INTERNATIONAL ASSOCIATION OF REHABILITATION PROFESSIONALS

The Rehabilitation Professional

Volume 23 Number 1 • 2015

The Rehabilitation Professional

The Official Journal of the International Association of Rehabilitation Professionals

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The Rehabilitation Professional is published quarterly by the International Association of Rehabilitation Professionals (IARP). The Rehabilitation Professional is published to promote the profession, to inform the public about activities of the organization, and to create responsible debate and discussion of relevant issues germane to the profession The Rehabilitation Professional is distributed to all members of IARP as a benefit of membership and is available through subscription to others interested in the activity of IARP.

Subscription Pricing: IARP Member — e-access no charge, included in dues; one print copy of each issue annual charge is $25.
Non-IARP Professional — e-access only four issues $60; e-access and one print copy of each issue $85.
Institutional — e-access only $125; e-access and print copy of each issue $150.

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Editorial: Introduction to the Present Issue

This issue marks several capstones regarding the *Rehabilitation Professional*, with some capstones planned and other serendipitous. Wesley (Dr. Austin) and myself, along with the editorial board, have successfully put forth and completed four very solid issues over the last year. Each issue had two CEU units, and the individual issues had a range of five to nine articles per issue. Next year, our goals are relatively the same, specifically produce four issues with a range of four to nine articles per issue, and similarly have at least eight CEU units over the next year.

Another accomplishment attributable to the future of the profession, specifically the students, must be applauded. Last July I submitted a request for student papers to be submitted for prospective publication in the November-December issue of the *Rehabilitation Professional*. I expected six, or perhaps seven so-so papers, with two or three to be truly publishable in the journal. Instead, I received greater than 100 papers, warranting not only a tremendous amount of work, but also great pride in the next generation of rehabilitation professionals whether in psychology, economics, nursing, or other career fields. From the submissions I narrowed down thirty-five papers for subsequent, blind review, with infinitesimal points separating the top 15 papers. From the top papers I selected the top nine, which are offered in the present issue. I completed minute editing, along with Dr. Austin, offering the current selection of papers. Later this year, perhaps in August or September, these papers will be collected, along with five to seven additional articles, in a collective work or book to be entitled *Ethics, Rehabilitation Counseling and the Mental Health Professionals, Volume 1*. It is a goal that every two years these articles can be collectively gathered into a CEU-based book and sold through IARP, with the proceeds to be donated to a scholarship fund. Again, I applaud the present student papers, as they indeed represent great marks of scholarship.

On another issue, the *Rehabilitation Professional*, based on my recollection of the last 8 or so years has the first commentary and rebuttal on a published article, reflecting divisive dialogue between scholars. Dr. Thomas Ireland offers a commentary on Dr. Joseph Crouse's article offered in the last issue. This type of dialogue is not only encouraged, but also in my opinion invigorates the profession. A quote that I have used throughout my professional career is linked to the philosopher Voltaire, very loosely, "I may not agree with what you have to say, but I will fight to the death for your right to say it." Calculation and projections about both worklife and life expectancy are not without controversy, with polemic expressed both formally and informally. I expect and encourage more or additional formal dialogue on controversial topics in future issues of the journal.

Lastly, I want to express appreciation to several individuals that enabled me to accomplish the last volume of this journal. I forward appreciation to individuals at IARP, including Rick Robinson, Lynne Tracy, Pat Sistler, and Carl Wagman, as their encouragement has not gone unnoticed, and they have indeed made this position as Editor, well, sort of fun. Moreover, I want to send a note of special thanks to Dr. Scott Beveridge and Dr. Thomas Climo, as I have enjoyed their contributions over the last year to the journal. I also want to say "thank you" to Janet and Tim Field with Elliott and Fitzpatrick. The last year has been a learning process. Furthermore, edits have been made with a joyful heart on everyone's behalf. Lastly, truly on a personal note I do thank my Department Head and Dean at the University of Louisiana at Lafayette, Dr. Cheryl Lynch and Dr. Jordan Kellman, respectfully, as they have given me encouragement and time to complete this task. I hope everyone enjoys the present issue, and similarly I am beginning to gear up for the second issue for the upcoming year.

Theodore Scott Smith
Editor, The Rehabilitation Professional

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Editorial: Losing Our Civility and Gaining Graciousness

At present, either on my desk, or via email I have four bits of information that I am processing. First, a report by a Rehabilitation Counselor that has ignored physician feedback for post-injury work restrictions, offering an unrealistic picture of employability, albeit billable work that will most likely offer fodder for a future mediation. Second, correspondence from an attorney asking for justification of a report, based on a Life Care Planner jockeying to expand a Life Care Plan to vocational rehabilitation services by degrading my work. Third, correspondence, specifically email, from a person that has complained that I have not returned their email, wherein, I checked my email and no so-called emails were every received. Lastly, an ill-mannered phone call from an author of a rejected article indicating that I should "just make the corrections" as "that is my job" for an article that does not deserve publication. At present, you may be suggesting, "Dr. Smith, step away from the keyboard." However, it is through these behaviors that I feel that the profession, and indeed, even our clients suffer, in which I will offer the following editorial.

Interestingly, two articles in the present issue specifically address the topic of bias in the forensic process. While economic enterprises encompass our professional practice, we must recognize that we are dealing with real people, independent of whether a person may or may not be classified as a client per se. Claiming someone is not disabled, when indeed they are disabled, based on physician feedback, may gain points on behalf of a referring attorney, but degrading a real disability destroys our essential duty—assist persons with disabilities to make efficient and effective vocational decisions. We must recognize that our reports may indeed cause harm, albeit perhaps psychological, for someone with a disability. Negating a disability when one is present does not facilitate the rehabilitation process, rather presents a bias that thwarts, not facilitates, the rehabilitation process. It is recognized that we often evaluate employability for individuals that perhaps have secondary gain associated with an injury, warranting a terse and aggressive report on realistic employability. In these circumstances, our professionalism and candor are warranted. However, limiting actual disability for solely litigious reasons, represents not only an ethical frailty, but also a mark on the profession itself.

In the field of science, methodologies and conclusions are debated simultaneously, warranting both continuance and advancement of the sciences. Considering our work must be based on established and accepted methodology, we similarly must expect critical feedback from our peers on both methodology and similarly conclusions. However, is the feedback geared towards understanding the circumstances surrounding employability and medical costs associated with an injury, or an attempt to demure another counselor in an effort to enhance our finances? The first act represents a responsibility to the profession, whereas, the second act represents, bluntly, greed and unethical practice. The fields of Rehabilitation Counseling, Forensic Economics, and Case Management has its external foes, questioning the professional practices themselves regarding reliability, validity, and biases. Internal foes geared towards enhancing one's financial status based on demurring another's practice certainly cannot help the profession. If someone's work deserves scrutiny, then offer scrutiny to enhance understanding of the case; however, the other option not only negates the profession, but harms the clients that we serve.

Technology, specifically technology to advance communication represents truly an advancement on behalf of mankind. Submission of reports have progressed from snail mail to facsimile to email. Reports and correspondence can happen quickly, facilitating speed and accuracy. However, electronic communication has its downfalls, including assurance of receipt, alongside the loss of non-verbal cues. Personally, my emails have been meant to be sent, but were never sent; sent, but placed in spam by the recipient; and, sent without attachments. In all of these circumstances the intent was there, but the message failed to reach its recipient. Whether or not this may be "grampa-ish" or not, I propose that communication cannot be minimized to electronic codes, but rather must be expedited through handshakes and phone calls. Yes, indeed, we live busy lives with multiple responsibilities. However, communication must involve a two-way street with both parties communicating ideas, not just one person claiming the recipient to be "it."

Lastly, considering the reality of autocorrect and assumed positive reinforcement for all of our acts (i.e., getting a trophy for simple participation), we must consider at times and accept responsibility for when we fail. Our failures must not be placed as the ineptitude or failure of others. At times, we simply do not meet the mark, or failed to meet expectations. We must learn from these experiences and carry forward these lessons towards completion of additional tasks. Rudeness or aggressiveness does not make our own

work better, but rather belittles not only our past work but sedates our future goals. In the last circumstance presented in the initial paragraph, most probably the article would have been publishable with changes and modifications and simple editing. With a conversation geared towards enhancement of a product (an article) the author would have most probably had a publishable paper; however, with the conversation geared towards belittling the person making the decision, most probably my framework for the author has been set, warranting extra scrutiny on future submissions by the author.

On a final note, I propose that we recognize the humbleness of the profession itself. We offer recommendations to the court, family members, physicians, and the public about ways and means a person with a disability may become whole or productive again. Alternatively, if their productivity is limited, we offer recommendations about the range of productivity the person with a disability may have achieved, barring a particular accident. This represents a laborious task that will be most likely met with some degree of confrontation by opposing counsel or others. The tasks we perform must be completed with civility and graciousness, with gratitude not only towards those that give us these responsibilities, but also the educators and teachers that have taught us these skills. Moreover, we must recognize that others offer opinions, sometimes within our range of acceptability of methodology and at times without this standard. We must question if our decisions are made for the betterment of enhancing employability and decision making for the person with a disability, or strictly to achieve wealth. Communication must be enhanced amongst ourselves and others to facilitate the profession. In conclusion, very simply, we must be careful about not only the daily decisions we make, but also the methods that we communicate our ideas and ideals.

Theodore Scott Smith
Editor, The Rehabilitation Professional

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Impact of Disability on Household Services: A Comment

Thomas R. Ireland

This short comment responds to Joseph Crouse's 2014 paper in this journal, "The Impact on Household Services: Evidence from the American Time Use Survey." The Crouse paper depends on the assumption that the amount of time spent providing household services is a measure of an individual's capacity to provide household services. Crouse points out that the productivity of time spent providing household services after an injury is "impossible to measure" and suggests that "data from the ATUS (American Time Use Survey) are available to measure the reduction in hours spent on household services." Crouse goes on to suggest that: "This number should serve as a lower bound for the reduction in household services for the statistically average disable person that suffers from a particular impairment."

The amount of time an individual spends on household services depends at least in part on voluntary choices of that individual. Regardless of disability, some individuals spend a great deal of time providing household services. Other individuals spend very little time. However, the choice depends on many other variables than the capacity of individuals to spend time providing household services. Everyone's week contains 168 hours that is divided between "Household Production," "Caring and Helping," "Personal Time," "Leisure," and "Work and Education" in the *Dollar Value of a Day: 2013 Dollar Valuation* (DVD 13) cited by Crouse. As is shown in DVD, time amounts must sum to 168 hours per week. Thus, if an individual is shown to spend less time on household production, it must follow that the individual is spending more time in some other fashion.

To use a simple example, Table 5 from DVD 13 indicates that, on average, "Married males, that work full time, spouse employed, youngest child ages 13 to 17" spent 14.39 hours per week providing household services. They also spent 3.90 hours per week on "Caring and Helping," 70.12 hours per week on "Personal Time," 34.24 hours per week on "Leisure" and 45.36 hours per week on "Work and Education," with the total amount of time each week summing to 168.00 hours. If it is assumed that the number of hours spent disabled individuals on household services, however, the disability category was defined, was 10.00 hours per week, Crouse's method would treat the reduction of 4.39 hours as reflecting a reduction in the capacity of the average person in that disability category to provide household services.

It is not self-evident that a reduction of 4.39 hours represents anything other than a changed number of hours providing household services. One must ask what those hours are now being used for. If the 4.39 hours per week are now being used to obtain medical treatments that were not needed before a person's injury (which would fall into Personal Time), there is a reasonable likelihood that 4.39 hours might represent the individual's loss of capacity to provide household services. However, if the 4.39 hours per week are now being spent on additional Leisure, or on Caring and Helping or on Work and Education, treating the 4.39 hours as a measure of loss of capacity to provide household services is less likely to be correct.

DVD 13 provides a total of 244 tables regarding time use from the American Community Survey, 200 of which are for specific categories of persons such as "Married males, that work full time, spouse employed, youngest child ages 13 to 17." Crouse's tables provide comparisons based on just three categories other than disability status: All persons, all males, and all females. His regression equations include influences of age, sex, whether or not employed, existence of spouse and children under age 18, but his conclusions are generic for persons of both sexes, males and females. For each disability classification, he finds differences in time amounts spent providing household services. However, the time amounts are generic to all persons, all males and all females who fall into those disability classifications in his Tables 2, 3 and 4. Thus, he finds, using his example, that an average male with a cognitive impairment "is likely to experience a reduction of 21.91 minutes of household services per day when compared to their counterparts without such an impairment."

It is not clear to this reader whether Crouse's comparison is between males with a cognitive impairment and males without a cognitive impairment *even if they have some other impairment* or between males with a cognitive impairment and males with no impairments of any kind. The difference between these two potential comparisons is important, but it will be assumed for current purposes that the comparison is between males with a cognitive impairment and all males without a cognitive impairment, even if they have other impairments. Thus, the 21.91 minute daily reduction in household services is assumed to apply to all males with a cognitive impairment in comparison

with all males, regardless of other impairments, who have a cognitive impairment.

DVD 13 does not provide a table for persons of both sexes, all males, or all females. It provides approximately 100 tables for males and 100 tables for females. The closest category to "all males" is Table 184 for all males over the age of 18. The closest category to "all females" is Table 193 for all females over the age of 18. Crouse does not make it clear what ages he is using in his comparisons, but Crouse also does not provide base values from which time reduction amounts are calculated. In other words, the reader can determine that Crouse is saying that a cognitive impairment results in a 21.91 minute reduction in daily time spent providing household services, but cannot determine from what starting time amount that reduction for males without a cognitive impairment the comparison is being made. Thus, based on Crouse's paper standing alone, the reader cannot determine what type of percentage reduction is implied by the 21.91 minute daily reduction.

While it is dangerous to use two studies without knowing precisely what methods were used in each study, it may be instructive to look at the time amount for household production from DVD 13 for all males over the age of 18 from Table 184 of that source. The amount shown is 14.01 hours per week, which implies 2.00 hours per day. 21.91 minutes is 0.37 of an hour. Thus, the reduction ratio is 0.37/2.00 = 0.18, or 18%. Based on this comparison, Crouse's paper would imply a reduction of 18% in the amount of household services provided by an average male without a cognitive impairment. To use the other tables provided in DVD 13, one would have to make 18% reductions from amounts shown in each of the other 99 tables for males in DVD 13. For example, Table 1, which is for "Married males that work full-time, youngest child under age 13," shows a weekly hours at 12.82 hours. A reduction of 18 percent would reduce that number from 12.82 to 10.59 hours (12.82 x 0.82) and would reduce the dollar value of a day shown in Table 1 of DVD 13 from $24.74 per day to $20.29 per day.

For reasons beyond the purview of this comment, using the category developed by Crouse for "males with a cognitive disability" is very questionable. However even if one accepts that assumption, to apply the Crouse study to values in DVD 13, which Crouse identifies as reliable, one must assume that the 18% reduction applies equally to all 99 other tables for household production by males in DVD 13. This is a very questionable assumption.

Earlier in his paper, Crouse sets out three methods for determining the value of lost household services for cases involving partial disability. The first method entails gathering information about the disabled person allowing a vocational expert to "approximate" the percentage reduction in household services over a lifetime. The second method is to project the value of an individual's pre-injury capacity to provide household services over a lifetime and let the jury determine how much of the value has been lost. Crouse then goes on to advocate his "data based approach that utilizes information gathered about the disabled individual and how individuals most like the disabled individual being considered fare on average." Crouse's Tables 2, 3 and 4 provide his "data based approach." The questions raised above make it clear that Crouse's "data based approach" requires an analyst to make extraordinary assumptions. The discussion above also makes it clear that an analyst must take a number of questionable steps to apply Crouse's paper to any real world report setting forth a dollar value for lost household services when a person retains residual capacity to provide household services.

This comment does not address other problems that are involved with any attempt to measure net lost capacity to provide household services following an injury. Those problems are not unique to the Crouse approach and will not be discussed here.

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Rebuttal: Clarifying Multiple Regression Analysis and a Reply to Ireland's Critique

Joseph T. Crouse

This reply addresses Thomas Ireland's comments on my paper "The Impact of Disability on Household Services: Evidence from the American Time Use Survey". The original article sought to provide a data-based approach to measuring the impact of partial disability on household services. It concludes by stating that it "represents the first contribution" in doing so. Ireland does not provide a better approach to measuring the impact of disability on household services, and instead, merely criticizes the first contribution to this important measurement while making misrepresentations about the interpretations available from multiple regression analysis.

It is noteworthy before addressing specific issues in Ireland's comment to mention that Dollar Value of a Day (DVD) is based upon cross-tabulations while the Crouse paper is based upon multiple regression analysis. This point alone addresses many of Ireland's comments.

