from Bosnia, I've seen a lot of them with more mental health issues, because of trauma. Those tend to be considerations that become important to understanding the rehab process.”
<Participant A>: “I mean the one from Jordan, I mean crossing the street was a new experience for her, not having to duck every time you heard a car backfire was a new experience for her. So there was a whole lot of things going on, not just with the disability but her whole environment, so I think with her it was kind of you had to be a little bit more laid back and a little bit… just patient with her…”

**Subtheme 1c. - Legal Status.** Counselors described the barrier caused by the expiration of client green cards and their losing legal U.S. status a total of 13 times. Clients who were not legal residents or who had lost their legal statuses during the time that they were engaged in vocational rehabilitation services, automatically became ineligible to legally work in the United States and interrupted service provision. According to the counselors, some clients would stop attending appointments out of fear.

<Participant E>: “Depending on the system I was working in, I may ask or may not ask, if they were legally able to work in this country. Some states, in terms of their Worker’s Compensation systems, required you to actually complete an I-9 form verifying that somebody is legally able to work in the United States. That's not the standard, so for the most part that will not be a question I would ask…”

<Participant C>: “She currently - she has lost her Social Security disability benefits, because she also lost her - her Green Card expired, and so she was faced with deciding whether or not she was going to go back to Mexico, or stay in the United States and not have an authorization to work or do very much of anything,
So, she lost her Social Security benefits, and at this time I believe she is not doing very much. She's barely following through with us, because I'm not sure if she thinks that we're going to tell Social Security on her about her expired Green Card. So, unfortunately, she is one of the ones that we haven't - I haven't had much success with. Her case is still open, but there is not much going on on it.”

**Subtheme 1d. - Education Level.** Fifteen participants reported issues with clients who had arrived in the United States without formal education, or without the ability to prove the education that they received in their native countries. They expressed that low educational levels negatively affected their employability and the type of work for which they qualified. It was more difficult for these clients to acquire jobs, and their choices of work were limited and at the most would require vocational education. It was also stated that country of origin was typically an indicator of level of education. For instance, one participant noted that clients from Europe came to the U.S. more educated than those from Latin America. Most clients discussed in the study pursued the following kinds of jobs and training: cosmetology, agricultural processing, housekeeping, cooking, babysitting, dishwashing, retail, office work, and medical assisting.

<Participant G>: “…they’re using their bodies more than they’re using their language skills or their knowledge skills, which is common I guess to immigrants who don’t have the training or the language.”

<Participant E>: “The ones that are from Europe are higher level of education. The ones that are from Latin America are lower level of education.”
**Subtheme 1e. - Migrant Femaleness.** Migrant femaleness was mentioned 36 times in the interviews, where experiences connected to gender and immigrant status negatively impacted client follow-through with services. Participants interviewed spoke of a higher occurrence of traditional gender roles within families of immigrant clients, with three instances of them being contrasted with American female clients, particularly in regard to female submissiveness to their husbands. Husbands were described as being very vocal and had the final say during decision-making around participation in vocational rehabilitation services. Counselors also discussed clients who prioritized home responsibilities, which included caring for minor children and grandchildren, caring for elderly family members, and caring for husbands who were ill. This affected whether or not the client would continue to pursue vocational services and also her attendance and reliability in the workplace. In some situations, the immigrant clients had no work experience or far less compared to their American counterparts. Or they lacked basic work skills, such as calling in sick or being on time, often with different expectations of the employer/employee relationship than they were used to having or expected. One participant described a client’s experience as a victim of incest, and how that sexual abuse as a child persistently impacted her current ability to obtain and maintain healthy relationships and trust. The client’s offenders, her uncle and father, currently reside in her home country.

<Participant H>: “So, after a disability there seemed to be a greater percentage of women expressing reluctance to get into looking too hard for work or they would describe various barriers to it and sometimes would say things their
husband doesn’t want them to work or at certain times won’t let them work or won’t let them work in certain areas. And so that’s quite a bit different from native born American women. I don’t know if I’ve ever had a conversation specifically like that with a non-immigrant woman.” And also, “Yeah, and actually security work, as it turned out, that’s something that I mentioned as a job that would potentially be available for somebody who has physical restrictions, who doesn’t have a whole lot of transferable skills from prior work that’s pretty entry level occupation. However, in terms of immigrant women, it tended not to fit very well. There was a certain level of fear with dealing with it, versus with women who were born here, for the most part. And very often, it would be a husband saying no, no, no, you can’t do that. “

<Participant F>: “This is just my experience… my perception and my interface with it, but it’s a very male dominated group of folks and definitely the women are expected to be sometimes seen and definitely not heard… And it is almost an impossibility to be able to meet with the Somalian women privately without a male being there and not just being there, but actually being a strong presence in speaking for the woman, even during an intake interview."

<Participant A>: “I think she was a mail order bride, actually. So when she entered into the country, it was under the false pretense of… probably not her… but the man. And that was kind of difficult for her because she was feeling a little bit trapped and she loved the United States but she felt trapped and was unable to proceed a lot of times because of this man. So once she was able to get
away from him and be able to really search for a goal and go to work somewhere, she kind of just blossomed.”

<Participant D>: “Well, I know there was some sexual abuse when she was younger. In regards to whether it was from her uncle or her dad it’s kind of unclear. I think it was both. So that has really discouraged her from being hopeful and finding relationships and then being healthy. She - I hate the word promiscuous but I don’t know what other word to use. I think because of that past that she had of sexual abuse, she really just kind of got into having sex with a lot of men, older men.”

Subtheme 1f. - English Proficiency. In this study, a major contributing factor for clients to not achieve their vocational goals was a lack of proficiency in the English language, which was discussed 58 times. This directly affected their desire for and follow-through with educational training services, whether or not they obtained a driver’s license, their ability to access public transportation, their ability to advocate for themselves in the workplace and during service provision, their effectiveness in job readiness activities (resume development, mock interviews, contacting former employers for references, computer skills, etc.), and their ability to understand any processes or procedures involved with vocational rehabilitation, health services, employment, and Worker’s Compensation legal processes.

<Participant H>: “…but what I definitely saw prior to that in terms of coming up with goals and plans for rehab is it’s a very reduced number of
opportunities because of educational background sometimes, because of language mostly, with immigrant women we’re looking at.”

<Participant C>: “I would definitely say the language barriers have been there for A.G. and for M.G., and the unwillingness to really maybe take up basic English or, you know, English as a Second Language class. Both of them, when I talked to them about that, they weren't very open to it. They were pretty resistant to the idea of having to go to school to learn English. So, that ended up being an employment barrier for them.”

<Participant F>: “They have succumbed to some vulture attorney that preys on, you know, our Hispanic population that has been injured. And that's mainly because of the language thing, too. They simply cannot understand the process, because it's not in their native language - what they're reading, what they're hearing - not from my perspective, but from the employer sending in information and the insurance company and the doctors and all of those things. And so I understand why those attorneys have to be involved; but then at the same time the success rate of vocational rehabilitation, I think, is hampered because those attorneys' biggest angle is a settlement.”

<Participant E>: “Then I would go through and try to understand what her perception of her limitations were, vis-a-vis, the medical records. Because I am Spanish speaking and, many times have worked in systems where providers are not Spanish speaking, sometimes there were huge discrepancies or some discrepancies between what the woman was telling me about her background, about her medical status, about what she felt she could or couldn't do, even work
history and educational background, that was very different from the record. I would spend quite a bit of time trying to get as accurate of information as I could to try to have my records be reflective of her reality…”

<Participant B>: “No, it's like a vocational school, but they call it ... It's like an AS in nursing… Which also brings up the issue that I have if you take these classes in Spanish, are you going to pass the board test which is in English, but they feel that they can do it, so. She has the grades for it, so, there's no reason why I shouldn't help her.”

<Participant G>: “I mean it’s very difficult for somebody who doesn’t speak English or is able to understand it but is uncomfortable speaking it, which I find a lot. They can understand but they feel like they’re gonna embarrass themselves and I had people tell me that time and time again, from all different cultures and all different languages.”

<Participant A>: “…just be patient with her and make sure you had interpreters and different things like that, even though… I mean that was one of the things that she was like oh no I don’t need an interpreter, but it was clear that she wasn’t really understanding everything that was being said but she… I don’t know if it was her self-esteem or she just didn’t want to be a burden, or what it was on her part, but I kind of tried to explain to her no we have to have an interpreter and I had to have the interpreter interpret that so she understands everything and so that I understand everything, so I kind of had to force it on her, I guess. We’re taught that if they request an interpreter, you give it to them. But I kind of had to force it on her because she didn’t want to be a bother. She didn’t
want, you know… to her it was fantastic just being here, just being able to leave that situation, right, and be here was enough. She was grateful enough for that and didn’t want… it was almost like that. She didn’t want to be a burden, you know, enough has been done kind of thing... I really liked her (laughs).”