It is unnecessary to provide a few hundred tables as in DVD because the goal of the analysis in the Crouse paper is to explore the partial effect of disability on the time spent performing household services. Multiple regression analysis is best suited in this particular instance for the several reasons, the most compelling of which is the sample size limitations that would preclude cross-tabulations as in DVD. The regression equations provided in the Crouse paper provide the answer to many of Ireland's critiques.

Ireland is incorrect in stating "Crouse's tables provide comparisons based on just three categories other than disability status: All persons, all males, and all females". The tables provided lend themselves to hundreds of possible comparisons. For instance, if an expert was interested in comparing the time spent on household services for a 40 year-old non-disabled female with no children who is employed and has a spouse, the regression equation in Table 4 could be utilized and solved to find:

$$\begin{aligned} \text{HHS} = \; & 3.66(40) - 0.030(40^2) - 68.52(1) + 43.39(1) \\ & + 114.52(0) + 57.35 - 26.63(0) \end{aligned}$$

$$\text{HHS} = \; 130.62 \text{ minutes per day}$$

It would imply that the average 40 year-old female with the aforementioned characteristics would spend 2.18 hours, or 130.62 minutes, per day performing household services. This number is 15.24 hours per week which is a bit lower than the 17.14 hours that DVD 2013 shows for the closest grouping in Table 70 (Married females, under age 45, that work full-time, spouse-employed, no children under age 18). Comparisons cannot be made between the two numbers, however, since the Crouse study is based on multiple regressions and takes disability status into account and DVD is based on cross-tabulations. In this regard, the Crouse study is more specific as it pinpoints the likely number of hours performing household services by age rather than lumping all ages under 45 together. Multiple regression analysis is more amenable to *ceteris paribus* analysis because it allows one to explicitly control for many factors that simultaneously affect the dependent variable (Wooldridge, 2009).

Now if we assume the same female suffers from a severe mobility disability, the regression equation would be:

$$\begin{aligned} \text{HHS} = \; & 3.65(40) - 0.030(40^2) - 67.66(1) + \\ & 44.24(1) + \; 4.54(0) + 56.43 - 52.27(1) \end{aligned}$$

$$\text{HHS} = \; 78.74 \text{ minutes per day}$$

These numbers are only pertinent to age 40. As this female progresses throughout her lifespan, assumptions would have to be made as to whether she is currently employed, whether she still has a spouse, etc. All of these factors will affect the level of household services in a given year. This analysis is best completed utilizing an Excel spreadsheet.

Furthermore, Ireland neglects the paragraph in the Crouse paper that explains how regression analysis can be used in this manner. The Crouse paper states that "The regression equations can be used to determine both the pre- and post-injury values of household services over time . . . . It may be preferable to use a statistical average across the lifespan". It is apparent that Ireland prefers not to use the statistical average across the lifespan, but he fails to realize that the three tables provided in the Crouse paper allow him to perform an analysis based on assumptions about the individual's employment, children, and spouse.

The "base values from which time reduction amounts are calculated" can be easily found by plugging the relevant values into the regression equations. For instance, one would plug in the individual's age, employ-

ment status indicator variable (=1 if employed, 0 otherwise), spouse indicator variable (=1 if spouse, 0 otherwise), kid(s) under 18 indicator variable (=1 if present, 0 otherwise), and disability dummy variable (=0 since we are interested in base values i.e. no disability). Once plugged into the regression equation and multiplied by the relevant regression coefficients, the constant is added and a base value can then be easily obtained for any analysis based on these variables. The percentage reduction is then straightforward to calculate.

An analyst would certainly not apply an 18% reduction to "all 99 other tables for household production by males in DVD 13" as Ireland suggests. If the analyst is not pleased with using the statistical average across the lifespan (as in Case Studies #1 and #2 in the Crouse paper), the analyst can easily use the regression equations provided in Tables 3 and 4 to be more specific and make assumptions about the individual.

While this author agrees with Ireland's comment that "the amount of time an individual spends on household services depends at least in part on voluntary choices of that individual", he disagrees with the notion that the reduction in hours providing household services is merely a numerical change without significance. It is obvious that the reduced hours must be expended in some other way if they are not utilized for household services. Nonetheless, it is most probable that the reduction in hours expended is due to a reduced capacity to provide household services. This, however, is a conservative estimate since it does not consider the likely productivity decline.

The three tables provided in the Crouse paper allow for hundreds of possible scenarios and comparisons. This approach requires neither extraordinary assumptions nor questionable steps unless applied inappropriately. A basic understanding of multiple regression analysis is necessary in order to properly apply and critique Tables 2-4 in the Crouse Paper. Chapter 3 from Wooldridge's *Introduction to Econometrics* will help in this matter.

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The Rehabilitation Professional, 23(1), pp. 11–22

Ethical Considerations of an Outcome Based Vocational Rehabilitation Fee Schedule

Scott Beveridge, Stacey Karpen, Christian Chan, and David Radecke

Abstract. The primary purpose of this mixed-methods study was to assess vocational rehabilitation (VR) providers' opinions related to how a vocational rehabilitation outcome based payment schedule (VR-OBFS) may affect VR services for injured workers. One hundred rehabilitation counselors currently working in the state of Ohio completed a survey comprised of Likert-type and open-ended questions. The survey instrument for this study was created by the researchers in collaboration with a Delphi Panel consisting of fifteen established VR providers from Ohio who have worked in VR for an average of 25 years (range of 7-34 years). Panel members collaborated during three rounds of review and feedback. Survey questions asked VR professionals to consider how a VR-OBFS may affect VR services for injured workers including factors such as duration and quality of services. Participants were also asked to describe the ethical challenges they may foresee as a result of the implementation of the VR-OBFS. The findings of the current study highlight concerns related to how rural areas will be affected, the financial consequences, complex case selection, and the ethical dimensions of the policy. Ultimately, VR professionals expressed fears that the best interests of the IW will no longer be the sole focus of treatment and, as a result, a VR-OBFS would sanction a direct contradiction to the CRCC Code of Ethics.

Keywords: rehabilitation counseling, VR, ethics, outcome based payment fee schedules

The Ohio Bureau of Workers Compensation (BWC) has recently proposed moving from a fee-for-service to a vocational rehabilitation outcome based fee schedule (VR-OBFS) effective January 1, 2015. In January 2014, in their presentation "VR Provider Fee Schedule Recommendations for 2014," the Ohio BWC indicated that principle guiding the fee schedule change is, "To ensure access to high-quality vocational services by establishing an appropriate benefit plan and terms of service with a competitive fee schedule which, in turn, enhances BWC's vocational provider network" (p.2). There is a growing concern among rehabilitation counselors that a "competitive" (outcome based) fee schedule may have deleterious effects on the ability of rehabilitation counselors to provide competent services in line with the ethical standards that VR professionals are obligated to uphold, and, most importantly, that the fee schedule change may result in risks to the wellbeing and best interests of injured workers (IWs). A multitude of ethical considerations should be taken into account before any policy changes are made. The purpose of the current article is to assess the opinions and ethical concerns of VR professionals currently working in the state of Ohio.

The proposed research questions for this study are:

1. How would the proposed VR-OBFS affect vocational rehabiliation services for IWs?
2. Would a VR-OBFS affect the duration of vocational rehabilitation services offered to IWs?
3. How do rehabilitation counselors describe the ethical considerations that could potentially occur as a result of the implementation of a VR-OBFS?

Literature Review

The Commission on Rehabilitation Counselor Certification (CRCC) is committed to advocating for both its Certified Rehabilitation Counselors (CRCs) and the profession of rehabilitation counseling (2014). The mandatory standards delineated in the *CRCC Code of Professional Ethics for Rehabilitation Counselors*

(2010) are intended to assure the community that the rehabilitation counseling profession accepts its responsibility to provide caring, competent and ethical services to individuals with disabilities (CRCC, 2010). The Preamble states, "Regardless of the specific tasks, work settings, or technology used, rehabilitation counselors demonstrate adherence to ethical standards and ensure the standards are vigorously enforced" (CRCC, 2010, p. 1).

A salient contextual factor that is imperative to consider in the domain of ethics in rehabilitation counseling settings is policy and legislative implementation as it relates to the provision of VR services. As a result of a VR-OBFS, the scope of services provided to clients may be limited in that rehabilitation counselors with higher return-to-work (RTW) rates may feel pressured to focus their energy on obtaining clients that may take less time to return to the workforce as compared to more complicated cases (e.g., traumatic brain injury) that will require more time before a return to work is possible. This dynamic could potentially create a VR environment driven by outcomes leaving clients with more acute medical/mental health conditions paired with rehabilitation counselors that may have lower RTW rates and, as such, less clinical experience.

Practices in rehabilitation counseling are influenced by numerous factors, including types of clients served, types of cases, laws and regulations covering the VR services, approaches to counseling, cultural diversity of clients, and ethics. In the area of ethics, additional factors can impact the services provided and the relationships between rehabilitation counselors and clients. Examples include consideration for multicultural competence, professionalism, confidentiality, appropriate boundaries, and development of assessments (Welfel, 2010). The newly published American Counseling Association Code of Ethics (2014) focuses extensively on developing the following values within the profession: (a) "autonomy;" (b) "nonmaleficence;" (c) "beneficence;" (d) "justice;" (e) "fidelity;" and (f) "veracity" (p. 3). The Commission on Certification for Rehabilitation Counseling (2010) similarly advocates for the profession and its clients, including the avoidance of harm, providing for the welfare of the clients, and advocating for the rights of clients (Barros-Bailey, Carlisle, & Blackwell, 2010). Although there are specific guidelines provided by professional associations, ethical boundaries are highly complex when considering the context of each situation. Ethical decision-making is not simple in that there are multiple interactions between counselor, client, and other professionals. Despite the Code of Ethics serving as a baseline, counselors also face challenges in the types of modalities (e.g., individual, family, group); professional identity (e.g., community, clinical mental health, rehabilitation, school); and work settings (e.g., managed care, private sector, public sector, non-profit sector). The confluence of these factors creates complex situations that may hinder counselors' abilities to operate effectively in providing services.

The Ohio BWC has proposed redefining the VR fee schedule affective January 1, 2015. This policy change resembles the (1998) study of Vaughn, Taylor, and Wright. Specifically, their study was formed in response to changing policies regarding managed health care and the continuous growth of both the private sector and the rehabilitation counseling profession. Due to this extensive change, Vaughn et al. (1998) hypothesized that ethical challenges would persist and become more complex. This study focused on how managed care professionals are challenged ethically as a result of pressures from the policies of overarching organizations. The results of their study demonstrated that rehabilitation counselors faced a variety of ethical challenges, which created conflicts among the ethical values of rehabilitation counselors (e.g., beneficence, justice). Similarly, rehabilitation counselors may be affected from the pressures of policy changes within the BWC. This pressure adds to the complexity of ethical issues that are inherent to private-for-profit rehabilitation counseling.

Effects on Client Services

When the focus of VR service provision relies heavily on outcomes, counseling relationships and services can potentially become less effective. McCarthy and Leierer (2001) noted that the decline of VR services has occurred primarily due to the discrepancy between viewpoints of providers and clients on needs and successful outcomes. In their literature review, they noted that clients observed that they were receiving rehabilitation services largely different than what was expected (McCarthy & Leierer, 2001).

Wagner, Wessel, and Harder (2011) also highlighted the importance of the "working alliance" between professionals and clients (p. 46). They noted that a major concern of clients was their service providers' investment in their needs. Clients often held the "working alliance" in high regard with the particular need for feeling respected, professionalism on the part of the counselor, and advocacy. Using the perspective of rehabilitation counselors, Lane, Shaw, Young, and Bourgeois (2012) explained that pressures from the workplace environment hindered the ability to develop stronger counseling relationships that would facilitate rehabilitation for clients.

Prior research that illuminates the perspectives of clients indicates that the most ideal service providers in rehabilitation counseling were often characterized as "client advocates" (McCarthy & Leierer, 2001; Wagner et al., 2011). The major theme in this characterization is the vital importance of the clients' perceptions of the working alliance (i.e., does the client feel re-

spected and understood by their service providers?). McCarthy and Leierer (2001) noted that clients often described ideal counselors, using the words "empathy" or "understand" (p. 15). A pertinent finding in their study is how clients regard behaviors and personal characteristics as more important than the training and credentials of their providers.

Although the findings from McCarthy and Leierer (2001) explained that personal characteristics and behaviors were significant, participants in this study noted that the minimum qualifications of counselors should include appropriate credentials and training. However, the theme of personal characteristics and professional behaviors were more consistent and significant to the clients in the study, as those characteristics facilitated perceptions of ideal counselors. A notable conclusion from both studies (McCarthy & Leierer, 2001; Wagner et al., 2011) is the significant theme of advocacy. Clients reported that providers who communicated their intention and dedication to advocating for the needs of their clients were more favorably perceived.

Ethical Conflicts

Altering the fee schedule for VR professionals may potentially trigger several ethical conflicts. Utilizing the findings from other researchers (Hagglund & Frank, 1996; McCarthy & Leierer, 2001; Wagner et al, 2011), counselors held under a more outcome-based fee schedule may operate in a manner that is different from the perceptions of ideal counselors. Operating under an outcome-based fee schedule could pressure rehabilitation counselors into moving forward with service plans too rapidly or before the client is medically stable (i.e., reaching maximal medical improvement), and, as a result, the trusting alliance between counselor and client may be impeded (Hagglund & Frank, 1996; Lane et al., 2012). Clients may then feel that their rehabilitation plan or VR services are not properly meeting their needs. While rehabilitation counselors may not be appropriately meeting clients' needs, the additional situation to consider is that rehabilitation counselors would have a higher potential to make mistakes due to an increased pressure to ensure outcomes are met within a specific time frame. The increased potential to make mistakes affects proper case note writing, case management, and consultation with other professionals (e.g., physicians, physical therapists, psychologists), which are vital to meet high standards in rehabilitation counseling practices (Ethridge, Rodgers, & Fabian, 2007; Zanskas & Leahy, 2007).

Informed consent. The CRCC holds the rehabilitation counseling profession to a high standard of best practices. Part of their high standards in the ethical code includes informed consent (Blackwell & Patterson, 2003). Considering the bounds of informed consent, proposed changes in the VR fee schedule could increase risk and complexity for rehabilitation counselors to properly communicate components of informed consent. Those risks primarily include explaining the fee schedule to clients as part of the informed consent process. Blackwell and Patterson (2003) argued that informed consent needs to require more specific guidelines in communicating fees to clients. These guidelines would help to ensure that clients are knowledgeable about their services and their ability to obtain affordable services. Since informed consent is a primary concern, changes in the VR fee schedule will force rehabilitation counselors to revise how they would communicate the outcome based fee structure to clients.

Transparent communication about services, competence, and fees are requirements of informed consent. A standard within the field of counseling is that practitioners are appropriately communicating the qualifications and skills necessary to work with a particular population (Welfel, 2010). When those qualifications do not match the needs of the client, rehabilitation counselors are encouraged to openly discuss their competencies with their supervisors and provide appropriate referrals. The primary challenge with the Ohio BWC proposed changes in the VR fee schedule is that the services may be primarily based on outcomes. When services are based on outcomes, more qualified rehabilitation counselors with higher return-to-work (RTW) rates could potentially favor cases that require a lesser complexity of disability. This course of action would be an effort to meet the outcome-based pressures implemented by the fee schedule change. Rehabilitation counselors with lower return-to-work (RTW) rates may not have enough experience to serve the higher complexity of disability in more acute cases. Rehabilitation counselors may be pressured to take on clients in order to manage their own counseling practice. As a result, the welfare of clients may inadvertently become a secondary priority.

The Current Study

The purpose for the current research study arose out of the concerns regarding the Ohio BWC proposed change in the VR fee schedule and the paucity of research regarding rehabilitation service provision and the ethical conflicts resulting from a VR-OBFS. Many of those concerns were based on how the proposed VR fee schedule change could potentially affect rehabilitation counselors and their clients. With a fee schedule change, the possibilities of changes regarding the practices of VR counselors are likely. The recent change would also elicit VR practices that are based primarily on outcomes. When practices are focused on outcomes, the margin for providing a respectable, ef-

fective working alliance with clients could potentially be diminished.

Method

A descriptive, convergent parallel mixed-methods research design was implemented for the current study. This approach utilized quantitative, qualitative, and ex post facto approaches to develop the model that would drive the research questions. In this design, the researchers aimed to collect both the quantitative and qualitative data from participants simultaneously. Both sets of data (quantitative and qualitative) were analyzed separately for possible themes and findings. Those themes were later merged together to form the findings within this study. The rationale for this research design was also derived similarly from the design of the study conducted by Szymanski, Leahy, and Linkowski (1993).

Delphi Method

The Delphi method was originally formulated to address a historical issue at the Rand Corporation in the 1950s (Hsu & Sandford, 2007). When the method was developed, the goal was to form a group consensus with the intention to predict both the present findings and future trends. By discussing future trends, researchers could seek findings that would develop innovation by hypothesizing the outcomes of specific changes in practice. This type of future trend prediction would be able to discuss the outcomes of policy changes, legislation, and practices. In the context of this study, the application of the Delphi method was salient to predicting the possible changes from the revision of the VR fee schedule in Ohio.

The first step in implementing this study was to utilize processes that embodied the Delphi method of research. The Delphi method utilizes consultation from a panel of experts in order to actively participate in the process of developing the instruments to be disseminated among participants and research questions for investigation (Vazquez-Ramos, Leahy, & Hernandez, 2007). The intention of using this method is to address a particularly complicated issue, which uses the group opinion of experts in a particular field. The intention behind operating within a group consensus is to prevent biased perspectives from the researchers and influencing views from the participants within the development of the study. During the process, the opinions held by the panel of experts are treated to several rounds of review and feedback, which would refine the consensus of the opinions (Hsu & Sandford, 2007; Vazquez-Ramos, Leahy, & Hernandez, 2007). Forming these several consensus opinions would allow for further exploration of alternatives to form resolutions for the specific issue addressed (Hsu & Sandford, 2007).

Participants

The sample for this study consisted of 100 participants. All participants were current VR practitioners working in the state of Ohio with workers' compensation clients. According to the Ohio Bureau of Workers' Compensation (2014), there are approximately 200 VR providers in Ohio. As such, our survey obtained approximately 50% of the total number VR providers in the state.

Participants were recruited via the secure email invitation program provided by Survey Gizmo, one of the country's leading professional, web-based survey providers. A list of email addresses of 127 vocational rehabiliation providers in Ohio was provided by the International Association of Rehabilitation Professionals (IARP). The sample included 100 out of 127 IARP members who provide VR services in Ohio. Thus, the response rate was 78.74% after sending three email requests to participate in the survey. Prior to sending the invitations and recruiting the participants, the researchers obtained Internal Review Board (IRB) approval from The George Washington University Office of Human Research. Participation in the study consisted of providing answers to the online questionnaire.

Of the recruited professionals, 126 participants started the survey; however, only 100 completed the survey. Responses to questions were optional, thus resulting in some questions with less than 100 responses. The final sample of participants included 71 females (71.7%), 28 males (28.3%) and one participant did not report a gender. Mean age for the sample was 51.62 years, ranging from 29 to 72 years of age. The majority of participants reported their ethnicity as Caucasian (90, 90%), followed by Asian American (2%), then Hispanic/Latino (1%), multiracial (4%), and "other" (3%). No participants identified as African American/Black, American Indian, Alaskan Native, Arab/Middle Eastern or Pacific Islander.

A majority of participants (57%) indicated a Master's degree as their highest level of education, 30% completed a Bachelor's degree, 5% completed a Doctorate, and 9% of participants indicated "other professional training" as their highest level of education. Participants' years in practice ranged from one year to 44 years, with an average of 20 years' experience for the entire sample. Participant certifications were as follows: Certified Rehabilitation Counselors (CRC) (57%), Certified Case Managers (CCM) (24%), Certified Disability Management Specialist (CDMS) (23%), case manager (19%), Registered Nurse (RN) (18%), other (18%), Licensed Professional Counselors (LPC) (17%), rehabilitation provider (11%), career counselor (11%), American Board of Vocational Experts (ABVE) (5%), psychological counselor (2%), licensed clinical social worker (2%), certified substance abuse counselor (2%) and life-care planner (1%).

Most participants reported working in suburban settings (52%), urban settings (49%), and rural settings (25%). Participants were able to select multiple geographic locations to reflect the diversity of Ohio's geographic landscape. As for state of licensure, 48 participants held licenses in Ohio, five participants were licensed in Ohio as well as in another state (MD, PA, KY, MI), one participant was licensed both in Ohio and nationally, three participants indicated that they were only certified nationally with CRC, CDMS, or CCM certification and four participants responded "not applicable."

Data Collection and Measures

Data was collected from rehabilitation counselors in Ohio via an online survey, comprised of eight demographic questions and 28 Likert-type questions, and four open ended questions. The survey instrument was created through the collaboration of 15rehabilitation counselors as part of a Delphi Panel. The purpose of the Delphi method is "to elicit perceptions or judgments held by experts who are knowledgeable in a specialized area. The opinions are then refined through subsequent reviews, with the eventual outcome being a converging consensus about a given subject" (as cited by Vázquez-Ramos, Leahy, and Hernández, 2007, p.112). After completing three rounds of feedback and changes, panel members with a range of seven to 34 years of experience, including an average of 25 years of clinical experience, agreed upon the content of the survey.

Participants received the survey via an email invitation provided by Survey Gizmo. The researchers configured this web-based application so that no IP addresses, email addresses, or identifying information will be collected or stored. All electronic transmissions both outgoing and incoming from Survey Gizmo servers were protected by SSL encryption. Once the data was collected it was exported into SPSS 19.0 for statistical analysis.

Data Analysis

Responses were downloaded from Survey Gizmo into Microsoft Excel and then imported into SPSS 19.0 for further analysis. Descriptive statistics were analyzed for each of the demographic variables including gender, race, education level, state of practice, location of practice, gender, age, ethnicity, years of experience, highest degree earned, certifications held, and work location. Qualitative data were extracted from responses to four open-ended questions. Participants were permitted the option to not respond to all questions. There were 99 responses to the first open-ended questions (Describe how the proposed VR provider fee schedule could affect VR services for injured workers.). The second open-ended question (Describe how the proposed VR provider fee schedule could affect the duration of VR services offered to injured workers) elicited 98 statements. The third question (Describe the ethical challenges you may foresee with the implementation of the proposed provider fee schedule) elicited 99 responses. The final question of the survey allowed the participants to provide "any additional thoughts or feedback." This question was answered by 56 participants.

The qualitative coding process was competed in multiple steps and coded by three independent raters. All qualitative data was entered into the qualitative software NVivo 10. This software was used to organize and code the qualitative data. Inter-rater reliability was used to assess the degree to which different raters agreed or disagreed in their assessment decisions. Where there were different responses, an agreed upon process and discussion were used to develop consensus. These data were initially organized and coded into four major themes based on the raw responses to the open-ended questions. A second coding analysis on the data was performed to further organize the statements into sixteen themes.

Results

Quantitative

Over 90% of participants agreed with the following statements: If an injured worker dies, is deemed medically unstable, settles his/her claim or in some way drops out of services, he/she should not be included in the statistics used for tally outcomes for providers (95%, M=3.71, SD=.627); a VR-OBFS will result in fewer injured workers entering plans as they will be deemed non-feasible as opposed to being given a chance to succeed (93.90%, M= 3.51, SD= .734); and if given the choice, case managers may reject high complexity cases in an effort to avoid lowering their RTW rate (93%, M=3.41, SD=.845).

Over 80% of participants agreed with the following statements: Complex cases will be less likely to get services from providers if a VR-OBFS is implemented (87.9%, M=3.32, SD=.87); a VR-OBFS will create ethical issues in provision of rehabilitation services to injured workers (86.9%, M=3.38, SD=.842); if providers are on a VR-OBFS, then managed care organizations (MCOs), doctors, BWC staff and all treatment providers involved should also be on this type of OBFS (86.80 %, M=9.39, SD=.956); a VR-OBFS will result in case managers/job placement service providers leaving the field (85.8%, M=3.23, SD=.793); a VR-OBFS could present an ethical conflict given the provision of similar services for different injured workers at different pay rates (84.9%, M=3.35, SD=.896); more importance will be placed on securing the RTW than providing the injured workers all the services they need for the best

possible outcome (84.9%, *M*=3.30, *SD*=.974); injured workers with acute medical/psychological impairments will have an increased difficulty recruiting a service provider as a result of a VR-OBFS (83.9%, *M*=3.19, *SD*=1.00); and a VR-OBFS will affect injured workers' access to services (81.8%, *M*{plain =3.24, *SD*=.98).

Over 70% of participants agreed with the following statements: pre-determined plan time frames will limit the length of services offered to injured workers so that the maximum outcome pay can be received by securing a RTW within the allotted time frame (77.7%, *M*=3.02, *SD*=.926); if an OBFS is implemented then providers should have 100% authority over the treatment plan in terms of which services an injured worker needs and will receive (76.7%, *M*=3.14, *SD*=1.14); injured workers' interests will be limited in favor of RTW options that may be contrary to their best interests so that the provider can receive outcome pay (75.8%, *M*=3.04, *SD*=.99); a VR-OBFS will affect the quality of services provided to injured workers (72.7%, *M*=2.93, *SD*=1.15); and if their complexity increases in the middle of a plan case managers may be tempted to transfer the case so it does not affect their RTW rate (62.7%, *M*=2.74, *SD*=.996).

Over 60% of participants believed that a VR-OBFS will impact their client selection process (62.6%, *M*=2.67, *SD*=1.24). Over 50% of participants agreed that a VR-OBFS will affect injured workers' RTW rates (54.60%, *M*=2.3, *SD*=1.31) and they would not accept a transfer case if it is a high complexity case as it could adversely affect their RTW rate and outcome pay (52.54%, *M*=2.47, *SD*=1.21).

Over 50% of all participants either agreed or strongly agreed with every statement on the survey. Only one statement had less than 50% agreement: 49.5% of participants believed that VR-OBFS will alter the way they provide services more so than the way they choose which clients they would be willing to work with (49.5%, *M*=2.41, *SD*=1.23).

Qualitative

After a thorough review of the qualitative data, the following four primary themes were identified: effect on case selection, effect on time-frames, effect on services, and ethical concerns. From there, the following sixteen sub-themes emerged and were later used to code participants' responses to the open-ended questions: cherry picking, complex cases, emotional response, independent providers/MCOs, leaving the field, lengthen timeframe, shorten timeframe, no changes, positive changes, not in best interest of the client, quality decrease, rural concerns, suggestions for change, impact on training, and ethical concerns.

The percentages that are reported reflect the proportion of responses related to the sixteen identified themes. Percentages do not add up to 100% due the authors' choice to allow responses to relate to multiple themes to reflect the rich diversity of the data. The first open-ended question (Describe how the proposed VR provider fee schedule could affect VR services for injured workers.) had a response breakdown as follows: not in best interest of the client (90.77%), ethical concerns (77.65%), cherry picking (61.26%), complex cases (61.71%), services based on outcomes (59.51%), independent providers/MCOs (28.94%), quality decrease (5.57%), suggestions for change (3.54%), impact on training (2.39%), rural concerns (1.02%), emotional response (1%), leaving the field (.44%), an no responses were related to lengthened timeframes.

The second open-ended question (Describe how the proposed VR provider fee schedule could affect the duration of VR services offered to injured workers) had a response breakdown as follows: complex cases denied (52.8%), shorten timeframe (47.73%), services based on outcomes (16.6%), not in best interest of client (9.76%), independent providers/MCOs (7.90%), unethical (7.49%), lengthen timeframe (7.15%), quality decrease (5.12%), emotional response (2.82%), impact on training (1.42%), rural concerns (1.34%), no changes will result (1.21%), suggestions for change (0.55%) and cherry picking (0.31%). No responses related to leaving the field of VR (0%) or positive changes (0%).

The third open-ended question (Describe the ethical challenges you may foresee with the implementation of the proposed provider fee schedule) had the following response breakdown: unethical (51.03%), complex cases denied (26.27%), rural concerns (15.28%), emotional response (13.65%), not in best interest of client (11.5%), services based on outcomes (9.39%), independent providers/MCOs (7.56%), cherry picking (6.9%), quality decrease (5.8%), leaving the field of VR (5.08%), impact on training (4.62%), shorten timeframe (4.41%), no changes will result (4.28%), positive changes (0.92%), suggestions for change (0.34%). No responses were related to the lengthened timeframes (0%).

The final open-ended question of the survey allowed the participants to provide "any additional thoughts or feedback." The response breakdown was as follows: ethical concerns (16.45%), leaving the field (5.08%), suggestions for change (4.42%), shorter timeframes (4.41%), not in best interest of client (5.13%), emotional responses (3.67%), positive changes (2.62%), rural concerns (1.43%), quality decrease (1.34%), complex cases denied (1.23%), cherry picking (.81%) and independent providers/MCOs (0.05%). No responses related to services based on outcomes (0%), impact on training (0%), longer timeframes (0%), no changes (0%), services based on outcomes (0%), impact on training (0%),

Discussion

Question 1. How Would the Proposed VR-OBFS Affect VR Services for Injured Workers?

Case selection.

Both the quantitative and qualitative data support the notion that VR professionals agree that the proposed VR-OBFS will affect services for injured workers. The overwhelming trend in the qualitative responses was that participants foresee the need for "cherry-picking" their cases based on expected RTW outcomes. Participants explained a concern that managed care organizations (MCOs) may be able to "pick and choose" rehabilitation providers for optimal RTW production with only the IWs who are "most likely" to return to work accepted. Participants wrote, "IWs will have fewer provider choices or none at all. Fewer cases going to job placement and job development (JPJD) when the complexity is high will result in fewer services for the IW."; "Complicated cases will be "weeded out.", "Providers may "cream for easy cases" for RTW and outcome pay"; "IWs will be forced into non-ideal jobs just for the RTW outcome, which may lead to more re-referrals."

Some participants explained their fear that rehabilitation services will be denied or less accessible to IWs with complex cases. The quantitative findings reveal this concern as over 90% of participants agreed that a VR-OBFS will result in fewer injured workers entering plans as they will be deemed non-feasible as opposed to being given a chance to succeed. The quantitative results also indicated that over 90% of participants agreed that if given the choice, case managers may reject high complexity cases in an effort to avoid lowering their RTW rate and that complex clients will be less likely to get services from providers if a VR-OBFS is implemented.

When asked how a VR-OBFS will personally impact how they work with cases, over 60% of participants reported that a VR-OBFS will impact their client selection process and that if the complexity increases in the middle of a plan case managers may be tempted to transfer the case so it does not affect their RTW rate. Participant responses included, "More emphasis will be made on selecting injured workers who are more employable, have more transferable skills and who are more likely to RTW without needing lengthy training or job readiness in terms of adjustment or career counseling services."

Some participants feared that the proposed fee schedule could result in a shift in which type of provider (MCO vs. independent VR provider) will take on cases with higher complexity. One participant wrote, "An MCO that owns a rehabilitation company will select individuals with minimal restrictions and refer those clients to their own company. Complex cases will be assigned to independent VR case managers, or will be determined to be medically unstable or not feasible." One participant summarizes this sentiment: "Simply put, the population of IWs that most need VR services because of barriers will be adversely impacted as VR providers will be unwilling to work complex cases." Participants detailed this thought process: "If everyone deserves a chance to succeed but giving them the chance cuts my pay 30% should I accept them as a client?", "I would not be happy about taking on more complex cases or IW's that have no GED, no valid driver's license, a felony record etc. as these are barriers to RTW now and more so if fee schedule is implemented", "I would have to choose between making money and staying solvent and doing what is in the best interest of the injured worker."

The quantitative findings indicated that the statement agreed upon by the largest percentage of participants was related to the situation in which an IW is deemed medically unstable, settles his/her claim, or in some way drops out of services. Over 95% of participants agreed that the IW should not be included in the statistics used for tally outcomes for providers. Nearly the entire participant sample agreed with this statement reflecting the concern that their RTW rate would be negatively affected by IW issues that are "beyond their control." Issues mentioned in participant responses included: settlement, the need for additional surgeries or ongoing medical treatment, physical therapy, or occupational therapy resulting in time when IWs are not available for rehabilitation services, etc.

Rural concerns.

The qualitative data revealed a specific concern for IWs located in rural areas. A participant wrote, "Injured workers in the rural areas are NOT on the same playing field as those injured workers in the metro areas or injured workers living in metro areas." Another participant detailed this specific concern: "Working in rural area does takes a while to obtain successful RTW. One rural employer may have one job opening and have over 125 applicants applying for the position." Another participant explained the impact that a fee schedule may have for IWs in his or her rural area:

"I work in a depressed rural area of Southern Ohio; I am one of only a few case managers who works in this area. Two case managers in my area have left the field due to the new fee schedule. A large part of my referrals are brain injury cases. They are always more complex and time frames are greatly extended in comparison to typical VR referrals. This would certainly seem to affect my ability to provide the most appropriate care to these individuals. IW will not receive the quality of services that they deserve."

Positive changes.

Not all responses were negative as some participants felt that the proposed fee schedule may usher in positive changes in the field of VR. The qualitative data details some of the positive consequences of the change. The quantitative data, however, does not reflect this potential outcome. Participants wrote, "Focus will be on efficient RTW not padding the billing cycle with extra activities to make more money.", "We hope it will help provide an incentive for QUALIFIED providers to use their professional expertise to determine IWs who truly have a RTW goal versus those advised by their attorneys to remain on compensation as long as possible." Some participants did not mention positive changes but noted that they believed that ethical VR providers will not be impacted by a change in fee schedule. Other participants felt that the fee schedule changes may reduce the duration of services to injured workers as a result of a better up front professional assessment of their "real" needs. One participant wrote, "CMs may extend services for reasons such as improved physical/functional abilities to increase the chances of successful RTW. IWs and case managers will need to work together for a successful RTW. The case manager now has some skin in the game. No more lazy stuff."