**Theme 2 - Level of Self-Confidence.** Participants reported in 26 instances that clients’ low levels of self-confidence and self-esteem negatively impacted the clients’ participation and follow through with services. In a reciprocal fashion, continued participation in services contributed further to improving self-confidence, interpersonal skills, and attainment of goals. One counselor discussed how her client’s shyness and lack of self-confidence improved after her new job provided her with the opportunity to interact and build friendships with individuals who shared her experiences with mental illness. The social impact of disability, such as family views, also affected self-esteem. Another participant discussed how her client’s lack of family support resulted in decreased engagement in vocational rehabilitation services.

<Participant C>: “Well, for A.G., she definitely was able to obtain employment, and by obtaining employment, she was able to definitely put herself in a better position in terms of gaining permanent housing. Part of the requirement with the transitional housing program that she was in is that she had to be out looking for work. Once she got a job, then that would make her eligible for subsidized housing through the mental health agency. And so by getting her a job, she was able to get her own apartment. So, that was great for her in terms of kind of accomplishments.”

<Participant D>: “And I think coming to groups is really giving her the words to articulate herself in a way that people can understand what she's going through. And so
with that, she's able to build friendships and understand that, you know, she's not on a deserted island all on her own. She's with everyone else. You know, it's universal in that group. Everyone's kind of going through similar things and trying to work it out, you know, and have a better life. So, she's getting it. I feel like gems are being dropped, and she's taking those mental gems and applying them to her life… It almost helps her recognize that, ‘Wow, my stuff might not be as bad as theirs.’ It’s building her confidence, it’s bringing her out of her shell, being shy sometimes, helping her to use the skills of conflict resolution, not only for herself but to help clients that are struggling, talking with them. She shares her positivity, and it’s positivity that I really haven’t seen until she started that position which is really, really cool.”

<Participant A>: “…I mean come to find out, she had graduated high school in Mexico and was trying to get a job in the United States with that high school diploma, so we chose to just get her GED. And when we did that, it opened up a lot of doors for her. And as her doors were opened, her confidence really built and she was able to get a job and really be kind of successful, but it took a long time…”

<Participant C>: “And then my lady from Mexico. I'm not exactly sure which part of Mexico she's from, but she is also someone that I worked with to try to [enable her to] go to work. She had a pretty significant language barrier. She did not speak English very well. Her family was kind of similar to (another client’s) family in which her husband worked and didn't really think that she needed to work and really didn't see the disability as something that needed to be considered. So, there was a reluctance on the family's part to allow her to participate in VR services, and there really wasn't much encouragement from the family to get her to appointments, to support her going to work…. she is
currently still a client. She had been a client with us for - let me see. I'm going to take a quick look. [Pause] She started with us - she was one of the first clients that I got when I came to VR in 2010.”

<Participant A>: “I just think that we need to understand that it takes longer. It takes more time. You have to have more patience. You have to have more consideration. And you really have to put your own opinions and leave them at the door. I mean you’re supposed to do that with everybody but I think with immigrants, especially women immigrants, disability, you have a lot of things going on there, a lot of changes in their life and you kind of have to sit back and let them develop and whatever pace it takes them to do it. Because disability in some countries isn’t looked on like it is here either. I know the one from Mexico, it was very difficult for her to share stuff with her mother. Her mother didn’t want to accept a disability. It was kind of like, get off your butt and go do what you need to do. So you have to deal with the family dynamic at the same time.”

**Theme 3 - Amount of Time.** Six out of eight participants indicated that the amount of time spent working with clients was correlated with the likelihood of reaching their vocational goals, in varying degrees. This was discussed 29 times. Counselors described service provision situations where limited time negatively affected goal acquisition. They also described situations where clients whose cases were open for extended periods (over a year) were also less likely to obtain and maintain employment. In general, service provision with immigrant clients required more time than with American clients, for reasons previously discussed, such as language barriers and lack of acculturation.
Practitioners who provided services through Worker’s Compensation were usually designated a maximum of three months to work with their clients in this capacity. Conversely, practitioners in vocational rehabilitation settings discussed circumstances when clients were on their caseloads for extended periods of time, or had been passed around to several counselors, which was not always beneficial to the clients, due to discouragement and subsequent disengagement. Depending on the services that were provided, as well as the diagnoses, the ideal amount of time for each client varied.

<Participant G>: “I didn’t like the abrupt… three months, to me, never was and never is long enough. It’s just not long enough for the people I work with to find a job.”

<Participant B>: “She’s older as well. She’s about fifty-ish. She has been with us forever. For at least ten years. So, we helped her with training, we helped her with training again, but she has many factors that are very difficult for her to be employed. She has fibromyalgia, she has issues with her legs, she’s overweight to the obese, severely obese, she has orthopedic problems because of that. She uses a cane. What else does she have? I think she might have, if I remember correctly, she has some kind of depression/anxiety and that just culminates all her conditions.”

<Participant F>: “And the other – the thing that is very frustrating in all of these populations is if I’m involved and we’re to the point of rehab services and we’ve eliminated the first three priorities to return to work, you’re going to have to hang with me for a long haul. We’re talking about one, two years until we’re at the point that I can help you market yourself directly into an employment position in the community given your injury and your English speaking abilities. So I think that frustrates a lot of folks,”
especially the Hispanic ladies, they just want to go back to work. And it’s true with the
Vietnamese and Philippine ladies too.

**Theme 4 - Motivating Factors.** Counselors discussed certain factors within the
lives of their clients that acted as motivators or sources of discouragement during the
rehabilitation and job seeking processes 38 times, such as family, independence, self-
confidence, and financial stability. There were instances discussed in the interviews
where a supportive family who provided transportation and verbal encouragement
contributed positively to client outcomes. Conversely, unsupportive families who did not
want the client to work or be disrupted from engaging in household duties acted as
motivators for some clients and demotivators for others. Participants reported on clients
who were motivated to be independent, no longer require supportive services, and
provide for themselves and their children financially. Also, one counselor described a
situation with a client who was encouraged by an advocate who assisted with language
barriers. Lastly, age of the client played a role, as it was directly connected to the age of
their children. At times, women with school-aged children preferred seasonal work, while
women with older children worked and engaged in services more consistently.

<Participant G>: “…the settlements for especially lower paid employees are not
big at all. They might be five thousand, ten thousand, thirty thousand. But by the time
they settle their cases, it’s an average of three years, they’re so behind, they’re so
overwhelmed with debt that there’s usually nothing left and not enough to go forward for
any length of time. So they have to go back to work.”, and “To generalize people that
immigrate to the United States from countries that are either war-torn or poor are coming
from situations where they don’t have much. They don’t have much food, they don’t have
much clothing. They have a lot of people, big families that are integral to in terms of support or feeding or care or whatever, and they come to the United States and it really is the streets are lined with gold because they can get jobs. And even if they’re not making a lot of money, a lot of people work two or three jobs and that’s not uncommon because it’s a bonanza and they can bring in all this money and educate their children…”

<Participant E>: “Yeah, I think opportunity is the driving force and I think that my role as a rehab counselor is to provide opportunity and it’s really fun to see when somebody’s provided opportunity, what they can do with it. So, I’ve seen women be able to do things they never thought they would and become the main driving force for their family, sometimes for their kids if they’re not in a relationship.”

<Participant H>: “I can think of one woman who was a single parent and had two kids and she just had a lot of issues with her ex-husband, she was really moving forward and just doing what she could to better herself and she went into some type of office work, she was getting computer training and English skills at the same time.”

<Participant D>: “She was really interested for a while in stripping, because she wanted money. She needed money, she had a kid. And her coming in there and exploring it with me - I’m not one to discourage clients from doing what they want to do, but we definitely went over risk factors of her doing that, and possibly adult men taking advantage of her. Which is really cool, she changed her mind after we talked.”

<Participant C>: “[A] couple [of] months later, she returned, and I said, ‘Hey,’ you know? ‘Where have you been?’ [Chuckles] ‘Where have you been?’ And she came with an advocate, because I think at that point she learned that she needed somebody that was going to be able to speak on her behalf, especially with the language difficulties.
And, you know, she came back; and she was insistent on reapplying for services and having me as a counselor and going to work.”

<Participant E>: “By the time the kids get in school and they have more hours in the day to be able to further supplement the family income, then I see them going from seasonal work to more year-round work. They might end up in a potato processing factory that runs for several months out of the year instead of a few weeks. Or, they might get a house-cleaning job, where they work year round kind of thing. So, their patterns for engagement in the labor market do change with age. Then, once their kids are self-sustaining, let's say teenagers or young adults, then I see them ... One of two things usually happens with women in that age group: Either, they are ready to engage a lot more in the labor market or if their husband or older children are such that they are then starting to support her, if she is maybe a widow or divorced, but that's rare to find that family pattern, then they choose not to participate as much in the labor market in those circumstances. So, age along the lifespan does seem to make a difference with these women.”