Research Question 2: Would a VR-OBFS Affect the Duration of Services Offered to Injured Workers?

Duration of services.

The overwhelming response to how the proposed fee schedule will impact the duration of VR services was related to the shortening of VR plans in order to accommodate a sole focus on RTW. Over 70% of participants agreed with the following statement: "pre-determined plan time frames will limit the length of services offered to injured workers so that the maximum outcome pay can be received by securing a RTW within the allotted time frame." In the qualitative data, nearly 70% of responses to the open-ended question related to how a VR-OBFS will result in shortened timeframes. Only 7% of responses indicated longer timeframes and only 1% of participants believed that there wouldn't be any change to the duration of services offered.

The research literature to support these findings indicates that operating under an outcome-based fee schedule could pressure rehabilitation counselors into moving forward with service plans too rapidly or before the client is medically stable (i.e., reaching maximal medical improvement), and, as a result, the trusting alliance between counselor and client may be impeded (Hagglund & Frank, 1996; Lane et al., 2012). The findings of the current study directly reflected these concerns. One participant wrote, "IWs would be hurried through services, to keep expected timelines, without giving the needs of the individual the sole consideration. In the long run, long term outcomes may decrease, even though short term outcomes may increase."

Some participants predicted that case managers may "over-project" the length of services to try and ensure a successful outcome, i.e. anticipated (projected) service duration will be inflated to capture all unexpected delays or interrupts so outcomes is not negatively affected. One participant detailed, "In order to stay in business service providers will likely shorten/amend length of services to be more appropriate for the outcome based fee but schedule, this eliminating opportunities to take full benefit of services and will only receive 'bare bones' programs."

Research Question 3: How do Rehabilitation Counselors Describe the Ethical Considerations That Could Potentially Occur as a Result Of The Implementation of a VR-OBFS

The Commission on Rehabilitation Counselor Certification (CRCC) is committed to advocating for both its Certified Rehabilitation Counselors (CRCs) and the profession of rehabilitation counseling (2014). The mandatory standards delineated in the *CRCC Code of Professional Ethics for Rehabilitation Counselors* (2010) are intended to assure the community that the rehabilitation counseling profession accepts its responsibility to provide caring, competent and ethical services to individuals with disabilities (CRCC, 2010). The Preamble states, "Regardless of the specific tasks, work settings, or technology used, rehabilitation counselors demonstrate adherence to ethical standards and ensure the standards are vigorously enforced" (CRCC, 2010, p. 1). Section F.4.a of the CRCC Code of Ethics states, "Rehabilitation counselors do not enter in financial commitments that may compromise the quality of their services or otherwise raise questions as to their credibility . . . . Payment is never contingent on outcome or awards." (CRCC, 2010). The findings of the current study highlight VR professionals concerns that a VR-OBFS may prevent them from working within the ethical guidelines that they are required to uphold.

Best interest of the IW.

Several participants detailed their concerns that a focus on RTW was not in best interest of IWs, specifically noting the potential for limitations on the accessibility and detriments to the quality of services provided for IWs. The most resounding theme in all of the qualitative data was related to concern that a VR-OBFS was not in the best interest of the IW. Over 90% of responses to the first open-ended question included (or were related to) some variation of the term

"not in best interest of IWs." Over 75% of the responses to the first open ended question included the term "unethical" and over 50% of the responses to the third open-ended question related to ethical concerns included the term "unethical." One participant wrote, "RTW based on pushing IWs to RTW in ANY job, is not addressing problems and creates a revolving door. Case managers may put a client into a position outside of the client's restrictions just to get them back to work quickly or not consider any sort of training."

Access to training also emerged as a potential consequence: "There will be less access to training due to pressure to RTW in short time frame. Fewer IWs will receive services, and said services may not be comprehensive in nature." Several participants made statements regarding how the proposed fee schedule may have an effect on the emotional wellbeing of their clients. Prior research that illuminates the perspectives of clients indicates that the most ideal service providers in rehabilitation counseling were often characterized as "client advocates" (McCarthy & Leierer, 2001; Wagner et al., 2011). One participant wrote, "A counselor develops a rapport with IW's and their families. We know about their kids, grandkids, hobbies etc. We are often the first ones to gain their trust b/c we are one of the few providers they see on a regular basis. I'm concerned about how the proposed fee schedule will affect them emotionally and personally if I have to decline a case simply b/c I can't guarantee they will go back to work."

Wagner, Wessel, and Harder (2011) highlighted the importance of the "working alliance" between professionals and clients (p. 46). They noted that a major concern of clients was their service providers' investment in their needs. Clients often held the "working alliance" in high regard with the particular need for feeling respected, professionalism on the part of the counselor, and advocacy. Using the perspective of rehabilitation counselors, Lane, Shaw, Young, and Bourgeois (2012) explained that pressures from the workplace environment hindered the ability to develop stronger counseling relationships that would facilitate rehabilitation for clients.

Ethical dimensions.

The majority of participants wrote responses explaining why they believed the propose fee schedule is unethical. Participants wrote: "Ethical CMs that do not allow the outcome based schedule to dictate their case choices, will be penalized for their convictions to accept cases when the difficulty/complexity is high.", "No consideration is given on how devastating this can be to people who are trying desperately to get back on their feet. We are treating clients as "files" and not as persons who have very complex situations that need to be addressed. This approach is simply wrong."

Several participants reflect on the ethical conflicts between the proposed fee schedule and the CRCC Code of Ethics: "CRCs are not permitted to take a commission to provide services to clients. The fee schedule is set up to provide a commission to rehabilitation counselors. It puts CRCs in a situation where they will have to go against their code of ethics." Some participants responded with questions related to ethical concerns: "How is due process in VR been removed from the law?" One participant referred to the fee schedule as a "draconian move" in that "payment becomes the first consideration, not the needs of the IW", "This structure suggests a pay cut with promise of a bonus at the end will somehow enhance RTW rates but not ethical decisions", "More attention to the dollars and not on the clients. People are VERY diverse and cannot not be considered for "cookie-cutter" rehab." One participant asks, "If a case manager's income is based on a fee schedule, then what is the incentive to provide services to complex clients or cases that are outside of the box? Has this job become more about money or is it really about helping injured workers?" These responses echo the concern that economic factors will influence counselors' ethical principles significantly decreasing their ability to be an advocate for people with disabilities.

Financial consequences.

Participants detailed how the financial consequences of the proposed fee schedule may personally impact their clinical decision making process. Over 85% of participants believed that a VR-OBFS will create ethical issues in provision of rehabilitation services to injured workers and could present an ethical conflict given the provision of similar services for different injured workers at different pay rates. Over 90% of participants agreed that a VR-OBFS will result in fewer injured workers entering plans as they will be deemed non-feasible as opposed to being given a chance to succeed and if given the choice, case managers may reject high complexity cases in an effort to avoid lowering their RTW rate. Over 50% of participants agreed that a VR-OBFS will affect injured workers' RTW rates and they would not accept a transfer case if it is a high complexity case as it could adversely affect their RTW rate and outcome pay.

Participants wrote, "Our focus will mainly be on making a living to financially survive; not on quality services.", "More complex cases require more hours, if I don't feel a client will be successful I will be tempted to offer fewer direct services/shorter durations of programs again out of fear for not being reimbursed fully for my work hours." Another participant wrote, "Obviously, if a case is deemed too difficult for whatever reason it will be closed…Under the proposed fee schedule, I will be more likely to close those individuals in a "gray" area due to fear of losing pay for the hours I've worked." There was a clear concern that "second chances" will not be allowed, and closures for non-compliance will increase. A participant wrote,

"My service recommendations may not be approved yet I will be the one penalized by pay rate. Feel we are being the scape goat on both sides." Overall, participant responses indicated that there will be a shift from client based needs to cost containment strategies thus negatively impacting the quality of vocational rehabilitation services delivered.

Over 85% of participants agreed that a VR-OBFS may result in case managers/job placement service providers leaving the field. Approximately five participants made statements related to their intention to leave the field if the proposed fee schedule takes effect: "I won't be in the bind this creates. I'll quit first. The benefit of the doubt that is part of decisions about the projected capacity to benefit from services (feasibility) will be given to my pocketbook and not the IWs program to restore vocational wholeness."

Limitations

Although efforts were taken to utilize sound mixed-method methodology, several limitations should be taken into consideration. The first limitation of the current study relates to the research sample and the study's external validity. Although the sample size of this study (N=100) was appropriate for the analyses completed, a larger sample would increase the generalizability of the findings. Additionally, this sample was comprised of VR professionals from Ohio and can only be extrapolated within Ohio and not to other states or to the nation as a whole. Other states or a nationwide sample would have a different demographic breakdown than the current study's sample as it included primarily Caucasian participants.

A second potential limitation related to the sample is self-selection bias. The VR professionals who did not respond to the survey may have different opinions as compared to those reported in the present sample. Self-selection bias occurs when the group being studied has any form of control over whether to participate. Participants' decision to participate may be related to traits that could potentially impact the study, thus, the participants who completed the survey may be a non-representative sample. Oftentimes, people who have strong opinions or increased knowledge in a particular subject area may be more eager to respond to a survey as opposed to those who are less interested in the nature of the subject matter.

The final limitation is the lack of generalizability inherent in the nature of qualitative research. This was an exploratory study and therefore, we utilized qualitative methods as a way to delve deeper into a topic that has had only a minimal amount of prior research. The data collected were obtained via self-report which is also understood as a potential threat to validity.

Conclusion

The findings of this study reveal a multitude of concerns related to how vocational rehabilitation providers and IWs may be affected if a VR-OBFS is implemented. The findings of the current study suggest that a more thorough examination, informed consideration, and collaboration needs to occur among practitioners, IW's and the Ohio BWC *before* a VR-OBFS is implemented. Concerns related to how rural areas will be affected, the financial consequences, complex case selection, and the ethical dimensions of the policy need to be considered. Ultimately, VR professionals expressed fears that the best interest of the IW will no longer be the sole focus of treatment and, as a result, a VR-OBFS would sanction a direct contradiction to the CRCC Code of Ethics.

Further research assessing how IWs experience care under this policy, how providers are affected, the financial implications, and how VR professionals across the United States may be impacted by a VR-OBFS will allow for a deeper understanding of the complexities that may result from a fee schedule based on outcomes. If implemented in Ohio and if other states follow, a VR-OBFS could potentially have a similar effect to how managed care impacted the medical profession and practitioners in the 1980s and 1990s. A more thorough consideration of how a VR-OBFS could affect independent VR practitioners who are not employed by large companies is needed. A national study done in conjunction with International Association of Rehabilitation Professionals (IARP) and the American Board of Vocational Experts (ABVE) will enable a fuller understanding of the far reaching implications of this policy change on the rehabilitation counseling profession.

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Ethical Lessons Learned from Viktor Frankl's *Man's Search for Meaning*

Jessica Auzenne

Abstract. Viktor Frankl's 1946 book, *Man's Search for Meaning*, chronicles his experiences in a concentration camp during World War II and provides not only his personal account of the prisoner's experience, but also offers an insightful commentary that became his proprietary clinical intervention following his liberation. Unfortunately, not all prisoners in the Nazi concentration camps were as prosperous. The individuals in positions of authority and responsible for prisoners during the Nazi occupation of Europe were able to engage in behaviors that are considered unethical by today's standards, especially in the profession of psychology, where we recognize a responsibility for others and position of authority as part of professional psychology. The following paper will outline the conditions faced by both prisoners and certain subgroups of German civilians during the World War I era, and the behavior of Nazi affiliates in positions of authority, most notably physicians. Further, responses to the Nazi agenda by both international courts and in the context modern ethical code will be discussed. Finally, a review of the implications of the actions during this era as well as applications of these to modern ethical code and the future of psychology is provided.

In the 1946 book, *Man's Search for Meaning*, Viktor Frankl chronicles his experiences as he spent time imprisoned in German concentration camps under the Nazi regime in the early 1940s. Within his work, Frankl, an Austrian neurologist and psychiatrist provides his personal account of the prisoner's experience, insightful commentary, and later, clinical applications of these insights. In the field of psychology, Frankl is hailed as a champion of his circumstances and has been very influential in the field ranging from the sub-disciplines of existentialism to contextual behavioral science. As psychologists, an understanding of not only the historical context surrounding Frankl's work, as well as the happenings during that period generally, might be important, as both have influenced and have impacted the field of psychology today in ways that are not always clear. It could be argued that clear connections between this time in history and implications for psychotherapy and trauma work, as well as research regarding social influence in the form of obedience and conformity exists. However, a less apparent, but essential connection can be made between this period and the ethical guidelines we currently adhere to in the field of psychology today. The lamentable occurrences during World War II have in many ways shaped the ways we acquire and use our knowledge, make ethical decisions, and navigate relationships. In his book, Frankl references each of these, and whether intentional or not, his commentary about life in a Nazi concentration camp provides the beginnings for further discussion about psychologists' responsibilities as figures of authority and responsibility to behave ethically.

In *Man's Search for Meaning,* Frankl describes his experiences of sent to Auschwitz and fortunately, being able to avoid death in the gas chambers. However, he later finds out that the other members of his family were not so lucky, as his separation from them plagued him throughout the duration of his imprisonment. Frankl spent three years in the concentration camp system as a prisoner at four different camps including those at Auschwitz and Dachau. The majority of his internment was spent in Auschwitz, and his time there was marked by malnutrition and hard labor which were rampant in those camps that provided inexpensive forced labor to Schutzstaffel (SS) –owned or operated businesses (United States Holocaust Museum, 2014).

Viktor Frankl also describes his experience of eventually serving as a doctor to his fellow prisoners and volunteering in a typhus ward, which occurred only during the last few weeks of his imprisonment. Illness was rampant within the camps, and prisoners who had

medical knowledge, like Frankl, were sometimes called on to serve as doctors in lieu of providing physical labor. In his book, Frankl describes the dire circumstances surrounding illness in the camps where those who were ill often died of their illness or were sent to their deaths. Resources were limited and prisoner-physicians, like Frankl, were often required to make impossible decisions usually having life-or-death implications.

Despite the deplorable conditions he faced during his time in the Nazi concentration camp system, Frankl survived and left with a broad collection of insights that would later become his proprietary approach to psychotherapy. Logotherapy is a form of psychotherapy that focuses on the future and the attainment of meaning in the life of the client. Rooted in existentialist philosophy, logotherapy posits that the ultimate freedom is in choosing one's attitude in the face of unchangeable circumstances, and finding one's ultimate meaning in the midst of suffering is of utmost importance. From his narrative, it is shown that Frankl had this experience during his time in the camp, and that this experience is what ultimately freed him although he was still physically imprisoned.

Unfortunately, the torture endured during one's imprisonment in the Nazi concentration camps was not typically followed by the discovery of meaning in one's life. More likely, one would face death or enduring psychological and physical torture at the hands of the SS officers, Capos, and other Nazi-affiliated personnel. Though *Man's Search for Meaning* also brings some attention to the injustice and inhumanity present during this period of history. This book reveals a less probable outcome of a prisoner within the concentration camp system. Under the regime of Adolf Hitler, the Nazi party successfully occupied much of Europe from their rise to power in 1933 to the liberation of the camps and suicide of Adolf Hitler in 1945 (United States Holocaust Museum, 2014). Along with cruelty to those considered racially inferior or dangerous to Germany, even certain German citizens (e. g., the mentally ill) were subject to imprisonment or death at the hands of those in power. Even before the war, Nazi-affiliates enacted policies that allowed for compulsory sterilization of those considered unfit to reproduce and euthanasia of those with medical or neurological disorders in Germany, and these and similar practices continued during German occupation and were generalized to psychiatric hospitals, prisons, and concentration camps (Strous, 2006).

Concentration Camps

The Nazi concentration camps were filled with mostly European Jews although other ethnic minorities (e.g. Gypsies), political opponents (e.g., Social Democrats, Communists liberals), homosexuals, and others with incompatible or less mainstream religious views (e.g., Jehovah's witnesses), who were ultimately put to work or death (Concentration camp system in depth, ushmm.org, Holocaust encyclopedia). As mentioned in Frankl's book and corroborated by many witnesses, prisoners were treated inhumanely and in most cases, were not even provided with bare necessities. Clothing was inadequate for harsh winter conditions, food was provided sparingly and portions were inadequate, and shelters were not adequately protective, sanitary, or allowing for privacy. Further, medical care was not commensurate and the physical and psychological well-being of the prisoners were not considered in the slightest when decisions were being made. Sadly, the total disregard for the well-being of these individuals was accompanied by a wealth of resources for forcing the prisoners to provide services on behalf of the Nazi party (e.g., labor, medical care, food service) and for ending their lives once they were unable to prove their usefulness. Possibly even more inhumane than methods causing instantaneous death, was the punishment enforced by Nazi officers and fellow prisoners who were put in positions of authority (Capos). Physical punishment was also prominent in the camps when there was dissatisfaction with the prisoners.