**Theme 5 - Collaboration.** This theme is three-fold and was presented 42 times. Counselors reported that when they and their clients worked cohesively as a team and had a strong working alliance, that this relationship contributed positively to rehabilitation outcomes. Also, incorporating appropriate community resources and members of the clinical team supported greater success in the vocational rehabilitation process. Lastly, involving client employers in the rehabilitation process was shown to be helpful. Clients who did not adhere to treatment were unsuccessful or had their cases closed.

Acculturation and the establishment of a working alliance are closely related to building
rapport, which will be discussed later. One participant described her frequent success with returning clients to work with their original employers, due to opportunities to educate the employers or provide job accommodations. Another counselor described how seeking help from her supervisor when working with a refugee client provided her with the assistance that she needed.

<Participant A>: “I didn’t really know anything about that. I thought oh gosh, how am I going to do this? What am I going to do? I know nothing about this. But I was able to get assistance from the refugee center, co-workers, which they hadn’t really experienced too much of it anyway but there is a supervisor where I work that does a lot of stuff with refugees and I was able to get a lot of … I find if you reach out, you can get help.”

<Participant E>: “…where I live, I know we're not supposed to talk about specifics, but where I live the state has a very good, let's say ... The employers are a lot more open to returning somebody to work or to placing people with disabilities, compared to where I started my career in California. So, I think about 80% of people actually return to work with employer post-injury. So, sometimes, it's employer education, sometimes doing job analysis, sometimes getting assistive technology to ease that return to work…”

<Participant C>: “She was discharged and spent probably about three weeks in the inpatient hospital, and when she came out, she was treatment noncompliant. She didn't want to have anything to do with treatment. She refused medication, and based on just her lack of ability to follow through after that, I was not able to provide services to her, and I had to close her case.”
Theme 6 - Cultural Sensitivity. The participants discussed cultural sensitivity 46 times and raised important points about needing to be culturally aware regarding their clients’ backgrounds, preferences, and experiences. Although the theme and importance of cultural sensitivity was inherent in the questions that guided this research, it was also important to address the acknowledgement of this significance in the responses of the counselors who worked with this diverse group of women. Again, many of the themes presented in this section were interconnected and at times overlapped, but some points that were raised on this subject also touched on the emotions, attitudes, and opinions of the counselors around the definition, appropriateness, and significance of cultural sensitivity. Counselors talked about the need to be engaged in constant learning about other cultures and cultural views on disability, such as familism, to not be judgmental, and to be aware of personal biases and stories that affect their worldviews as counselors. Two participants discussed the role of client religion in service provision, with different views on the matter.

<Participant D>: “I think, and I always stress the importance of being culturally aware, I don’t think – and this is just my personal opinion – I think that to work with someone that’s an immigrant that is completely either the same as you or completely different than you, is to be culturally aware is to learn. Keep learning about people’s cultures. No one else thinks you can be competent in another, because you just – that word just doesn’t fit with culture – you can be aware and have knowledge about culture and not thinking that your culture is better, because those clients that are immigrants will feel that. And I think that’s so important to keep in mind when you’re working with
someone that’s so different than you – ethnically, culturally, religiously, politically. It’s so important just to have an awareness and a knowledge on the differences. Be curious, not judgmental.”

<Participant A>: “And what I found out was that sometimes in some situations disability could be a demon or it could be a punishment in the family or something like that, so I kinda had to be considerate of that and kind of enforce in her and explained to her about the medical component of disability to make her feel a little bit more comfortable and that might have been where her self-esteem was coming from because, especially with Lupus, because that’s something that not a lot of people know a lot about. There’s some phantom pain involved and different things like that, so I kind of had to be aware that thought process might be with her, but at the same time, let her know that I had a different opinion without saying somebody else’s opinion was wrong.”

<Participant E>: “: I think it's helped in the sense that my Mom fit the description of your study group and so she was a woman who came to this country at 39 years old, didn't speak a word of English, had four years of education, was married, had two young daughters, and had worked as a subsistence farmer and held one job for maybe a few months cleaning somebody's home and that was the only job she held outside the home before she came to this country and then she came to this country and started working in the world of work, and so having been a member of that household, I have knowledge of what it took to make that transition. So it's not abstract to me, it's very real to me on what the sacrifices these women do when they go and participate in the world of work, how much of a change that is for them, the struggles that they deal with socially, linguistically, and my Mom ended up with disabilities as well and so, how the medical system treats
them, how their lack of knowledge of certain systems kind of precludes them from certain services and a lot of times how that impacts them and impacts the family. So, I've lived that reality, so I think that is helpful and probably because I believe in the multicultural counseling standards of our profession, I think I have to also be aware that maybe my own experience has also created blinders to other realities, other cultural realities, and even the mainstream cultural reality, really…”

<Participant C>: “Working with these three over the last couple of years, it has definitely brought up for me the importance of culture and considering culture especially in a traditional VR process - that not everything is going to work for this VR process the way that it is set up to work; and that, you know, the family has to be involved as much as possible. And also, the concept of self-sufficiency, while that's something that's inherent in the VR foundations, it may not be something that is consistent with specifically these three ladies - you know? Family support was important, and independence is important; but I also think that there is also some kind of dependence on the family and needing the family to be around and be there.”

<Participant C>: “I didn't really touch too much on religion and spirituality with any of them, to be honest, so I'm not sure. I know that A.G. used to talk about going to church and saying, "Bless you," and, "Thank you," and all of that kind of stuff; but I really didn't kind of go there with the clients.”

<Participant F>: “And their (Somalian) population has to adhere to a pretty strict prayer schedule. So, sometimes they’re looking for employers that will accommodate their religious background, so that they can pray at a certain time during the shift or something.”
**Theme 7 - Rapport.** There were 24 instances of rapport being discussed by the participants of this study. According to the counselors, the development of trust and respect between counselor and client within the therapeutic relationship was shown to be a factor that positively affected vocational service outcomes. According to participant interviews, client perceptions related to their worldviews, having to do with difficulties with acculturation, misconceptions, or mistrust of Americans, negatively affected the process of rapport-building. The participants stated that the building of rapport tended to be a slower process with their immigrant clients.

<Participant G>: “…many of the immigrants are not truthful. They will either obscure, not answer, pretend not to understand or flat out lie to you. So this lady … it took me a while to gain her trust…”

<Participant D>: “And when I first met her, she had a really hard time opening up to me, not wanting to share anything. Seems like in my career, first look is a white girl that’s been born with a golden spoon, you know, and I really try hard to share and open up a little bit and disclose a little bit so my clients feel that, hey, she’s relatable, she’s kind of been through what I’ve been through. And this façade of who they think I am drops off, which is really cool, and I see that happening with her, where bit by bit, little by little, every meeting, she’s just learning to trust again, the service providers, and knowing that we really have her best interests at heart. It’s been almost a year now I’ve been working with her, and I’ve seen tremendous strides.”
**Theme 8 - Altruism.** Two participants spoke five times about supportive interactions with clients that encompassed a spirit of advocacy or a desire to meet client needs in a way that was not necessarily required of them in their job functions. These actions contributed positively to the working relationship and to client outcomes. For example, Participant G provided a job-seeking client with a briefcase that she needed, which the participant perceived to have increased the client’s self-esteem. Participant F helped to create a job opportunity for her client, by identifying a unique and culturally significant need, and sought financial assistance from the insurance company to be able to support it.

<Participant G>: “…so I took her next door to Staples and I bought her a bag, a briefcase. I just couldn’t stand looking at her anymore. She was a mess. And I didn’t tell the insurance company about that. I didn’t ask for compensation. It was just… I thought she needed it. It made her feel really good. I could tell. She felt professional. She looked more professional.”

Participant F>: “When she was in Guatemala, from what I learned, doing her intake interview and assessing her transferrable skills, she was one heck of a sewer. She sewed these beautiful gowns for coming of age parties, and weddings, and all sorts of stuff, and there was a tailor in this little town and the tailor was getting to be quite old. And oh gosh, it was all the discussion, what would happen if he wouldn’t be able to sew anymore. So what I did was negotiate an OJT where the insurance company paid the wages of this gal, my gal, to basically work there for six months learning how to interact with the public and some English skills on the job, even, and basically establish herself there without having her employer expense that, that she wouldn’t have been able to do
so in the other situation. And then the gal is still working there. My gal is still working at the seamstress’ company. The owner has semi-retired but still goes down every day, and it’s really cool how it worked out.”

Research Question Two: What do rehabilitation counselors know about domestic and international disability policy, and how have they applied this knowledge in their practice with immigrant women with disabilities?

Six of the eight participants spoke of the Americans with Disabilities Act of 1990, which is arguably the most well-known piece of disability legislation in the country. Dependent upon the field of work and the population that they worked with, the counselors mentioned various other pieces of legislation related to disability at the state and federal levels, such as Section 5150 of the California Welfare and Institutions Code, the Civil Rights Act of 1964, the Fair Housing Act, the Family and Medical Leave Act, the Randolph-Sheppard Act, the Age Discrimination in Employment Act (ADEA). One participant was knowledgeable of international disability policy and mentioned the Convention on the Rights of Persons with Disabilities.

Not all legislation mentioned in the interviews was specifically applied during service provision with immigrant women. In response to how they specifically applied this knowledge to their work with immigrant women with disabilities, Table 4 lists the legislation named by the participants and the purposes that they served in practice with that client particular group.
When asked where they obtained their disability policy knowledge, all participants mentioned their Rehabilitation Counseling Master’s degree programs. All participants but one also attributed their knowledge to their job trainings or functions. Three participants mentioned learning about policy at conferences and related meetings. One participant’s family member also had a Master’s degree in Rehabilitation Counseling and a Forensic Rehabilitation practice, with which the participant had assisted. She had been predisposed to the field as well as a branch of the field that is closely connected to law. Another participant had an additional Master’s degree in Public Administration, which is a degree that prepares individuals for public sector careers – including within the U.S. government. One participant also had a doctorate in Rehabilitation Counseling, which provided her with more opportunities for research and learning. Two participants began working in the field before they completed their Master’s degrees, which

<table>
<thead>
<tr>
<th>Legislation or Policy-Related Resource</th>
<th>Purposes</th>
<th>Number of Participants n = 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADA and Amendments</td>
<td>Interpreter services, job accommodations, and accessibility</td>
<td>4</td>
</tr>
<tr>
<td>Section 504 of the Rehabilitation Act</td>
<td>Reasonable accommodations and accessibility</td>
<td>1</td>
</tr>
<tr>
<td>California Mental Health Services Act (MHSA)</td>
<td>70% subsidy of rent for residential clients</td>
<td>1</td>
</tr>
<tr>
<td>Tarasoff Law</td>
<td>Duty to protect</td>
<td>1</td>
</tr>
<tr>
<td>State Worker’s Compensation Law</td>
<td>Qualification for immigrant clients, regardless of whether they had authorization to work in the United States</td>
<td>3</td>
</tr>
<tr>
<td>Social Security Disability Insurance</td>
<td>Benefit to individuals with disabling medical conditions and a U.S. work history</td>
<td>2</td>
</tr>
<tr>
<td>Federal Pell Grant</td>
<td>Financial support for post-secondary education</td>
<td>1</td>
</tr>
<tr>
<td>Civil Rights Act</td>
<td>Anti-discrimination</td>
<td>1</td>
</tr>
</tbody>
</table>
could have provided them with an opportunity to tailor their learning to their specific job
interests or goals. Lastly, one participant received job accommodations at the time of the study,
which allowed her a first-hand perspective while providing information and accommodation
assistance to her clients.

Some participants displayed insecurity while discussing their policy knowledge by asking
for additional prompts or examples, and laughing and joking about it. In-person and video Skype
interviews allowed me to observe changes in body language and expressions, which could be
interpreted as insecurity or deep thought, such as widened eyes or sunken eyebrows. The
following examples illustrate the verbal indications of where participants learned about disability
policy, and instances of participant lack of knowledge and insecurity.

<Participant B>: “I started working with this agency before I started my Master’s
program, so I kind of learned policy and procedure before I went to school for it. Then I started
the program and I learned everything else that went with it, the ADA and all that other good
stuff... Everything from the ADA to the Rehab Acts, the 504 ... Mostly I've learned it, I want to
say in both, between work and school. At school I get the practical and at school you get the
theory, so it's kind of a little bit of both.

<Participant A>: “Work. My master’s program at the [University named], there’s a whole
class on that.”

<Participant F>: ”When I was in grad school back in 1991, it was when Reagan pushed
through – was it Reagan, or Bush – anyway it was pushed through… When the ADA was signed
into law, actually I went through some additional training to be an ADA surveyor while I was in
grad school… And I’m also – I also own another company, and I’m an employer here in my
hometown of about 30 people. So I’m cognizant of what the ADA says.”
<Participant E>: “That's a harder one. You know, I could think of immigration policy, but disability policy is harder. Again, policy tends to "cookie cut" and these women, a lot of times, don't fall out into that cut... I haven't really had a case over the years where I'm looking at ADEA (Age Discrimination in Employment Act), which is really kind of interesting. Because, that tells me something that I haven't explored yet, which is the work life expectancy of these women if they're not in the labor force as long as other people within our society where they kind of fall into ADEA kinds of cases.”

<Participant D>: “In school, at [University named] in the Rehabilitation Counseling Program. It’s going to be three years now, since I graduated, so I feel like, ‘Oh, what if my professors heard this and I don’t know s--t right now.’”, and “…so legislatively, I'm not sure about every - I'm almost embarrassed talking about it, 'cause I should know more, but I don't.”

Some participants acknowledged a need for greater advocacy for immigrant women with disabilities in the realm of disability legislation. Participant E discussed how a lack of English proficiency and a lack of disability policy knowledge among female immigrant clients could preclude them from being able to advocate for themselves in situations where they needed accommodations on the job. She also iterated that rehabilitation counselors have a responsibility to remedy that. Also, Participant G provided an example of an experience with an immigrant client, while although he was male, the same conclusion can be drawn. She realized the need to be aware of the resources that were available to assist this client in his pursuit of post-secondary education. In this case, it was the Federal Pell Grant.

<Participant E>: “ADA, in general, I don't see these women understanding what policies apply to them and how much they could advocate and access within those policies. I think they are under the radar for those, because I don't think that ... I've seen within the systems that I work
in, definitely, behaviors by employers, even service providers within the disability systems, let's say, that exclude these women. These women don't know enough because of language and that type of thing, to be able to understand they're being discriminated against, and to advocate for themselves. I think as a rehab counselor it makes me more apt to do more education and provide them with more resources within those systems. So, an example, under ADA is somebody who needs a simple accommodation to be able to access a line to sort potatoes so they don't have to be bent over the conveyor belt. Instead of asking for that accommodation, they leave their job because they feel they can't do it. That kind of thing. I think access and understanding and advocacy are the biggest issues with disability policy in the application of the disability policy.”

<Participant G>: “I’ve rarely had a client not eligible in a re-training situation for the Pell grant. And although the insurance companies can’t demand it, I routinely do it because it offsets the cost and if I want to go for a more expensive training program, I know it’s going to be more palatable to the insurance company if I can reduce the costs at the front end. I have a client now, again it’s a male, and his training is completely paid for by the Pell grant and the insurance company is only paying his monthly benefit. But even though he’s been on benefit two years longer, this guy was not gonna get a job. He had barely a twelfth grade education, and very street smart, but without the Pell grant I don’t think I could have talked the insurance company into sending him to school. So I think it’s imperative that you know what’s out there or you find out about it.”
Research Question Three: How does the narrative inquiry method support or oppose the process of reflection on practice among rehabilitation counselors working with immigrant women with disabilities?

Reflection on Practice. Participants stated that this research provided them with opportunities to reflect on interactions, service provision, feelings, and clinical dilemmas with clients. And it also gave them ideas for next steps with clients. Four out of eight clients described that the act of reflection on practice compelled the practitioners to rethink previous actions or helped them to think of future plans for intervention. They reported that this mental processing provided opportunities for improved practice. For instance, Participant D acknowledged the need to educate herself further on legislation. Participant G explained that during the process of reflecting on past clients, that it was “interesting” for her to think and speak of clients individually, as it was not something that she typically did. Also, Participant B was inspired to retry a past intervention with a client. And Participant A decided that she needed to research international disability policy, as a result of the narrative process, and also deduced that researching disability policy for past clients might have assisted the service provision process. These findings support Schön’s Theory of Reflective Practice, where practitioners tend to alter clinical approaches, address challenging issues, and develop a new and better understanding of their client interactions, from the act of reflecting on practice. The following are interview excerpts of these revelations.