Responsibility for Prisoners

Though the substandard conditions of the concentrations camps was inappropriate and unacceptable behavior of authority figures were ubiquitous during Nazi occupation, it was the case that the camp system stood outside of German law. This allowed the camps to run without being subjected to review by any German authorities other than the SS and other internal Nazi policing bodies (United States Holocaust Museum, 2014). So formally, German legislators and judicial authorities cannot be held responsible for the activities within the concentration camps neither legally nor ethically.

However, Nazi party officials, SS officers, and other authorities involved in the handling of prisoners could be deemed responsible for the happenings in the camps as well as for the prisoners and their safety, well-being, and livelihood. Along with SS officers, physicians were instrumental in the concentration camps' development and maintenance during the German occupation. Although some prisoners, like Viktor Frankl, who had medical training served as doctors in the camps, Nazi-affiliated physicians also had a place within the camp system (Strous, 2006). These individuals were in the Nazi party and had roles that were central and necessary for Nazi success in carrying out their agenda. Nazi physicians were ultimately responsible for the health of prisoners and filled that role in some ways under certain circumstances. However, they also sent some of the sick to their deaths. Other applications of the physicians' skills were implemented during the war, many of

these being reprehensible. Strous (2006) gives a comprehensive review of some of the confirmed actions of Nazi-affiliated physicians during the Nazi occupation of Europe.

Even before the war as the Nazis were gaining power, it was physicians who are credited with providing both the groundwork and logistical means by which hundreds of thousands of the mentally ill and ethnically and mentally inferior were killed (Strous, 2006). Nazi doctors also provided medical expertise with regard to forced sterilization and options for the burning of large quantities of dead bodies. In the camps, specifically in Auschwitz, physicians not only supervised killings, but performed killings by shooting new arrivals sent to be killed (as opposed to labor camps), and they were also the individuals who presided over killings using carbon monoxide within the gas chambers and using their medical knowledge, determined when victims were dead. Physicians were also responsible for deciding who should not be sent to the gas chambers so that they could be used for medical experimentation (Strous, 2006). These experiments were carried out for the supposed purpose of contributing the body of medical knowledge as well as to better serve German military troops who were fighting in the war. Experiments testing immunizations for diseases (e.g., malaria, typhus, smallpox, cholera, etc.) and conducting anatomical research (e.g., by collecting skeletons) were justified by the Nazi physicians for their possible contributions to future medical interventions. Other experiments that were in response to experiences within the German armed forces included those involving the effects of high-altitude, freezing, mustard gas, salt-water, and poison, and treatments involving sulfanilamide, tissue regeneration and bone transplant to name a few. Sterilization experiments were also conducted to further the Nazi agenda of eventually eliminating enemy populations (Harvard Law School Library, 2003).

Ethical Concerns and the Nazi Regime

This period during the late 1930s through 1940s was marked by ethical concerns by today's most broad ethical standards. A general trend in the behaviors of the SS officers, Nazi authorities, and Nazi physicians was the presence of maleficence, oppression, dehumanization. Maleficence was present in the form of refusal to adequately provide the most basic necessities, tend to the sick, and take responsibility for those whom were dependent upon them for survival. Oppression was rampant in the forced physical labor imposed on the prisoners as well as the forced participation in painful and fatal medical experiments. The use of physical punishment perpetuated both harm and control in the prisoners, and each of the previous ethical failures contributed to what is possibly the most repugnant ethical fault, namely the dehumanization of the individuals forced into this imprisonment. The ideologies held by the Nazis that certain groups should not exist, reproduce, be allowed to have certain rights, etc. and reduced prisoners to animals "below" human beings are contributed to the overall harm done within the camps. Additionally, the objectifying and instrumental view of these individuals as subjects to be experimented without consideration for their safety, health, or opinion contributed to their being treated as less than human. Also, the denial of their individuality and autonomy by authority figures further created a context where the prisoners were dehumanized (Haslam, 2006).

Although the abuse of those held in the Nazi concentration camps went on for an unacceptably long period of time, as soon as outsiders realized the extent of harm done, steps were taken to issue consequences and prevent future occurrences of such widespread abuse. Charges were brought against the physicians suspected of participating in criminal activity, and the following international war crimes tribunal provided the start of this process.

Trials at Nuremberg

Criminal trials following the end of World War II were held in Nuremberg, Germany from November 20, 1945 to October 1, 1946. In the case of *U. S. A. v. Karl Brandt et al.*, or the Doctors' Trial, Nazi doctors were tried for criminal activity during the war. Karl Brandt, the senior medical official of Germany, and 22 other senior doctors and SS administrators were indicted on four counts. They were charged with: 1) conspiracy to commit war crimes against humanity, 2) war crimes, 3) crimes against humanity, and 4) membership in a criminal organization. Specific charges related to counts two and three were mostly in response to experiments and other medical crimes inflicted on those in the concentration camps. (Harvard Law School Library, 2003). Of those tried in court, Karl Brandt, along with six others were convicted and sentenced to death, nine were convicted and sentenced to prison terms, and seven were acquitted (Harvard Law School Library, 2003). Convictions were made on the specific charges of: conducting of experiments on prisoners (i.e., high altitude, freezing, malaria, mustard gas, sulfanilamide, bone/muscle/nerve regeneration and bone transplant, seawater, epidemic jaundice, typhus and other vaccine experiments, sterilization, and poison experiments) as well as killing Jewish individuals for anatomical research and euthanasia of sick and disabled German citizens. The doctors on trial were also convicted of criminal conspiracy as part of Count 1 and membership in the SS (Count 4).

Following *U.S.A. v. Karl Brandt et al.*, direct statements were made involving ethics, namely within the field of medical research. At the time of World War II,

there was no available statement that clearly differentiated between ethical and unethical experimentation. Nazi physicians took advantage of this lack of specificity and conducted experiments, many of which were deemed criminal due to the harm imposed on the participants in the form of injury or death. Another concern was that the physicians in question subjected prisoners to these conditions without their knowledge of risks or permission. In direct response to this, concern about the rights of research participants were addressed for the first time on the international stage.

Nuremberg Code. A direct result of the Nazi Doctors' Trial was the Nuremberg Code. The code was established in 1948 and became the first international document which advocated for the rights of the research participant. The ten points on the code specifically address concerns elicited from the crimes of the Nazi physicians during the period of Nazi rule. The first point emphasizes the necessity of acquiring voluntary informed consent from the human subject, and that consent can only be obtained from those legally able to give consent and in the absence of any coercion. Related to this, the ninth point requires that the human subject should have the right to terminate the experiment at his or her own volition. Experiments must also have justification and clear connections to prior knowledge. The idea that experiments should be based on prior knowledge of animal experimentation and knowledge of the phenomenon, disease, or problem under study is part of the third point. This point also states that conducting experiments in this way allow for justification of the performance of the experiment. Points four and five suggest that experiments should be conducted in ways that avoid all unnecessary suffering and injury, both physically and mentally, and that experiments should not be conducted if there are grounds to believe that death or disabling injury might occur. An extension of this is seen in the seventh point which calls for preparations to be made to protect against even the slightest possibility of injury, disability, or death. Points eight and ten make suggestions about the experimenter's qualifications and judgment, where experiments should only be conducted by those who are scientifically qualified and that experimenters should be prepared to terminate experiments if there is reason to believe that it is in the best interest of the participant to do so. The last group of points illuminates the underlying purpose for research which is to contribute to society. The second point states that research experiments should produce results that are useful and for the good of society, and that they should not be random or unnecessary. Further, should be conducted only when no other means of obtaining needed knowledge is available. The sixth, and final, point states that the degree of risk taken in an experiment should be appropriate as a function as the humanitarian benefit of the knowledge to be gained. Risk imposed on human subjects should be justifiable by the value of the information to be gained by the performance of the experiment. This is especially important, as the lives of humans are deemed more valuable than knowledge itself, which was a dramatic shift from Nazi research philosophy and justification.

Nazi Germany: Applications to Modern Ethical Code

In addition to the Nuremberg Code, other documents outlining ethical principles and standards have addressed some of the concerns present in the behavior of Nazi affiliates including the SS officers and physicians and have aimed to prevent future occurrences of similar patterns of behavior both on small and large scales. The American Psychological Association Code of Ethics, for example, provides a framework for ethical behavior within the profession of psychology that has served as a model for the development of other modern ethical codes. Though the individuals involved in the activities of Nazi officials and physicians were not bound to this ethical code, the implications of the activity during this time are of utmost relevance and importance to the field of psychology, as professionals in the field are often responsible for the well-being of others while also being in a position of authority.

This specific code contains two major sections: General Principles and Enforceable Standards (APA, 2002). The principles reflect moral values present within the enforceable standards and are meant to guide the behavior of psychologists. The enforceable standards are a set of behavioral rules also intended to guide behavior, but can be enforced by the APA Ethics Committee and can definitively establish what is and is not acceptable. When applied to the behaviors of those in positions of power and authority in the Nazi concentration camps, clear connections to ethical violations by our standards can be made.

Ethical Principles. When examining the behavior of those involved in the atrocities presented by both Frankl and other corroborated accounts, many behaviors of those in positions of authority and responsibility are blatantly unethical by the American Psychological Association ethical criteria (APA, 2002). First, each of the ethical principles presented in the APA code (i.e., Principles A – E) are violated. Principle A aspires to beneficence and nonmaleficence, and this principle reflects the obligation to do no harm while simultaneously seeking out opportunities to do what is good. In the evidence provided previously, it is clear that authority figures, including physicians, in the camps were not striving to fulfill these principles on behalf of those for whom they were responsible. Principle B seeks to establish fidelity and responsibility as vital components in relationships. Psychologists, by this standard, should be aware of and accept their re-

sponsibilities to their clients, community, and society while also building relationships of trust with others. German physicians and Nazi authorities neglected these ideals as they were unable to be trusted with the lives and well-being of the prisoners for whom they were responsible. Also, it can be noted that they did not accept a responsibility to society as a whole and held ideologies that greatly decreased any possibility that they might have even considered this. Integrity (Principle C) was lost during that period as truth was often misrepresented and the deception directed toward others, especially the prisoners, was not of benefit to them. Principle E recognizes that justice and fairness are essential and that all individuals should have equal opportunities to benefit from contributions put forward by the field of psychology. Applied to concentration camp experience, injustice was an underlying theme and means for expanding Nazi ideologies and agendas. Thus, there are convincing pieces of evidence that would reject the existence of justice in the actions of the Nazi party. Finally, Principle E calls for respect for people's rights and dignity. This principle reflects the desire for psychologists to aspire to ensure that their actions allow individuals their rights to privacy and self-determination. Additionally, psychologists should aspire to protect those who are in vulnerable conditions, while respecting differences including those based on age, culture, religion, ethnicity, disability, etc. Those in authority who were directly responsible for prisoners in the concentration camps neglected this value in their dealings with the prisoners, who were vulnerable and denied basic human rights under the deplorable circumstances of their imprisonment.

Ethical Standards. Although ten ethical standards exist for psychologists, the three that are most relevant to the activities of the Nazi part during World War II are Standard 1: Resolving Ethical Issues and Standard 3: Human Relations, and Standard 8: Research and Publication. Standard 1.03 involves conflicts between ethics and organizational demands. The activities of the Nazi party within the concentration camp system clearly illustrate how the demands of the SS and Nazi organization directly conflict with the ethical principles outlined by the APA. Standard 3.01 prohibits unfair discrimination of the basis of age, race, ethnicity, culture, religion, sexual orientation, disability, etc. Further, Standard 3.04 mandates that psychologists take reasonable steps to avoid harming anyone with whom they work. Conflicts of interest are addressed in Standard 3.06, and exploitative relationships are identified as unethical by Standard 3.08. Those operating the concentration camps and implementing the Nazi agenda engaged in discriminatory behavior, mostly on the basis of religion (e.g., Jews), but also on the basis of sexuality, age, and ability or disability. Also, those in power openly exploited those over whom they had power by forcing labor and participation in experiments, for example. Conflicts of interest also existed mostly clearly in the role of physicians. Physicians are bound to "do no harm" and heal the sick, but under these circumstances, they also had the responsibility of carrying out experiments and killing the sick, infirmed, or "inferior" in clear conflict of both medical and psychological ethical codes.

Another important ethical standard directly connected to this period of history are Standard 3.10, which necessitates informed consent for assessment, therapy, counseling, and outlines what constitutes adequate informed consent. Also, Standards 8.01 and 8.02 illustrate the need for institutional approval when conducting research as well as more specific guidelines for obtaining informed consent in a research setting. Other standards under Standard 8 outline clearly what is acceptable in research. This is directly related to the Nuremberg Code created following World War II and seeks to prevent future disregard for the rights of participants in a research setting.

Man's Search for Meaning and the Future of Ethics

As a profession, psychologists have been successful in preventing widespread disregard for ethical behavior and improper treatment of others, in direct opposition to those professionals involved in the systematic torture, killing, and further dehumanization of the millions of European Jews who lived through the Nazi occupation of Europe. However, psychologists still have room for improvement in their aspiration to embody the values of the profession. One theme in Viktor Frankl's book is the freedom to choose, and although psychologists are generally able to adhere to the standards regarding autonomy, there is still some room for debate whether certain practices in psychology truly allow for freedom of the client. Two examples of this might be the decision to force-feed clients with eating disorders against their will or involuntary commitment. Although we assume that these actions are in the best interest of those for whom we are responsible, it is important that we notice the possible harm caused by taking away the freedom to make a choice.

The time period encompassing the events in *Man's Search for Meaning* also brings attention to issues surrounding the identification of basic human rights. It is apparent from Frankl's writings as well as other accounts in the concentration camps that individuals were deprived of their basic right to live, much less live freely. However, as we notice shifts in what constitutes basic human rights (e.g. marriage, health care, a living wage, etc.) it is important that the field of psychology continues to adapt its ethical standards in a way that is sensitive to the basic rights of all people. As a profession, it is important that psychologists

continue to move forward and continue to pave the way for individuals to be treated with respect for what makes each of them human regardless of personal and societal biases. Though these biases always exist, it is our responsibility as professionals in psychology to act objectively, in ways that best serve others.

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Maintenance and Continuance of Ethical Standards While Completing Forensic Vocational Evaluations

Craig Bock

Abstract. Forensic rehabilitation settings present multiple challenges for potential deviation from ethical standards. This article offers a framework for avoiding bias during completion of vocational evaluation and ultimately rendering an opinion. Particular emphasis is placed on specific ethical codes and canons.

This offers an opportunity for the forensic rehabilitation counselor to examine prospective ethics while completing vocational evaluations. Particular emphasis will be on specific canons and components of applicable ethical codes. A vocational counselor must initially consider the actual relationship with the client, as a component of the ethical process continuum.

Per the Commission on Rehabilitation Counselor Certification (CRCC) Code of Ethics, Section A.1.a – The Counseling Relationship: Welfare of Those Served by Rehabilitation Counselors - Primary Obligations:

> *The primary responsibility of rehabilitation counselors is to respect the dignity and to promote the welfare of clients. Clients are defined as individuals with, or directly affected by a disability, functional limitation(s), or medical condition and who receive services from rehabilitation counselors. At times, rehabilitation counseling services may be provided to individuals other than those with a disability. In all instances, the primary obligation of rehabilitation counselors is to promote the welfare of their clients. (Commission on Rehabilitation Counselor Certification, 2010, p. 3)*

Per the CRCC Code of Ethics, Section F.1.a. Forensic and Indirect Services: Client or Evaluee Rights – Primary Obligations:

> *Rehabilitation counselors produce unbiased, objective opinions and findings that can be substantiated by information and methodologies appropriate to the evaluation, which may include examination of individuals, research, and/or review of records. Rehabilitation counselors form opinions based on their professional knowledge and expertise that can be supported by the data gathered in evaluations. Rehabilitation counselors define the limits of their opinions or testimony, especially when an examination of individuals has not been conducted. Rehabilitation counselors acting as expert witnesses generate written documentation, either in the form of case notes or a report, as to their involvement and/or conclusions. (Commission on Rehabilitation Counselor Certification, 2010, p. 15)*

Per the International Association of Rehabilitation Professionals (IARP) Code of Ethics, Standards of Practice and Competencies: Forensic Code: General Definitions: Client:

> *Clients are defined as individuals with or without disabilities who are the subject of the litigation. The primary obligation and responsibility of Forensic Rehabilitation Experts/Consultants is to the client. Regardless of whether direct client contact occurs or whether indirect services are provided, the primary obligation remains to the client. (International Association of Rehabilitation Professionals, 2007, p. 4)*

"Experts, for the purpose of trial testimony, are witnesses in possession of knowledge that is beyond the ken or understanding of the average lay person and which the trial court deems helpful to a jury. Experts are persons duly and regularly *engaged* in the practice of a profession who hold professional degrees from a university of college and have had special professional training and experience or those possessed of special knowledge or skill regarding the subject upon which their testimony is based" (Bourgeois, Decoteau & King, 2011, p. 49-50). Bourgeois et al. detail that you cannot be an expert unless you have experienced the very thing you are presumably have expertise. Therefore, you cannot practice ethical behavior in one setting, but not the other.