<Participant D>: “Well, I was with her when she went to the intake, and we talked about it there. She seemed willing to go – it was just finding the time and going. I need to push her more and go with her. You’re making me think I need to do that.” And at the end of the interview, “It sparked some ideas with me, made me want to get some books on legislation!”
<Participant B>: “She did very well for some time with her [therapist] and was helpful for her to kind of have somebody to tell her actual personal problems to. They all come to me with personal problems, but I can only hear so much and they would only tell me so much. I thought that having this therapist was beneficial to her, especially to her self-esteem. Because she is down on herself as to why, ‘People won't hire me. I'm willing to do anything for any amount of money.’ She kind of educated her as to why people are like that and not to put herself down. There's nothing wrong with her, other than she has a few limitations that she can't do. So, it was very helpful for her. You actually gave me an idea, maybe I should start her back up on that, but I don't know if she would like that or not…”

<Participant A>: “Now I'm going to have to research on International [policy]. Now I'm just curious. And you know, to think about it, I should’ve really researched that for those countries when I was working with those people. What the disability laws were in those countries. That would’ve been helpful… learned something. Wow, because maybe I was approaching it as how do I make this conform to the United States instead of thinking how do I compare it for them. I should’ve done that. Oh Abigail, you’re so intelligent. It worked on me.”

**New to Narrative.** Narrative inquiry as a research methodology is scant in the field of rehabilitation counseling as an interviewing tool with practitioners. In this study, three out of eight participants found it difficult most of the time to initiate or maintain the storytelling format, and required continued prompting. This was the result of difficulties with memory recall, or an expressed discomfort with the idea of talking excessively. Five participants were able to engage in narrative comfortably after prompting, and for extended periods. But all participants experienced at least occasional moments where they had difficulties with figuring out what to say next.
<Participant F>: “Any questions? Should I keep going?”, “I feel like I’ve droned on and on, Abigail.”, and “I wish I had a better outcome for you.”

<Participant B>: “I hope this was helpful… I felt everything was rambling, I don’t know.”

<Participant H>: “…I think I’d like a new question at this point.”, “Okay, is it possible for me to speak more globally rather than about specific people?”, and “Feel free to jump in.”

<Participant D>: “That was in a nutshell. That’s definitely in a nutshell for sure.”, and “So, yeah. I almost need questions to answer.”
CHAPTER FIVE
DISCUSSION

This study is the first to explore the experiences of rehabilitation counselors who provide services to immigrant women with disabilities, though narrative inquiry. In this chapter, discussions regarding results of the research questions, implications of this project, and limitations of this study are presented.

Research Question One: What do rehabilitation counselors perceive to be the barriers/successes for their female immigrant clients during service provision?

Based on the findings of this study, immigrant women with disabilities face a specialized set of social, psychological, physiological, and economic issues directly related to their gender. Research question one explored the barriers and successes of immigrant women with disabilities as perceived by their rehabilitation counselors. Eight main themes arose as the most prevalent factors or factors worthy of discussion that impacted the success of this population. Some of these themes, independently, might not seem unique to immigrant clients, such as establishing rapport, collaboration, or education level. However, the data presented by the participant interviews suggest that manifestations of some of these themes within the immigrant context make them interesting points of discussion and shaped the perspectives and clinical approaches of the counselors interviewed.

The most prevailing theme was the immigrant status of the client, which included six subthemes: acculturation, refugee status, legal status, education level, migrant femaleness, and English proficiency. The subthemes identified here support the concept that female immigrant clients do present with a unique set of circumstances that shape certain common rehabilitation experiences that exist in the intersection of gender and country of origin. These raise a question
about how and whether current multicultural approaches to rehabilitation service provision and education incorporate these differences. The issues faced by the clients in this study require practitioners who acknowledge that they exist and are equipped to address them. The clinical approach of the rehabilitation counselor in practice might warrant a level of sensitivity to the unique experiences of immigrant women. While rehabilitation counselors in academic training might benefit from broader course offerings on the topics of psychosocial and cultural aspects of disability that include a wider definition of culture and acknowledge differences between genders and also between ethnic minorities and immigrants.

To address issues of acculturation with immigrant clients, rehabilitation practitioners need to work extra hard in building rapport. Also, patience seemed important. The participants reported that mistrust was a greater hurdle with this population and that acculturation was more difficult. Cultural awareness extends to our clients, but also back onto ourselves (Flores et al., 2011). Counselor biases and misunderstandings about other cultural groups can be remediated through self-reflection and a level of openness with their clients about counselor questions and misconceptions (Banks, 2008; Beach et al., 2011). Counselors can also open communication with clients and invite them to address their perceptions of counselors as Americans. Counselors can also seek assistance, by consulting with a supervisor or collaborating with a colleague who is more knowledgeable or familiar with the particular culture (CRCC Code of Ethics, 2012). Sometimes transferring cases may be necessary if a counselor is aware of a bias that weighs heavily on their interactions with a specific client and needs assistance or training to address those issues. Another option is for the counselor to seek out community support groups or organizations with members of that particular cultural group present. Client participation in this group can help them to establish themselves in their new communities and connect with
resources through other individuals with whom they share cultural experiences (Stebleton & Eggerth, 2012). But while group membership can foster solidarity and a sense of belonging through religious and cultural activities, it can also hinder assimilation (Ramisetty-Mikler, 1993). The strong sense of group identity, along with social and financial support can both help and encumber adherence to service plans.

In addition, the implications of client legal status are also closely related to rapport and trust, as it can be a very sensitive matter for immigrants. Counselors can offer to assist clients with paperwork or accompany them to INS appointments before green cards expire. They could also self-disclose about their own or family member experiences with U.S. legal status. Clinical supervisors can assist their staff by providing standardized protocols for addressing this very issue with clients before, during, and after a lapse in legal status.

When working with refugees who are transient, a solution may be to wait to provide vocational services until they are more stable. A study by Mosselson (2006) with Bosnian adolescent refugees recounted a comment by one of the participants, who described her stay in the U.S. by saying, “it’s fun, but it’s not real life” (p. 24). A lack of a permanent address or phone number will greatly hinder the employment seeking process. The lack of stability can also take an emotional toll on clients. Counselors or therapists who specialize in work with refugees, involving experiences with trauma and transience should be readily accessible to address emotional needs of these clients. Also, refugees and immigrants who cannot return home for financial or legal reasons might experience a sense of mourning or cultural bereavement for family that they will never see again, and past trauma and pain (Eisenbruch, 1991). There might be a lack of closure because of this, in many areas of one’s life, such as the client discussed by Participant D who was sexually abused by her family members in her native country.
Results for research question one also revealed that client level of education and whether they decided to further pursue further education in the U.S were impacted by their familial roles, self-esteem, and knowledge of resources. Rehabilitation counselors should be mindful of educating their clients about all educational opportunities available to them, access to financial aid, and also the availability of accommodations and supports. Culturally experienced counselors may even be able to mediate among the client and their family members, to provide information in support of the client’s goals. Exploration of careers and interests, in order to encourage clients to think outside of the box about typical jobs that individuals in their situations pursue may also assist with motivation and ambition in the area of education. It is also important for counselors to use assessment tools that are cultural appropriate.

Furthermore, migrant femaleness tended to serve as a limitation for immigrants with disabilities in pursuit of vocational goals. Again, being mindful of the significance of the client’s culture and embracing family involvement displays respect and can garner respect from the client and the family. Support services for women, such as transportation, child care, and flexible work scheduling should be considered when providing services to this group. The female immigrants described in this study were less likely to have or be able to obtain driver’s licenses, and their primary family responsibilities precluded many of them from wanting or being able to maintain a traditional work schedule. Brice-Baker (as cited in Banks, 2008, p. 188) also discussed racialized gender concerns of immigrant women with disabilities, including their multiple roles in and out of the home, fear of deportation, and abuse defended by cultural beliefs. There is a CORE requirement for training on the topic of gender in rehabilitation counselor Master’s programs (CORE Accreditation Manual, 2013). Offering courses on the implications of gender on disability would be a great source of information for all rehabilitation counselors.
The last subtheme of immigrant status was English proficiency. Clients who were not proficient in the English language experienced communication difficulties with all members of their clinical teams and their employers. This also directly affected their ability to advocate for themselves and lowered self-esteem. Participants indicated that some of their clients refused to take advantage of opportunities to learn English. If self-esteem is a barrier, then it might be beneficial for clients if their counselors or rehabilitation agencies offered less formal formats of English language acquisition, such as one-on-one tutoring, on-site classes, or adult community education courses. Comprehensive counseling services involve extensive research into resources and options, and providing clients and families with as much information as possible to make informed decisions about their futures. The use of in-house or third-party translation services, in the meantime, is a client right. For issues related to confidentiality, family dynamics, sensitive topics of discussion, and lack of training or familiarity to services and terminology, client family members should not be used to provide translation services (Lee, Batal, Maselli, & Kutner, 2002; Rosenberg, Leanza, & Seller, 2007). According to this study, some states allow for the use of family members as translators. However counselor education and training in immigrant culture can refute this and encourage formal translation services as a best practice. Likewise, rehabilitation research can advocate for clients by informing policymakers who make these types of decisions.

As evidenced by the present research, immigrant status is a significant factor to be considered in the rehabilitation service provision process. Multicultural and ethnic studies are broad categories that oftentimes do not highlight the particular experiences of individual cultural populations (Feist-Price & Ford-Harris, 1994). The CORE accreditation manual requires that rehabilitation counselors should be able to “Promote ethical decision-making and personal
responsibility that is consistent with an individual’s culture, values, and beliefs” (CORE Accreditation Manual, 2013). Rehabilitation counselors who work with immigrant populations owe it to their clients to become aware of the individual, as opposed to the universal, cultural experience. And rehabilitation counseling educators should train practitioners who are prepared to work with individuals from ethnically diverse backgrounds (Feist-Price & Ford-Harris, 1994), with knowledge on how to explore with clients in regard to their individualized experiences.

Theme two was the effect of client self-confidence on progress toward goals. In this study, clients who lacked self-confidence in their vocational aptitudes or their English skills were engaged in services to a lesser degree. The lack of self-confidence stemmed from cultural beliefs about disability within the family, isolation, lack of employment, and limited education. These findings are in agreement with a previous study conducted by Awan, Mahar, and Memon (2011), where the authors described how social perceptions of disability limited opportunities for education and negatively affected self-esteem. A lifestyle of limited social interactions and rejection often leads to depression. This phenomenon is described in Social Oppression Theory, where social exclusion and societal ignorance contribute to social oppression and stagnation of individuals with disabilities (Simarasl, 2012). Educating communities and providing resources for disability awareness is a common approach in the field (Chikara & Manley, 1991; Schirmer & Markuns; 2014). Rehabilitation counselors working with immigrants can educate clients and their family members about disability, implications, and causes to help combat some of the stigmatizing misconceptions and subsequent oppressive attitudes and behaviors.

Immigrants facing isolation may experience these feelings to a greater degree upon immigration to the U.S., because of the additional isolating and discriminatory factors inherent in being an immigrant, female, or a refugee. Similarly, immigrants who enter the U.S. and then
acquire a disability once they are in the U.S. could experience feelings of resentment, shame, fear, and confusion, especially if they are hindered from working. Yeung and Chang (2002) presented findings on an Asian American family whose father had been unemployed and unable to provide financially for the family. This produced feelings of inadequacy, depression, resentment, and anger, which he often took out on his family. Immigrants, especially of adult age, often feel pressures from family members in their home countries, because of perceptions projected onto them by family members about the wealth of America or expectations about financial independence upon arrival in the U.S. (Ramisetty-Mikler, 1993; Sy & Romero, 2008). These expectations might fuel some of the aforementioned sentiments. Counseling or therapy can be integrated into the services provided to assist clients with identifying and addressing these issues. One of the most important things for counselors to remember is that many immigrant clients who are experiencing these types of feelings may not be forthcoming about them or amenable to the counseling process (Kim & Omizo, 2003). And feelings of frustration and depression can then be manifested in psychosomatic ways and affect behaviors, physical health, and engagement in services (Lindström, Aresköug, & Allebeck, 2002). Counselors working with immigrant populations, especially women, will benefit from being trained to be able to identify situations such as these, and to sensitively approach them.

The third most prevalent theme covered issues around the amount of time spent working with the clients. The amount of time that counselors in this study had to work with their clients was at times perceived as insufficient due to issues related to Worker’s Compensation laws, interruptions by client familial responsibilities, or cultural beliefs that took precedence over rehabilitation services. According to the study participants, Worker’s Compensation cases lasted for an average of three months. Furthermore, one participant described how a case open for a
long time can be good, if the client requires extensive services, yet remains engaged throughout the process. Participants also experienced the other extreme, where some of their clients would remain on their caseloads for extended periods of time of one to ten years, frequently transfer to the caseloads of other counselors, or move slowly through the rehabilitation process. These issues can be difficult to remediate, as federal laws and contracts have dictated timelines in both counseling settings. Large caseloads can also contribute to decreased levels of efficiency in service provision. The results obtained from this research expose an opportunity for rehabilitation counselors and researchers to advocate for their clients. Rehabilitation counselors and researchers can use the data presented here to inform legislators about some of the barriers present when providing Worker’s Compensation services to immigrant and refugee clients.

Another consideration to make regarding time is the cultural implications. Perception, value, importance, and significance of time can vary across cultures. For instance, Ramisetty-Mikler (1993) discussed how Asians have a tendency of valuing the past and the future, more than they do the transitory present. Religion can also play a role here, by affecting beliefs about final destination and predetermination. A qualitative study by Juiiu (2000) found that immigrants experienced behavioral changes and changes in views regarding socialization, work, and perceptions of time. Immigrant clients, who present with beliefs such as these, may not regard the present, plans of service provision, or rehabilitation goals in the same way that members of their clinical team regard them.

The next most common theme was the role of motivating factors in the rehabilitation process of immigrant women with disabilities. These factors were generally common to immigrants and non-immigrants alike, which included an understanding of the value and benefits of attaining a goal, and perceived barriers and supports (Wagner & McMahon, 2004). However
while the reasons or sentiments may have been similar, the intensity of these feelings were arguably greater among immigrant clients because of the circumstances in their native countries and the circumstances surrounding their migration. The perspective about educational and employment opportunities was different for some of the immigrants in this study, because it is newly attainable for them in the U.S. That increased its value. Being able to obtain financial stability and a level of independence, being able to provide for their families, being able to offer formal education to their children, and also being able to attain a piece of the American dream were factors that motivated clients to follow through with rehabilitation services. Demotivating factors, such as a lack of education, a lack of English, or greater family priorities have previously been discussed. Counselor awareness of the motivating factors of their clients is very valuable in the rehabilitation process. Sources of motivation are useful assets and protective factors, during the development of employment plans and the implementation of clinical interventions.

Theme five in the research was the presence of collaboration, which was constituted by strong working alliances between the counselors and their clients, collaborative relationships among the clinical team members and outside agencies and working relationships between the counselor and employers. Some examples from the research were multiple team member input in rehabilitation service provision, client involvement in planning and adherence to treatment, and counselor ability to seek advice. This supported positive relationships and attainment of goals among clients. Rehabilitation counseling as an allied health field of practice is designed to thrive on the structure of the clinical team and the professional relationships (Briand, Durand, St-Arnaud, & Corbière, 2007). Team members should remain in consistent communication, be provided with opportunities for input, and constantly reassess their roles, responsibilities, and abilities to carry out their functions with the client’s best interest in mind. In this study, cultural
perspectives and immigrant family dynamics directly affected how and to what degree a client maintained a working alliance and adhered to treatment.

Rehabilitation counselors working with immigrant clients can benefit from collaboration with professionals that are not currently a typical component of the rehabilitation clinical team. Collaborative leadership is a term that encompasses the popular notion that organizations value networking and the exchange of knowledge with one another and that this process requires a level of organization (Kolb & Gray, 2007). Collaboration requires special skills, structure, and leadership in order to be carried out effectively. Kolb and Gray (2007) identified several obstacles to collaborative leadership, including unclear goals, lack of time and resources, and a lack of engagement or team members not carrying out designated responsibilities. These characteristics were highlighted as being especially important in collaboration between faculty members. Recommendations of this study included structured training and leadership consortia. Vangen and Huxham (2003) identified that at least one individual must be vigilant about championing and nurturing the collaborative relationship, which is not an easy or enviable task. Collaborative leadership in rehabilitation counseling can start among faculty members, by identifying collaborative needs, an appropriate leader(s), and developing training for colleagues and students. The results of the present study are an impetus for collaborative leadership training among rehabilitation counselors working with immigrant populations, for the purposes of collaboration with professionals in policy and lawmaking.

Sixth was the theme of cultural sensitivity, which was another topic within the interviews on the list of considerations to be made when providing services to this specialized client group. Counselors recognized the importance of being aware of cultural similarities and differences, as well as personal biases. Some clients revealed perceptions of their diagnoses that were dissimilar
to American cultural or medical standards, which raised an interesting point regarding the ability of counselors to present personal viewpoints while respecting differences. Counselors witnessed instances of familism that went against the American cultural norm of independence and privacy in service provision. Interestingly, differing opinions were raised regarding the appropriateness of discussing a client’s religion, and the potential role it could play in service provision and employment. For some clients, religion and spirituality are closely intertwined with culture and identity. Research supports its utility as a therapeutic resource for clients, and that is reason enough for rehabilitation counselors to explore ways in which client faith can be integrated into service provision (Ironson, Stuetzle, & Fletcher, 2006). Morrison-Orton (2004) interviewed 15 rehabilitation professionals and found that they lacked adequate knowledge of religion and/or spirituality and their relation to practice. Although the purpose of the present study was not to assess counselor awareness of religion and spirituality, the topic is supported by research to be an issue of importance. And differing participant opinions on the subject warrant further discussion and research on counselor knowledge, attitudes, and skills regarding spirituality and religion in clinical practice.