I believe that the first sentence of the CRCC Code of Ethics - *The primary responsibility of rehabilitation*

counselors is to respect the dignity and to promote the welfare of clients. (Commission on Rehabilitation Counselor Certification, 2010, p.3) should be the guide, filter, litmus test etc. that guides the CRC in whatever capacity (active rehabilitation counseling or as an expert) they are fulfilling with the person they are working.

As a Certified Rehabilitation Counselor (CRC) and front line vocational rehabilitation counselor working within RCW 51.32.095 in Washington State, I can be in direct violation of my CRCC Code of Ethics (Commission on Rehabilitation Counselor Certification, 2010) on several levels unless I follow a few simple but crucial steps.

In my initial letter to the evaluee, I must include the following documents:

- Business Card
- Professional Disclosure Statement
- Vocational Questionnaire
- Professional Consent for Release of Information
- WAC 296-19A-030 (What are the responsibilities of the parties?)
- WAC 296-14-410 (Reduction, suspension, or denial of compensation as a result of noncooperation.)
- RCW 51.32.095 (Return to Work Priorities)
- WAC 296-19A-070 (What is Ability to Work Assessment?)

These items are included with the introductory letter to establish a clear understanding of my role as a VRC and what our "counseling" relationship will be in a professional framework. Professionalism and responsibility calls for the VRC and the Forensic Vocational Expert to understand, establish, and enforce professional boundaries with all parties in the case – evaluee, referral source, payers, or secondary parties (Robinson, 2014). As stated, along with making sure the evaluee knows my role as a VRC, the employer, defense attorney or other payer for my assessment time must be clearly informed that they are not buying a certain opinion. They are purchasing my time and I will arrive at my opinion after I have completed my methodology for arriving at a vocational and employability opinion. Unlike active vocational counseling and case management where the worker being evaluated is considered my client, in a forensic setting the person is considered an evaluee. To enable a CRC to adhere to Section A.1.a of the Code of Ethics even in a forensic setting, the CRC needs to clearly define and explain the role they are taking with the evaluee.

By establishing a clear understanding of what role the CRC is going to complete, we as CRC's adhere to Section A.1.a in the following manner: the CRC respects the individual and evaluee by not insulting their intelligence when they explain their role and what the steps are knowing it may be difficult for some people to understand when they are presented with the information for the first time but realizing they need to understand the process they are going through more than ANY party in the process, and the CRC promotes the welfare of the client/evaluee by performing an objective, thorough assessment within the regulations and laws of a given system so they can move through the system and get on with their lives. Closure, done correctly, of a portion of a person's life experiences, allows them to move through to the next stage of their life journey. Realizing early, that as VRCs and CRCs, we will always effect our clients and evaluees on a positive or negative depending upon our actions (or, quite frankly lack thereof) is crucial. In active practice or in a forensic setting rehabilitation professionals are involved in an inherently moral practice. "Their judgments are influenced by their beliefs of what ought to be. However, their actions can be greatly controlled by their beliefs about what can be and what is cost-beneficial. Thus, it is crucial for (VRCs) to achieve self-awareness that can potentially shape their beliefs and thereby influence their decisions and actions [sic]" (Ruben et al., 1995, p. 174).

"It can be argued that the ethical principles of beneficence (helping others fulfill their basic needs), autonomy (respecting the choices of others), and justice (making fair decisions regarding distribution of scarce resources) greatly help define ethical behavior by (VRCs)" (Ruben et al., 1995, p. 173) in active rehabilitation settings. However, I believe it can also be argued that beneficence (providing an accurate, objective assessment), autonomy (respecting others) and justice (being true and honest in one's approach to the evaluation of the case, opinions, and presentation of findings) define the forensic assessment as well. Just because the CRC/VRC is removed from active rehabilitation services in a forensic evaluation setting, does not mean that their opinions and recommendations will not have the same powerful impact on the person they are evaluating. Even if the forensic evaluation FEELS removed and or cold in its application (if the Forensic Examination does not physically meet with the individual during the assessment) the CRC or VRC need not forget they are making recommendations about a person's life and not a file.

Per Field (2014) an example of unethical and then ethical behavior illustrates how CRCs and VRCs impact the court room in a forensic/legal setting: In *Fashauer v. New Jersey Transit Rail Operation*s, a vocational expert, during trial testimony, offered a single job recommendation which he found in the newspaper the day before the trial. The expert was dismissed when the court ruled that the VE's testimony was so ludicrous; laughably ludicrous that it did not require rebuttal. Conversely, Field (2014) points out that an expert who does their homework, and can present their opinions with a degree of passion and practicality and

speaks well, the receiver (judge / jury) of their information is able to benefit from said presentation as they are allowed to build upon the information that adds to their own opinion rather than trying to slog through confusing opinions that were given to divert logical thinking. "The FE must proceed on the presumption the case will go to trial and methods used to calculate losses will have to potentially (be) explained to a jury and defended under cross-examination. It is important the FE be a good 'teacher' given he/she must be prepared to present and explain all aspects of the report to juries, judges and attorneys that may be unfamiliar with (vocational) economic concepts" (Austin, 2014, p. 172). An ethical approach to explaining data generated during an assessment and respecting the dignity and promoting the welfare of clients or evaluees starts with a sound methodology that is reliable and valid.

As a front line vocational counselor guided by the WA State L & I assessment "boxes" (WAC 296-19A, RCW 51.32.095 & WAC 296-19A-130) my methodology when arriving at an employability recommendation does not waiver. The same methodology (to the extent that I can have direct contact with the evaluee) remains the same in the forensic or legal setting as it does in an active file. I adhere to my methodology as strictly as possible in either setting as it allows all parties involved the opportunity to see and understand first-hand how I arrived at my opinion. There are no smoke and mirrors with which to hide behind in my assessments. And if one of the parties involved has an issue with my opinion, they can see what data I generated or used for my opinion and refute it as they deem necessary. Such a methodology also continues to assist me in staying within my expertise and not straying outside of it to give an opinion based on what I think I know rather than what I know. ". . . ethical statements (CRC, IARP, etc.) should be read and understood and serve as a daily guideline for the work of the rehabilitation consultant. As a general rule, the rehabilitation consultant (CRC/VRC) should not go outside the consultant's area of expertise and should clearly attempt to achieve a level of competency within his /her particular are of specialty. In the final analysis, the ultimate test of the rehabilitation consultant's competence is the consultant's presentation in settings of adjudication. In a very real sense, the judicial setting is where all the world watches with respect to the performance of the rehabilitation consultant" (Field, 1999, p. 84).

A question I welcome in active practice or the forensic setting is the following: "How did you arrive at your opinion?" I enjoy this question as my answer is the same and it gives me the opportunity for a teaching moment. My assessment begins with usually answering the following question, "I would like to make a referral to you for an assessment. What part of the file would you like me to send?" To that I answer, "All of it please." I always request the entire file (and any documents that come in after I begin my assessment) as I do not want to feel that I arrived at my opinion based on partial/incomplete information given to me by someone who has a vested interest in my opinion going one way or the other. I can then ethically/morally believe that I can state the following when I am submitting my overall opinion, "Based upon all available medical and vocational information for review my opinion is . . . ."

Once I have received the file, a file review of the documents received is completed and a File Review Summary Report generated. This is not a report wherein I arrive at an opinion; it is simply a summary of what I have received. It is a form that has places for data such as name, birth date, type of injury, date of injury etc. The form allows me to capture data into a user friendly format to see how the claim started, what the issues are and what I maybe missing that I need to generate before I can arrive at my opinion.

I will then send a letter of introduction with the items listed above in page 3, including a Professional Consent for Release of Information. (If the evaluation is for the Department, I will also include WAC 296-19A-130 – What are the requirements for a forensic evaluation?) The professional consent reads:

> *I authorize* ***Craig Bock, M.A., CRC or a representative of Bock Consulting*** *to be permitted to obtain and review copies of all vocational, hospital, medical, employment, school, military, union and other records, and to discuss relevant information with professionals involved in my vocational assessment. I give my permission to share the information obtained with any organization that, through an insurance program or otherwise, is paying all or part of the cost of my vocational assessment. I agree that a copy of this authorization be accepted if necessary.*

All of these items are sent to the client / evaluee in an effort to communicate what the process will entail and what expectations the system they are in have of them. "In terms of ethical obligation, an individual has a right to know what to expect when working with a rehabilitation counselor, with clearly defined expectations at the beginning and throughout the process" (Carlisle & Neulicht, 2010, p. 75).

I will then meet with the client/evaluee to review the information I was given and to go over the vocational questionnaire. If I cannot meet in person with the evaluee in a forensic setting, I will ask the attorney to obtain any information I do not have or clarifications of information I do have directly from the person. I will review with the client why I have been asked to evaluate them, what information I need from them (vocational, educational, medical) and what possible recommendations I could arrive at. Under RCW51.32.095, I could arrive at any one of these rec-

ommendations as well as that the worker is a straight pension or a second injury pension:

(a) Return to the previous job with the same employer;

(b) Modification of the previous job with the same employer including transitional return to work;

(c) A new job with the same employer in keeping with any limitations or restrictions;

(d) Modification of a new job with the same employer including transitional return to work;

(e) Modification of the previous job with a new employer;

(f) A new job with a new employer or self-employment based upon transferable skills;

(g) Modification of a new job with a new employer;

(h) A new job with a new employer or self-employment involving on-the-job training;

(i) Short-term retraining and job placement.

Forensically, customarily, I will arrive at an employment recommendation similar to RCW 51.32.095, but will take into account loss of earning capacity. I would be doing the client/evaluee undue harm if I did not explain to the best of my ability (and also directly ask them if they understand the information I have presented) what the assessment will entail and what my overall vocational opinion could mean to them. Dispelling myths (such as . . . you do not receive millions of dollars in this particular kind of system) is also my ethical duty as many clients I work with have a misconception of what the system will bear for them if they are found not employable on any level.

During my interview with the client or evaluee, I might test them (aptitudes, interest, personality, IQ) as well. I let them know that there are no pass/fail grades in such assessments. It is simply data that allows me to comment on their overall employability. Here again, if I did not let the client/evaluee know the reason for the testing, the process generates undue stress and anxiety.

I will then complete a transferable skills analysis (Weed & Field, 2001) in an effort to break down the client's background into data that I can analyze for cross employment applicability. I will generate my own job analyses for the assessment by going onsite and generating data or utilize job analyses that I have done in the past as a starting point to move to the next step – medical review of possible return to work options.

I will then either meet in person with the medical professionals associated with the file or send to them data (job analyses) for their review and commentary. I do not try to make assumptions of what a person can or cannot perform vocationally from historical data that doctors have generated on the file. In my assessments, I need medical opinions directly related to data that I can speak to regarding how it was generated. It would be unethical to utilize someone else's work product (vocational histories, job analyses, labor market surveys), have a medical professional review and state their opinion as to whether the person can or cannot perform the job and then arrive at an employability recommendation. It is imperative to arrive at recommendations based on data that you know how it was generated.

Once I have medical releases, I then will complete labor market surveys to generate real world employment data. National data can be helpful to start with, but unless the applicable counselor contacts businesses in the client's geographically relevant labor market, you will not be able to ethically comment on the client's employability (exists if a person possesses skills, abilities and traits necessary to perform a job; the kinds and types of job which a person with a disability might be able to perform) nor their placeability (economic conditions and employer attitudes are such that a person can actually be placed in a job; the difficulty in placing a person with a disability in a job) (Field, 1999).

Once I have generated the aforementioned data I can then arrive at an employability recommendation that can include whether or not a loss of earning capacity has happened due to the injury or condition. A report is generated and sent to the client/evaluee directly or indirectly through their counsel.

The CRC/FE has a primary obligation to the client/evaluee when completing employability assessments …. *to respect the dignity and to promote the welfare of clients.* To do this the counselor needs a crystal clear understanding of the system the counselor is a part of when asked to arrive at their opinions, applicable education/life experience to use as their paradigm filter and a repeatable/objective assessment methodology. Anything less removes the counselor's ability to adhere to their applicable Code of Ethics.

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Washington Administrative Code 296-19A-010

Washington Administrative Code 296-19A-070

Washington Administrative Code 296-19A-130

Washington Administrative Code 296-19A-140

Endnotes

[1] Revised Code of Washington 51.16.120: *Whenever a worker has a previous bodily disability from any previous injury or disease, whether known or unknown to the employer, and shall suffer a further disability from injury or occupational disease in employment covered by this title and become totally and permanently disabled from the combined effects thereof or die when death was substantially accelerated by the combined effects thereof, then the experience record of an employer insured with the state fund at the time of the further injury or disease shall be charged and a self-insured employer shall pay directly into the reserve fund only the accident cost which would have resulted solely from the further injury or disease, had there been no preexisting disability, and which accident cost shall be based upon an evaluation of the disability by medical experts.*

The Rehabilitation Professional, 23(1), pp. 35–40

The Expert Witness: Insulating Against Bias

Bruce S. Bloom

Abstract. Credentialing bodies in the field of mental health have tried to create ethical standards that would guide those that conduct forensic work to remain unbiased and produce neutral work. Unlike traditional vocational rehabilitation counseling, forensic rehabilitation counselors produce work that may affect legal proceedings. In these cases, the contracting party may have specific opinions that they want to defend or promote, which may put direct or indirect pressure on the Forensic Rehabilitation Counselor (FRC) to validate the contracting party's position. This paper explores several biases that can occur when a partisan party contracts an expert witness, and how the FRC can insulate against these biases.

Forensic Rehabilitation Counseling is performed in a highly adversarial environment, where the opinion of the Forensic Rehabilitation Counselor (FRC) affects the outcome of high stake arbitrations and court cases. Unlike lay witnesses, who can only testify on what they see, the Expert Witness can offer opinions based on their "knowledge, skill, experience, training, or education" (Robinson, 2014, p. 303). However, forensic rehabilitation counseling is not an exact science, and opposing FRC may come to a completely different opinion based on the same data set. "Variability in opinion and methodology is particularly problematic in legal/forensic settings where vocational consultants are retained by opposing parties routinely evaluate the same data and apply peer-reviewed methods yet arrive at incongruent or contradictory opinions" (Robinson, 2014, p. 57). In order to maintain credibility and an ethical practice in accordance with the CRCC code of ethics, the FRC should be aware of potential bias that can arise from fees (financial gains), selection bias, adversarial (conscious and unconscious) bias, and confirmatory hypothesis testing, and take steps to ensure that the FVE remains neutral and their opinion is both reliable and valid.

One area that may cause ethical conflicts for the expert witness is their desire to provide quality service to their client. In traditional vocational rehabilitation counseling, the client is typically the individual with a disability that wants to reach an employment outcome; however in private forensic practice, the client is not as clearly defined. In Section F.1.C of the CRCC Code of Professional Ethics, the CRCC states, "In a forensic setting, rehabilitation counselors who are engaged as expert witnesses have no clients" (CRCC, 2010, p. 15). The goal of this ethical structure is that the FRC will produce unbiased, neutral work without any thought towards a specific client, and therefore the FRC will act as a neutral party and produce neutral opinions. However, the CRCC created an ethical framework that may be challenging to apply in a business where an expert is being contracted. In discussing the variety of FRC opinions in forensic work, "Grimes suggests that, in part the variability in expert opinions may be related to the application of vocational rehabilitation theory in adversarial settings where parties have competing interests" (Robinson, 2014, p. 57). Therefore in personal injury, product liability, or divorce cases, it is clear that the forensic expert must take care to evaluate their own opinion to ensure that they are reaching logical conclusions from the data reviewed, rather than giving an opinion that confirms the position of the contracting party.

In forensic work with the Social Security Administration (SSA), the vocational expert is contracted by the SSA, is paid by the SSA, and is questioned primarily by the administrative law judge that oversees the trial. In this setting, it remains relatively easy to remain neutral, because the administrative law judge has no personal stake or vested interest in one outcome or another. Additionally, the FRC is paid by the SSA and scheduled for more trials regardless of their testimony, as long as they produce quality work. While an expert witness can be cross-examined by an attorney and/or another expert witness, the general trend of these proceedings is non-adversarial. The goal of the expert in this setting is to produce evidence that a claimant can or cannot achieve substantial gainful activity. However, as opposed to the work with the SSA and in state VR, the forensic work that occurs in product liability cases, personal injury cases, and divorce cases is generally more adversarial. While the position of the CRCC Code of Ethics is clear, there is a

potential for the FRC to view referring attorneys, insurance companies, or claimants as clients.

Because contracting parties have a vested interest in supporting specific positions, the FRC may feel obliged to provide an opinion that is favorable to the person(s) paying for evaluations. The legal profession has recognized this bias in expert witnesses and tried to exploit this relationship. For example, opposing attorneys often examine fee schedules to discredit opposing expert witnesses. In their article entitled, "Money Talks: Exposing Bias Using Expert Witness Fee Arrangements", Kuppens & Goodfellow (2012) encourage attorneys to examine fee schedules for contingency fee arrangements. They state that compensation that is based on contingencies of winning the trial would be inherently biased. They encouraged opposing counsels to examine the expert witness's financial stake in litigation outcomes (Kuppens, et. al 2010). Aware of the ethical issues with contingency payments, the CRCC addresses this issue with section F.4.A section on payments and outcomes, "Rehabilitation counselors do not enter into financial commitments that may compromise the quality of their services or otherwise raise questions as to their credibility. Rehabilitation counselors neither give nor receive commissions, rebates, contingency or referral fees, gifts, or any other form of remuneration when accepting cases or referring evaluees for professional services. While liens should be avoided, they are sometimes standard practice in particular trial settings. Payment is never contingent on outcome or awards" (CRCC, 2010, p. 17). However, even when a counselor is not being paid on a contingency basis, there may be other financial factors that come with running a successful business, such as the desire for repeat business, that may contribute to a biased opinion.

A possible solution for this ethical conflict related to rendering an opinion that would not be favorable to the contracting attorney is that a forensic vocational expert should take measures to ensure that they are only taking cases with merit. Blackwell, Field, Johnson, Kelsay, and Neulicht (2005) state that prior to accepting a case, a review of the cases merits should be made, and a FRC should try to determine if the contracting attorney is trying to push the FRC towards a favorable conclusion. According to the CRCC Code of Ethics (2010), "While all rehabilitation counselors have the discretionary right to accept retention in any case or proceed within their area(s) of expertise, they decline involvement in any case when asked to take or support predetermined positions, assume invalid representation of facts, alter their methodology or process without foundation or compelling reasons, or where there are ethical concerns about the nature of the requested assignments" (p. 17). A FRC should remain in contact with the referral sources, and after their initial evaluation, if the FRC cannot support the attorney's position, they should contact the attorney and recommend that they stop working on the case (Blackwell et al., 2005, p. 29). Therefore, in order to maintain neutrality and avoid ethical quandaries, a FRC should decline cases without merits based on their initial file review, and should discontinue working on cases after they have finished their evaluation, if their opinion will not support the contract attorney's position.

Because of the marketing and business aspect of running a consulting business, forensic counselors may develop business relationships overtime. These business relationships may inherently carry risk of pressuring experts to skew their opinions so that the expert can retain a positive business relationship. In their research Edens et. al. (2012, p. 259) stated that "Although in principle the legal system expects and professional ethics demand that expert witnesses be unbiased and objective in their forensic evaluations, anecdotal evidence suggests that accusations of financial bias, partisanship, and other forms of non-objectivity are common." Edens et al. document that there is an overall theme of distrust of forensic experts by those in the legal field, because a biased party pays experts for their work.

Another factor that may put additional pressure on an FRC towards forming a biased expert opinion is the selection process. Attorneys and insurance companies are going to seek out expert opinions that will favor their position. Slovenko (2010, p. 35) in his research states, "Selection bias means that the experts retained by a party will not represent a random sampling of expert opinions. Rather, they will represent the perspective the attorney wants to present at trial," and that experts are chosen because of their predisposed opinions. As a result, "the court does "not get fair professional opinion" from each party's experts, but an exceptional opinion" from each side." (Slovenko, 2004, p. 35) While a FRC may seek to produce work that is fair, evidence based, and neutral, they may have been chosen specifically because their reputation and/or methodologies favor a specific type of opinion. According to the CCRC it is up to the individual counselor to examine his own biases and to "decline involvement in any case when asked to take or support a predetermined position" (CRCC, 2010, p. 17). When an expert is chosen for a methodology or reputation for calculating losses in a specific way, the FRC may feel pressured to produce those same type of opinions or they may feel hesitant to change methodologies based on the nature of a case or the current research in the field. While this may be the case, "Deutsch advised that there should be no difference in either the methodology for evaluating the client or the manner for which conclusions are drawn, despite referral of the case from the plaintiff versus the defense viewpoint" (Robinson, 2014, p. 335). While the FRC may have been chosen for a particular methodology or

reputation, the FRC should continue utilize widely accepted methodologies for evaluating clients in order to remain neutral. There is be no easy solution to section bias, however the FRC should take into consideration alternative views of the data sets to determine if these opinions have validity. According to Robinson, vocational experts should identify the alternative opinions, and "adequately account for obvious alternative explanations" (Robison, 2014, p. 309). Therefore the Forensic Rehabilitation Counselor should look for and acknowledge opposing or differentiations in interpretation. For this reason the FRC may need to obtain additional training in scientific reasoning to allow them to "view all assumptions as tentative, problematic, and subject to revision as their observations fails to conform to initial expectations" (Robinson, 2014, p. 268).

Once an expert witness accepts a case, attorneys may pressure the FRC to "fight" for their clients. "In procuring the assistance of an expert, the attorney typically talks in terms of "if you take the stand," reviewing the topics and the facts of the case. Once the expert agrees to serve, the attorney expects them to take on the role, in effect, of an advocate-to make the best case they can for the lawyer's client" (Slovenko, 2004, p. 34). Attorneys are retained to argue a specific point and win for their clients, as noted previously in this paper, their lack of neutrality may put pressure on the FRC to produce results that would lead to an attorney to continue utilizing their services. Bernstein (2008) refers to this as conscious bias, "the problem of conscious bias arises when "hired guns" adapt their opinions to the needs of the attorney who hires them" (Bernstein, 2008, p. 454). In his article, "The Biased Expert Witness in Louisiana Tort Law", Alford (2000) stated, " Because the 'universe of experts is defined only by the virtually infinite variety of fact questions in the trial courts,' the ranks of professional experts are ever increasing. This proliferation has resulted in the creation of the expert-advocate who, lured by the prospect of a substantial fee, testifies in conformity with the needs of the principal who engages him" (p. 181). Because there is a tendency in industries that have an abundance of experts, the may be additional pressure on the FRC to be "the hired gun" nefor their clients so that their referral sources will not move on to a more agreeable expert.

he FRC is conducting business in the competitive market place; attorneys and insurance companies are looking for expert witnesses that will consistently render opinions that are consistent with their goals. To this end, some insurance companies retain in-house forensic rehabilitation experts. As noted, in case of personal injury or divorce cases, attorneys may have long standing working relationships with experts that are inclined to give specific types of opinions. But even if a FRC sets out to be neutral, there may be an unconscious bias that affects their work. Bernstein (2008) stated, "Undoubtedly there is a natural bias to do something serviceable for those who employ you and adequately remunerate you" (p. 455). Unconscious bias exists across various categories of expertise, but because of the external pressures of fees and selection, and the desire to retain business, the expert witness may naturally identify with their employer. A forensic expert's unconscious bias can easily affect his conclusions, especially when these conclusions necessarily rely, on subjective judgments (Bernstein, 2008). Murrie, Boccaccini, Guarnera, & Rufino (2013) found that forensic psychiatrists and psychologists swayed their expert testimony and scoring of "objective" tests depending on who they thought was paying them. In their study, Murrie et al. note that most experts try to be objective, but the findings suggest that the side that retained them swayed some of the experts. As previously discussed, as a business person, the forensic counselor/expert witness may rely on "reviews" by attorneys and claims managers to obtain additional business. "In light of the pressure felt by many experts to ensure future demand for their services by way of zealous advocacy for their clients, the concern that the present method for use of experts in court does not exert sufficient quality control on their opinions" Alford (2000, p. 203). So even when they may not be asked to take a specific side or support a predetermined position, the FRC may feel inclined by the nature of their relationship to the contracting party to skew their opinion in their "employers" direction.

Because of court decisions in *Daubert*, *Joiner*, and *Kumho* over the last few decades, FRC have sought the solution for ethical dilemmas through engaging in more scientific protocols, and utilize more scientific research that would meet court standard for expert testimony. For example, under *Daubert* the courts follow a four-part test for measuring the reliability of expert testimony offered in court, which included the following:

1. Whether the theory or technique on which the testimony is based can be tested;
2. Whether the theory or technique has been subjected to publication and peer review;
3. Whether there is a known or potential rate of error for the theory or technique; and
4. Whether the theory or technique has attained a level of general acceptance in the particular discipline (Younger, 2005).

Yet it is clear that forensic rehabilitation counseling is not a hard science conducted in the same scientific manor as chemistry (or the likes), courts have given some leeway to the *Daubert* standard, (in *Kumho v Carmichael*) to allow the trier of fact to admit evidence that does not meet all four *Daubert* standards (Robinson, 2014, p. 308). Fruchter (2014, p.1) in his blog writes "the Ninth Circuit held that pop culture could

substitute for scientific methodology in special circumstances where an expert could reliably apply widely accepted cultural norms to the facts of a case. As the Ninth Circuit explained: "The Advisory Committee Notes to Rule 702 of the Federal Rules of Evidence recognize that some types of expert testimony will not rely on anything like a scientific method, and in certain fields, experience is the predominant, if not sole, basis for a great deal of reliable expert testimony. In our esteemed view and humble opinion, pop culture is no less reliable than professional experience as the basis for expert testimony. That is not to say that all pop cultural references will survive scrutiny. Instead, an expert relying on pop culture must explain how the cultural reference leads to the conclusions reached, why the cultural reference is a sufficient basis for the opinion, and how the cultural reference is reliably applied to the facts." While a FVC can provide testimony on their opinion and experience with the work "culture", it is not acceptable to ignore data. "It is important to first consider science-based information (Daubert), and then rely on other factors when necessary . . . Daubert factors does not preclude other factors such as clinical judgment. Both domains, scientific evidence and clinical impression may be equally important in offering to the court sufficient and adequate opinions and expert testimony that will assist the Trier of Fact in reaching a fair judgment" (Robinson, 2014, p. 274).

Because of pressure to be biased, a FRC may engage in confirmation bias. Wright et al (2013, p. 4) describes confirmation bias as "search for formation that is consistent with the hypothesis and by lack of attention to information that is inconsistent with, would discredit, the hypothesis." Wright goes on to state that the rehabilitation counselor develops hypothesis throughout the counseling relationship and use their clinical judgment to make inferences regarding client functioning. These inferences assist the counselor with case formulation and recommendations for case planning. However the FRC through confirmation bias can lead an individual to "search for formation that is consistent with the hypothesis and by lack of attention to information that is inconsistent with, would discredit, the hypothesis" (Wright et al., 2013, p. 7). Recognizing this difficulty the CRCC states that it is the duty of the FRC to confirm information (CRCC, 2010). However as previously discussed, part of the issue with confirming information is that if there is an unconscious bias towards a certain opinion, the FRC may not be fully aware they are engaging in this type of bias.

Therefore as part of their work, the forensic rehabilitation counselor should attempt to utilize decision-making models to help formulate an opinion that is neutral, valid, and reliable. "Just as a scientist would want to duplicate the outcome when evaluating a colleague's claim that he had developed a technique for cold fusion, a vocational rehabilitation counselor would want to test the underlying hypotheses and review the standards controlling the technique's operation in an attempt to reproduce the results originally generated. If such testing did not generate consistent results, [the expert's] method would be exposed as unreliable because it is subjective and irreproducible" (Barros-Bailey & Neulicht, 2012, p. 12). Barros-Bailey and Neulicht (2012, p. 12) recommend using a decision-making rubric to integrate qualitative and quantitative measures and obtain an opinion that would be valid; in what they term *Opinion Validity* they combine "internal and external qualitative and quantitative validity research methods to arrive at a defensible opinion that is more probable than not." Utilization of an opinion rubric such as Opinion Validity may assist the FRC in maintaining neutrality and creating an opinion that is more probable.

Practitioners in forensic rehabilitation counseling faces multiple ethical challenges in conducting work as expert witnesses when compared to work within public vocational rehabilitation systems. While the SSA contracts with Vocational Experts this work tends to be more neutral because it is contracted and funded by a neutral party. While bias is a recognized issue in forensic work in different fields, there is no simple solution to overcoming these biases. In his research, Slovenko (2004) noted that in most other countries, the court appoints expert witnesses. This allows the expert to be completely unencumbered by the business of FRC, and it would allow the expert to operate in a manner similar to that of the FRC in a Social Security hearing. But this type of change would require a legislative change and significant funding from both the federal and state government.

From the research reviewed it is challenging for the FRC to remain neutral in the competitive market place, when they may be hired to defend a specific position. In this adversarial environment, the expert witness may feel pressure from potential financial gains, selection bias, both conscious and unconscious bias, and confirmation bias to produce a certain standard or opinion. Because this is a recognized challenge, the CRCC has created guidelines for FRC to help guide their ethical decision-making. Prescreening cases, use of self-examination, and utilization of decision-making matrixes such as Opinion Validity can assist the Forensic Rehabilitation Counselor to produce work that is ethical and bias free and that is defendable in a court of law.

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The Rehabilitation Professional, 23(1), pp. 41–48

Let's Talk About Sex: The Relative and Practical Importance of Sex Therapy in Rehabilitation and Mental Health Counseling

Sara L. Gibson and Theodore Scott Smith

Abstract. Sex therapy offers unique insight into the mental, physical, and social well-being of people. Sex therapy, despite its controversy today, has been utilized as a therapeutic modality since ancient times throughout many cultures. In practice, sex therapy addresses and treats a multitude of social, psychological, and physiological issues preventing someone from attaining, developing, and maintaining a healthy sex life. Well established therapeutic and ethical guidelines exist to assist sex therapists in providing consistent and successful care for their clients several of which deserve evaluation and scrutiny. Damaging social and psychological implications of unhealthy sexual practices today constantly present professional and logistical challenges for Sex Therapists. This article proposes emphasis on comprehensive and applicable sex therapy practices and protocol alongside proactive sex education for rehabilitation and mental health professionals to implement in multiple therapeutic settings. Additional discussions are developed around life care planning strategies.

Keywords: sex, sexuality, sexology, therapeutic intervention, sex therapy, sex education, sex counseling

It is difficult to separate sexual behavior from the overall human condition. Sex is considered one of the three basic primary drives of human behavior, alongside food and water. From facilitating evolutionary processes in all living organisms, to dismantling entire societies over marital infidelity, sex has had an extremely rich and diverse history. Considering sexuality has been a focal individual and social issue across human existence, disregarding its influence on human behavior as taboo or irrelevant is simply irresponsible on behalf of the professional mental health community. Its importance to the human experience warrants incorporation into treatment planning.

As psychology and other mental health professions began its early steps to becoming an established and respected science, sexual behavior was largely overlooked (Berry, 2013). However, there were highly influential figures in the history of psychology who recognized the usefulness of incorporating sexuality into their theories and research. Unfortunately, much of their work was considered controversial or dismissed as inappropriate at times (Berry, 2013). Thankfully, several major contributions during the 19th and 20th centuries from psychologists and physicians like Sigmund Freud, Alfred Kinsey, William Masters, and Virginia Johnson opened the doors for the study of sexual behavior to be taken seriously. These leaps and others like them made possible the advent of sex therapy and the overall incorporation of sexuality into mental health and rehabilitative science and professions. Although discussing the topic of sex may still make many people uncomfortable due to social influences, its importance to psychological wellbeing has been thoroughly established and should not be ignored. As such, the present paper seeks to present a framework establishing the importance of open discussion and implementation of sexual therapeutic techniques throughout mental health and rehabilitation services.

History of Sex Therapy

The history of applying sex in psychologically therapeutic settings can be traced back to ancient times

(Bhugra, 1995). Ancient cultures incorporated sex into religious ceremonies designed to worship the miracle of humans' ability to create life and the mysticism of fertility (Bhugra, 1995). Different forms of sexual therapy in these ancient cultures was also believed to aid in treating some deviant behaviors (Berry, 2013). Ancient India, China, Greece, and Rome all viewed sex in different ways, but never ignored its importance to the human condition (Shea, 1992). Many Eastern cultures developed manuals, spells, aphrodisiacs, tantric yoga practices, and other forms of therapy to address psychological and physiological issues surrounding sex (Bhugra, 1995). Ancient Western societies viewed sexuality as highly influential on human behavior as seen in the powerful role sex played in the religious stories of their gods. Causes for sexual dysfunctions were largely thought to be physiological as well as metaphysical in nature (Berry, 2013). All societies have had changing cultural trends regarding the acceptance or rejection of certain sexual practices. Mainly, different sexual behaviors' endorsement or repression has reflected the religious attitudes of the society (Shea, 1992). What we have learned by studying these trends is that extreme repression of sexual behavior often results in social phenomena such as increases in gender inequality, sexual violence, and other unhealthy social practices (Shea, 1992).