The next theme encompassed the effect of rapport building between counselor and client. Results showed that the establishment of rapport was closely related to favorable rehabilitation outcomes, but this process proved to be more difficult with the immigrant population, who was generally less trusting and more fearful in the beginning of the service provision process. Efforts that improved the likelihood of developing rapport between counselor and client included advocacy efforts, client self-confidence, and motivation. Also, clients who had the opportunity to develop a sense of community with other individuals from their native countries had the opportunity to reap the benefits of social capital, by developing trusted networks and feelings of
belonging in a foreign land. Developing rapport with a client cannot be guaranteed, even after a counselor’s best efforts. In a field where relationships are counseled (romantic partners, parent/child, etc.), perhaps aspects of the counseling relationship can be counseled as well. Rehabilitation counselor training and clinical supervision on problem-solving techniques to address issues with rapport-building can be helpful. Perhaps a client’s cultural worldview, preferences, or tendencies have shaped the ways and depths to which they can build rapport with a counselor. Perhaps the client feels that he or she has built rapport with their counselor, but it is displayed in a way that is different from what the counselor expected. Client feelings or intentions may not be apparent or clearly decipherable and may warrant exploration.

The eighth and final theme captured incidences of counselors’ altruistic behaviors, as they used personal resources and extended themselves in acts of advocacy. Some could argue that there is a fine line between advocating for a client and doing too much for a client or being unethical. Working in human services will undoubtedly evoke compassion and empathy for clients, and those feelings should compel us to be advocates and instill in us a great work ethic. These actions resonate with clients and can support the development of rapport and trust in the counseling relationship (Ivey and Faust, 2001; Martinez Jr., McClure, Eddy, Ruth, and Hyers, 2012), and can be especially helpful when working with immigrants.

There are common factors in the field of rehabilitation counseling that have been established to contribute to rehabilitation outcomes (Corrigan, 1995; Drebing et al., 2002; Evans et al., 2004; Marini, Lee, Chan, Chapin, & Romero, 2008; Mwachofi, Broyles, & Khaliq, 2009; Ottomanelli & Lind, 2009), however they are not mentioned by participants in this study. For instance, all but one counselor did not discuss the severity of the disability as an important factor that contributed to the vocational rehabilitation outcomes of the immigrant women. Also,
assistive technology was not mentioned as a support service or contributing factor. Other factors include supported employment, substance abuse, and expenditures for services. The fact that these factors were not mentioned do not implicitly indicate that they were not contributing factors and may have been minor or overshadowed by more prevailing factors related to gender and immigrant status.

Lastly, this research was framed by Feminist Migration Theory, which encompasses the unique intersection of gender dynamics and migrant conditions and circumstances related to border-crossing (Passerini et al., 2004). This theory acknowledges the tendencies of stereotyped job functions, issues with low self-esteem, and considerations to be made when providing services to immigrants and refugees who are women. The present data provides information on how other factors, such as difficulties with acculturation, language, and legal status also contribute to the unique experience of the female immigrant. From a biopsychosocial standpoint, this study supports that providing services to the whole individual involves the consideration of family, culture, work, emotional health and self-esteem, gender, and health and disability status.

Research Question Two: What do rehabilitation counselors know about domestic and international disability policy, and how have they applied this knowledge in their practice with immigrant women with disabilities?

In this study, the narrative process provided opportunities for the counselors to revisit their experiences in working with female immigrant clients with disabilities. These stories presented a myriad of client issues, barriers to employment, and potential best practices to be able to meet the rehabilitation needs of these clients in various clinical settings. Many barriers to vocational goals were discussed, but not as many policy-related solutions. In general, the counselors in this study were able to recall some of the popular disability legislation, as well as
some legislation that is directly related to their clinical expertise. Yet questions about the usefulness of application of this knowledge, specifically in regard to their immigrant clients with disabilities, were difficult for most of them to be able to address. It appeared that those counselors who had obtained disability policy knowledge through continuing education, membership in professional organizations, or employment training had a better recall than those who relied more on their Master’s degree educations.

Disability policy and related services and resources provide rehabilitation counselors the opportunity to advocate for their clients, as mentioned by one of the participants. Immigrant women with disabilities are at a greater disadvantage of not being aware or capable of taking advantage of these resources because of the barriers inherent in their statuses, such as a lack of English, a lack of education, instability in legal status, a lack of trust, and a general unawareness of what services and resources are available to them. Again, Social Oppression Theory embraces a need for cooperative social and political interventions to address societal barriers, which in this study precluded the accessibility to social services of the female immigrant clients (Oliver, 1998).

Counselors in this study working in Worker’s Compensation (WC) were all aware of WC laws, however they were not necessarily more inclined to be knowledgeable of more disability legislation than the non WC counselors. Providing Worker’s Compensation and medical case management services to clients raised additional barriers to successful outcomes, as compared to public vocational rehabilitation services. Immigrant women who were seeking compensation for an on the job injury were likely to be initially employed in a job that required a level of physicality. These types of jobs typically required little to no education or specialized skills. So when these clients began to seek employment again, they were unskilled, uneducated, and in
addition physically limited – this dynamic plagued the narratives from the WC counselors. These issues were not as pervasive in the public VR system. Also, WC cases involved attorneys who oftentimes had alternate agendas to that of the rehabilitation process. Some clients became easily convinced of settling cases and less inclined to pursue employment. Lastly, in some states WC clients’, pre-injury incomes proportionately determined the amount of money that could be spent to retrain them. So a likely unskilled, uneducated laborer with low wages would experience a ceiling on their potential to pursue further training and employment services post-injury.

In this study, it appeared that counselors’ limited application of disability policy with their female immigrant clients was related to limited awareness of its importance or potential usefulness in practice, as well as limited knowledge. The participants in this study did have opportunities to apply the disability policy knowledge that they gained in their Master’s degree programs. However, there was little evidence of major expansion of this knowledge post-Master’s – especially in regard to international disability legislation and current policy trends, such as CRPD and the Affordable Care Act. The results here are different from the Leahy et al. (2003) and Leahy et al. (2013) studies where the rehabilitation counselors scored above average on a Likert scale of perceived importance of disability policy knowledge in the rehabilitation counseling field. However, a major difference between Leahy’s studies and the current study is the discussion of disability policy knowledge and application specifically with female immigrant clients. Although the study populations were different, the present study’s results do relate to those identified in the Hennessy et al. (2006) study, which identified a necessity for increased policy knowledge for rehabilitation professionals. Overall, extensive disability policy knowledge and application evades rehabilitation counselors, despite its usefulness. CORE requirements regarding policy training in rehabilitation counseling Master’s programs is a good starting point,
but is not sufficient by itself. In order for counselors to successfully apply policy knowledge with clients and specialized groups of clients, such as immigrant women and those involved in Worker’s Compensation cases, then continued training on the topic should be encouraged.

**Research Question Three: How does the narrative inquiry method support or oppose the process of reflection on practice among rehabilitation counselors working with immigrant women with disabilities?**

Donald Schön (1987) identified a need for the integration of a reflective practicum or curriculum into academic programs, for the purpose of preparing practitioners to address the artful areas of practice that are typically indeterminate or imprecise. Reflection on practice through narrative is a method of reconstructing those experiences, thoughts, and feelings with clients that can ultimately result in the identification of areas in practice that need development, reassessment, or improvement. Asking practitioners to reflect on their work through the telling of their stories naturally delves into the root of how they made their clinical decisions (Mattingly, 1991), and can enrich future service provision. This phenomenon was found to be true with the half of the counselors interviewed in this study. Some participants acknowledged a need for better knowledge and understanding of disability legislation, as well as new approaches to service provision that they plan on undertaking, as a result of the reflective nature of the narrative inquiry. Overall, reflection on practice was supported through the narrative storytelling process as a helpful tool for the counselors.

The “New to Narrative” trend at times negatively impacted the reflection process, by preventing the counselors from telling a full story because of impaired memory, the need for frequent prompts, and their timidity in speaking for extended periods of time. In this study, when a research participant was unfamiliar with or new to the narrative inquiry process, they may not
have benefited as much from the reflection on practice component. Rehabilitation counselors who engage in qualitative research may be more familiar with traditional structured or semi-structured interviews and might have a difficult time shifting their thinking and format of response. They may also be inclined to rely on researcher prompting and question-asking. In conclusion, reflection on practice stimulated rehabilitation counselor development and specifically helped them to identify a need for greater knowledge in disability policy for the purposes of application in practice, with their immigrant clients and clients on their general caseloads as well.

**Limitations of the Study**

This study was limited by having a sample pool of all female rehabilitation counselors. Of the men that indicated interest in participating in the study, one qualified but did not follow through with participation. Although the representation of male rehabilitation counselors in the field is disproportionate to that of women, this study exaggerates that disparity. The study findings might also have been improved by having more participants from varied ethnic backgrounds. Having participants contribute their stories from a number of geographic regions within the United States provided a richness in counselor and client experience, however it confined the majority of the interviews to electronic interaction due to distance. Skype interviews lack a level of intimacy that is present with in-person interviews.

In addition, because qualitative research relies heavily on the researcher’s point of view and interpretation, reliability is a limitation of this study. It might be difficult for future researchers to perfectly replicate this study and analysis methods. Also, a limitation of the narrative inquiry method is that it relies mainly on the strength of recollection, selective memory, and the subjective experience of the participant. Analyzing the stories of several participants
helps to corroborate these recollections through the consensus reaped from multiple perspectives on the same issue. Some participants had difficulty recalling information, which shortened their stories. If a participant is completely “New to Narrative,” it might be helpful if the researcher provides the participant with a short tutorial, or fact sheet that explains the format and uninterrupted storytelling process. Not providing participants with in depth information about the narrative process, and the lack of a pilot study are limitations of this study.

Offering participants the opportunity to conduct the interviews over video Skype was intentioned on breaking down the barrier created by phone calls. However, Skype created an alternate inter-relational dynamic, as participants tended to look at the screen instead of the camera. It did not seem to be conducive to obtaining or maintaining eye contact or observing full body language. Researchers who need to observe full body language and maintain eye contact are not advised to use Skype for interviewing.

Lastly, the findings of this study are limited, in that they are the experiences of a select group of female counselors who worked with a select group of immigrant women. The intention of this study was not to present generalizable results to counselors working with immigrant women from all countries, however the information presented here can be useful to many rehabilitation counselors, researchers, and educators regarding immigrant women with disabilities. Readers can decide how this information can be transferable to their own clinical situations, and how it can lay the groundwork for future exploration and improved techniques in practice.
Implications for Research and Practice

While the counselors spoke mainly of their experiences and observations as service providers, their narratives were inherently inclined to a level of subjectivity about their clients’ feelings and experiences. A future and related study on the subject should seek the perspectives of immigrant women with disabilities receiving rehabilitation services. Furthermore, there were areas in the U.S. that were not represented in this research, where immigrants with disabilities from other parts of the world are prevalent. Recruiting counselors and clients from these excluded regions may offer additional information about the unique needs and experiences of clients and counselors in this unique working relationship. Also, conducting in person interviews, as opposed to telephone interviews, might offer a level of intimacy and observation in the research process for the purposes of encouraging the storytelling process. The perspectives of male rehabilitation counselor experiences with female immigrant clients would offer insight into how the gender of the counselor plays a role or contributes to the factors that affect vocational goal acquisition of immigrant women. The implications of counselor gender on migrant femaleness or the working alliance, for example, would be interesting to explore. It would also be interesting to explore whether the difficulty in finding male participants for this study had anything to do with a lesser likelihood of male counselors working with immigrant female clients.

For future narrative studies, participants might be helped by having their own copies of the interview questions/prompts, as well as a notepad and pen. It might be useful for them to collect their thoughts and write down ideas before they lose them, which would ultimately contribute to a richer and more complete story. Also, a copy of the prompts can act as a reminder for storytellers who may not stay on topic. Conversely, the power of silence is important to
remember during narrative inquiry, in order to promote participant thought, reflection, and
dialogue when he or she is having difficulty recalling information. Narrative researchers can feel
free to allow for silence during the inquiry process. Lastly, Ospina and Dodge (2005) posit that
practitioners are more likely to implement research into practice when they have established
relationships with researchers. A possible follow-up longitudinal study could test this theory by
inquiring into whether implementing and teaching narrative inquiry techniques to practitioners
might encourage them to employ the method with their clients.

From the interviews of the Worker’s Compensation counselors, one of the main issues
discussed was the pervasiveness of clients working unskilled, physically demanding jobs. Once
they acquired a disability, providing services for re-employment became difficult for many
reasons related to their immigrant status. Further exploration is needed in this area to support
immigrant women in the acquisition and maintenance of skilled jobs that are less physically
demanding. Initiatives to support their successful pursuit of vocational training and education are
needed as well.

Additional research is needed to further assess the application of disability policy
knowledge of rehabilitation counselors, as assessing only their knowledge seems to be
insufficient. And, while it is not the focus of this study, disability policy, education, and related
research particular to the plight of refugees and their unique concerns are areas needing more
attention and research in the rehabilitation counseling field.

Graduate students and counselors working with immigrant populations should seek
cooperative relationships and resources through professionals and organizations in neighboring
fields that specialize in policy and the legislative implications of immigrant status on disability,
such as lawyers, policy analysts, policy researchers, legislators, the Association of University
Centers on Disabilities, the Institute for Women’s Policy Research, and the National Council on Disability. These collaborations could invite opportunities for legislative advocacy that is supported by research and practice. Likewise, membership in professional rehabilitation organizations in this study supported greater knowledge in disability policy and the importance of the consideration of culture in practice.

**Implications for Training**

In this study, inquiring about when and where these participants gained their knowledge of disability policy, along with the data retrieved from question two, was helpful in identifying recommendations for student training and continuing education for rehabilitation counselors. It might be in the best interests of rehabilitation counselors and their immigrant clients if the counselors were engaged in continual policy education efforts at their places of employment and within professional rehabilitation organization trainings. Legislation affecting individuals with disabilities and advocacy for individuals with disabilities are both suggested topics under the CRCC domain focus area of “Foundations and Professional Issues” in the continuing education requirements for certified rehabilitation counselors, however they are among a group of topics that are not specifically required for every renewal period (CRCC, 2013).

Clinical supervisors can incorporate this subject matter into new hire trainings and professional performance evaluations, to encourage continual and current education on the topic. Likewise, Master’s-level rehabilitation counseling degree programs may consider proposing elective courses on domestic and international disability policy, or specializations/tracks in disability policy, as is present in neighboring academic programs (i.e. Public Health). And while Master’s-level training in policy provided a good foundation for the participants interviewed, it
seemed to be insufficient. Counselors working with immigrant populations should be inclined and encouraged to pursue those types of training opportunities.

Narrative inquiry is useful in rehabilitation counseling research and service provision, for that reason its integration into counselor education curriculum is valuable. The narrative approach might also be useful in the counseling supervision relationship as well. Designating a portion of supervisory time to student narratives about academic learning and practicum experiences can enrich the process for both parties, and also prevent the supervisor and supervisee from completely consuming supervision time with case conferencing or student feedback. Also, in keeping with Schön’s theory, these narrations can serve as moments of reflection that can assist the supervisees in their processes of self-assessment and problem solving within their counseling relationships. In order for a practitioner to truly be culturally aware and sensitive, he or she must first reflect on his or her own beliefs, biases, and experiences around culture and the subsequent views that he or she has developed about cultures different from his or her own (Congress, 2005; Flores, Hsieh & Chiao, 2011).

Rehabilitation counseling degree programs might benefit from integrating narrative inquiry into research methods coursework, for the benefits of research and practice, as it is a scarcely used method in the field and might assist with addressing the “New to Narrative” phenomenon that was encountered in this study. The incorporation of narrative in Master’s degree programs can also be useful for counselors in training to use in practice during the intake interview or while providing counseling and guidance services.
Conclusion

The results of this research show that immigrant women with disabilities face unique barriers to the successful obtainment and maintenance of employment, and their counselors should be aware of the many unique circumstances and experiences that shape their lives and worldviews. Experiences related to their gender, culture, and migration directly affected rehabilitation outcomes. Disability policy is a useful source of information, resources, and opportunities for advocacy. Lastly, reflection on practice is a method that is useful for rehabilitation counselors to be able to identify areas for growth, and ways in which they can better serve the clients that they work with. Providing services to clients who are women and/or who are immigrants place counselors in situations where reflection on practice can be particularly useful.

The immigrant experience is increasingly prevalent in the United States, and it presents with many clinical and vocational issues that a rising number of rehabilitation counselors will have to face. Likewise, gender presents a number of implications regarding vocational success and engagement in the vocational rehabilitation process. A lack of policy knowledge and a lack of application of policy knowledge in the field of rehabilitation counseling acts as a disservice to the clients who are served, particularly clients who are immigrants. Client advocacy is incomplete without an ability to implement legislation-related sources or an informed voice to teach clients about their rights and to provide policymakers with evidence from research and practice about the experiences of these clients.
REFERENCES


Coole, C., Radford, K., Grant, M., & Terry, J. (2012). Returning to work after stroke: Perspectives of employer stakeholders, a qualitative Study. *Journal of Occupational Rehabilitation, 1*-13.


Zannettino, L. (2012). “... There is no war here; It is only the relationship that makes us scared” Factors having an impact on domestic violence in Liberian refugee communities in South Australia. *Violence Against Women, 18*(7), 807-828.