Separating sex from religion became particularly salient during scientific advancements made in Western society during the 19th and 20th century. Largely dominated by physicians and psychiatrists, the 1800's and 1930's are considered by some to be the period of development for sexology becoming its own distinct scientific field. Sigmund Freud's unrestricted discussion of sex during this period, particularly the human sex drive termed "libido," brought the subject of human sexuality to the forefront of psychological discussion. Although his theory of Psychoanalysis and associated methods were and remain extremely controversial, his groundbreaking work opened doors for the study of sexual behavior and implementation of sex therapy.

Psychologists such as Alfred Kinsey and Henry Havelock Ellis brought the study and discussion of human sexuality even further by conducting in depth research in the area during the first half of the 20th century (Goodwach, 2005). In his two books that would become known as The Kinsey Reports—*Sexual Behavior in the Human Male* (1948) and *Sexual Behavior in the Human Female* (1953)—Kinsey assessed a wide variety of topics related to human sexuality. Particularly innovative as well as controversial was Kinsey's study of sexual orientation. Although many scientific criticisms concern his methodology and statistical analysis, social outrage about the publications mainly surrounded the open discussion of topics previously considered taboo. The Kinsey Reports are widely considered as an important precursor to the sexual revolution of the 1960's and 70's.

From there, William Masters and Virginia Johnson continued to break down barriers and progress sex therapy in many ways. By specifically addressing sexual dysfunctions and physiological aspects of sexual activity, scientific knowledge of human sexuality expanded greatly. They also introduced sexual surrogacy, work with couples, and the implementation of cognitive behavioral therapeutic techniques.

Medical breakthroughs and intensified focus on the biomedical model during the last three decades of the 20th century brought about the "medicalization" of sex therapy in dealing with sexual dysfunction (Tiefer, 1996). "Medicalization" refers to the usage of pharmaceutical and/or other medical interventions in the treatment of a diagnoses. The advent of pharmaceutical drugs like Viagra and different hormone therapies as well as advanced surgical procedures on genitalia pushed sex therapy even further into the biomedical model during this time (Tiefer, 1996).

Today, sex therapy experts and other mental health professionals trained in sexology advocate for a more biopsychosocial model when approaching the treatment of sexual dysfunction and the study human sexuality (Berry, 2013). As the scientific study of sex evolved in the 19th and 20th centuries, sex therapy emerged as its own branch of therapeutic specialization made up of a community of professionals focused on helping individuals struggling with sexually related problems.

Sex Therapy as a Profession

The components required for an occupation to be considered professional, especially in the realm of psychology (Greenwood, 1957), are all met by Certified Sex Therapists (CST). First, theories laden with social, psychological, anatomic, and physiological foundations provide the basis for sex therapy. Second, knowledge base in how to treat an extremely complex set of issues with regard to sexual behaviors is required of sex therapists; their educational attainment, training, and competency must reflect this. Thirdly, there are numerous subspecialties within sex therapy such as physiologically concentrated therapy that addresses issues like erectile dysfunction or socially concentrated problems that may include pedophilia, voyeurism, etc. Fourthly, sex therapists have publicly and legally recognized authority to practice as professionals and must answer to a specific board in order to be licensed and certified. For instance, the American Association of Sexuality Educators, Counselors, and Therapists (AASECT) has an established code of ethics and strict guidelines for certifying their members. As stated, sex therapists must be adequately knowledgeable in a wide range of areas to be effective in

their practice. For this reason, educational requirements for certification to be a CST are extensive (AASECT, n.d.); a list of AASECT core knowledge areas can be found in Table 1.

Lastly, sex therapists belong to an exclusive community with a deeply professional culture. Publications, conferences, sponsored talks, workshops, and sex education courses represent some of the professional outlets CST's and other sexology practitioners utilize to get their knowledge and work out into the public realm. Several scholarly journals like *Sex Roles* and *The Journal of Sex Research* focus on publishing important psychological and physiological research specifically related to sexual behavior (see Table 2). After becoming a CST, one is expected to utilize the empirically supported therapeutic techniques that have been established to ensure the consistent and professional practice of sex therapy.

Therapeutic Goals of Sex Therapy

Sex therapy in practice is a form of psychotherapy with the ultimate goal being to help the client(s) overcome psychological and/or physiological barriers preventing them from having a healthy, active sex life. It is often implemented specifically to treat sexual dysfunctions when a physiological cause is not obvious or as a complement to medical treatment. Sexual dysfunction can apply to any number of psychological or physiological problems. Psychological problems that are sexual in nature can manifest as unwanted sexual fetishes, sexual addiction, or a lack of sexual confidence. Physiological problems are usually seen as erectile dysfunction, low libido, or painful sex. Many other issues can potentially be caused by a combination of psychological and physiological issues such as premature ejaculation or absence of/diminished sexual desire. Helping victims overcome damage caused by sexual assault is also considered a form of sex therapy. Lastly, everyday factors such as stress and relationship problems can greatly impact a per-

Table 1
AASECT Core Knowledge Areas

A. Ethics and ethical behavior.

B. Developmental sexuality from a bio-psycho-social perspective across the life course.

C. Socio-cultural, familial factors (e.g., ethnicity, culture, religion, spirituality, socioeconomic status, family values,) in relation to sexual values and behaviors.

D. Issues related to Sexual Orientation and/or Gender Identity: heterosexuality; issues and themes impacting lesbian, gay, bisexual, pansexual, asexual people; gender identity and expression.

E. Intimacy skills (e.g., social, emotional, sexual), intimate relationships, interpersonal relationships and family dynamics.

F. Diversities in sexual expression and lifestyles, including, but not limited to polyamory, swinging, BDSM, tantra.

G. Sexual and reproductive anatomy/physiology.

H. Health/medical factors that may influence sexuality including, but not limited to illness, disability, drugs, mental health, conception, pregnancy, childbirth, pregnancy termination, contraception, fertility, HIV/AIDS, sexually transmitted infection, other infections, sexual trauma, injury, and safer sex practices.

I. Range of sexual functioning and behavior, from optimal to problematic, including but not limited to common issues such as: desire discrepancy, lack of desire, difficulty achieving or maintaining arousal, sexual pain and penetration problems, difficulty with orgasm.

J. Sexual exploitation, including sexual abuse, sexual harassment, and sexual assault.

K. Cyber sexuality and social media.

L. Substance use/abuse and sexuality.

M. Pleasure enhancement skills.

N. Learning theory and its application.

O. Professional communication and personal reflection skills.

P. History of the discipline of sex research, theory, education, counseling, and therapy.

Q. Principles of sexuality research and research methods.

Table 2
Publication Samples

Sex Roles	Burn, S. M. (2009). A situational model of sexual assault prevention through bystander intervention. *Sex Roles*, *60*(11-12), 779–792. doi:10.1007/s11199-008-9581-5
	Franiuk, R., Seefelt, J. L., & Vandello, J. A. (2008). Prevalence of rape myths in headlines and their effects on attitudes toward rape. *Sex Roles*, *58*(11-12), 790–801. doi:10.1007/s11199-007-9372-4
	Ryan, K. M. (2011). The relationship between rape myths and sexual scripts: The social construction of rape. *Sex Roles*, *65*(11-12), 774–782. doi:10.1007/s11199-011-0033-2
Journal of Sex Research	Albright, J. M. (2008). Sex in America online: An exploration of sex, marital status, and sexual identity in internet sex seeking and its impacts. *Journal of Sex Research, 45*(2), 175–186. doi:10.1080/00224490801987481
	Morgan, E. M. (2011). Associations between young adults' use of sexually explicit materials and their sexual preferences, behaviors, and satisfaction. *Journal of Sex Research*, *48*(6), 520–530. doi:10.1080/00224499.2010.543960
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Journal of Sexual Medicine	Bronner, G., & Ben-Zion, I. Z. (2014). Unusual masturbatory practice as an etiological factor in the diagnosis and treatment of sexual dysfunction in young men. *Journal of Sexual Medicine*, *11*(7), 1798–1806. doi:10.1111/jsm.12501

son's sex life; so, sex therapists must also be able to address these concerns when helping client(s). As sex is often considered a taboo topic, especially in Western cultures, when dealing with sexually related issues such as these, professionalism on behalf of sex therapists is of the upmost importance.

An overall transformative approach is taken when developing a treatment program in sex therapy. Sex therapy aims to understand the psychological, biological, pharmacological, relational, and contextual aspects of sexual problems. Because the underlying causes of sexual problems are so variable in nature, extensive medical and psychological evaluations are needed before a treatment plan can be assessed.

Certified Sex Therapists are expected to follow Jack Annon's PLISSIT model which outlines a structure system of levels when conducting sex therapy and formulating treatment plans. The PLISSIT model, separated as P-LI-SS-IT, represents four levels for sex therapists to address (AASECT, n.d.). First, level "P" of the model represents Permission mandating that the therapist create an open and comfortable environment for the client(s) to feel permissible in sharing sexual concerns. The therapist should accomplish this by introducing basic information about sexuality being an important human behavior and validating its legitimacy as a psychological and/or health issue. Second, level "LI" represents Limited Information where the therapist addresses the client(s) specific sexual concerns correcting any myths or misinformation that may surround them. The third level of the model "SS"—Specific Suggestions—instructs the therapist to compile and evaluate a sexual history of the client(s) and then: 1) define issues and concerns, 2) determine how these issues have evolved over the client(s)'s history, 3) guide understanding of and offer a number of resolutions pertaining to main issues, and 4) help the client develop healthy and correct perceptions about the causes for issues while formulating attainable and appropriate plans for resolution. Certified Sexual Counselors under AASECT's guidelines are expected to be trained in these first three levels of the PLISSIT model, while Certified Sex Therapists must be trained in all four. The fourth level of the model—"IT"—represents Intensive Therapy where a CST must design and provide extensive therapeutic intervention for client(s)'s whose sexual issues share comorbidity with other complex issues such as mood or personality disorders, substance abuse problems, physical disabilities, and/or intrapersonal or interpersonal conflicts (AASECT, n.d.). Duration of sex ther-

apy depends on the causes of the problem and so varies accordingly. For instance, if a male presents with erectile dysfunction caused by physiological deficiencies in blood flow, simple pharmaceutical intervention with drugs like Viagra can be implemented relatively quickly. However, if a female client presents with sexual dysfunction caused by an extensive history of sexual abuse, therapy could take several months to years to correct a multitude of problems. Overall, the strict guidelines for conducting sex therapy are designed not only to ensure sexual dysfunction is handled professionally, but also to debunk social myths that mock sex therapy as being irrelevant or even humorous.

Social Implications of Myth Acceptance Surrounding Sexuality

Social, religious, and educational systems are hesitant to embrace sex therapy research findings although much of their data has been shown to significantly improve psychological wellbeing of individuals as well as preventing sexist attitudes in groups that may lead to sexual violence. For instance, myths surrounding female sexuality such as believing women do not desire sex result in women experiencing significantly less satisfying sex lives (McCabe et al., 2010). Considering a satisfying sex life has been shown to improve self-esteem and decrease stress (Tiefer, 1996), many women are at a disadvantage when myths such as this are widely accepted and perpetuated in the media. In addition, females who express sexual desire openly are often equated with being immoral and suffer stigmatization (McCabe et al., 2010). Similarly, damaging myths surrounding male sexuality can also negatively impact men's self-esteem. For example, social expectations that men are constantly wanting sex and the pressure to sexually perform can severely effect men's self-worth after experiencing erectile dysfunction (Tiefer, 1996). Correcting socially-perpetuated myths such as these in individuals are relatively easily addressed with simple sex education and therapy.

However, the most dangerous myths surrounding sexuality that sex therapists must address are those that perpetuate rape culture and contribute to sexual violence. For a definition of "rape culture" and other terms, see Table 3. Most importantly, those myths that place women in subservient sexual roles to men propagate rape myth acceptance, increase men's propensity to rape (Herman, 1988), and present specific problems for sex therapists. For example, when a woman engages in flirtatious behavior with a man, expresses sexual interests, but then refuses the man's advances, the likelihood of her being raped significantly increases. This social reality stems from the pervasive sexual myth that women owe sex to men and that men are entitled to sex after a woman shows interest or "teases" him.

Perhaps the most majorly influential social myth that influences members of a society to blame victims of sexual assault and deny them the proper justice and care they deserve is when rape is attributed to uncontrollable sexual desire. All too often rape is excused by a person's uncontrollable sexual desire towards another (Herman, 1988). Rape of another human being is never about sexual desire, instead it stems from the need to exert power, humiliation, and entitlement over a person's existence. Victim blaming occurs when a society accepts this myth and puts the victim at fault for luring the perpetrator in with sexually provocative behaviors (Herman, 1988).

Similarly, the systematic and widespread objectification of women in a society transforms her body into a commodity that can and should be possessed by a man (Fredrickson & Roberts, 2006). When a woman internalizes these messages and experience self-objectification, attaining a healthy sex life becomes a serious challenge because they are taught to place their desires second to the man's sexual satisfaction (Calegaro & Thompson, 2009). Considering most young men today first learn about their sexuality by watching pornography and majority of pornographic materials reflect these myths, serious problems often arise in their sexual behaviors (Brod, 1988). The lack of accurate sex education and extreme accessibility to porn through technology has become as major problem for sex therapists to confront. As such, a major component of sex therapy is addressing myths such as these and correcting maladaptive sexual attitudes and behaviors that result from them.

Discussion

Sex therapy occupies a unique branch of mental health professions operated by a highly professional community whose goal is to improve the human condition by addressing sexuality and its implications in society. Although sex therapists, counselors, and educators already significantly contribute to the mental health and rehabilitation community, they should not be the only professionals equipped to address human sexuality issues. The entire mental health and rehabilitation community should not underestimate the importance of incorporating sex into their research and therapeutic settings. Sexual drive, behaviors, and social implications make up a significant part of the human condition; so, when mental health and rehabilitation professionals evaluate a client looking to improve their livelihood, their sex life and attitudes towards sex should not be ignored. All practitioners in these fields should take professional responsibility for addressing the needs of their clients and society at large when human sexuality is threatened, overlooked, or misunderstood. Better educating mental health and rehabilitation professionals on basic tenants of human sexuality and methods for handling

Table 3
Important Terms for the Practice of Sex Therapy

Sexuality	An ability to get pleasure from sexual activity; all aspects of sexual behavior
Biological sex	The property or quality by which organisms are classified as female or male on the basis of their reproductive organs and functions
Gender	The condition of identifying as male or female or neuter; implies cultural, social, behavioral and psychological aspects
Sexual orientation	A person's enduring attraction to one sex or the other: usually categorized but not limited to: 1. heterosexuality (opposite sex) 2. homosexuality (same sex) 3. bisexuality (both males and females) 4. asexuality (no sexual attraction to any sex) 5. pansexuality (any sex or gender identity)
Sexual activity	The manner in which humans physically experience and express their sexuality
Intercourse	One's penetration vaginally, anally, and/or orally of another person; usually penetration of a penis, but may include other body parts or foreign objects
Masturbation	The process of manipulating one's own genital organs, whether a penis or clitoris for the purposes of self-stimulating without a partner
Libido	An individual's overall sexual drive or desire for sexual activity
Sexual dysfunction	A heterogeneous group of disorders that are typically characterized by a clinically significant disturbance in a person's ability to respond sexually or to experience sexual pleasure
Sexual fetish	Any object or nongenital part of the body that causes a habitual erotic response or fixation
Sexual confidence	One's comfort with communicating, developing, and experiencing healthy sexual desires
Intimacy	The level of commitment and positive affective, cognitive and physical closeness one experiences with a partner in a reciprocal (although not necessarily symmetrical) relationship; can also describe sexual activity with another person
Pornography	The visual and/or auditory depiction of erotic behavior intended to cause sexual excitement
Cyber sexuality	Any expression or experience of sexuality over the Internet
Sex-typing	Behaviors that results from socialization about what activities and expressions a male or female should do; also known as gender-typing
Sexual assault	Any involuntary sexual act in which a person is coerced or physically forced to engage in against their will; any non-consensual sexual touching of a person
Rape culture	A theoretical concept or qualitative theory in which rape is pervasive and normalized due to societal attitudes about gender and sexuality
Pedophilia	A psychiatric disorder in which an adult or older adolescent experiences a primary or exclusive sexual attraction to prepubescent children

sexual issues would improve these profession and increase client care.

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Endnote

This article is a summation of the literature presented in conjunction with the professional experiences of the second author.

The Rehabilitation Professional, 23(1), pp. 49–58

ETHICS: Reaching Toward Excellence

Jean M. Murray

Abstract. Expert witness testimony and forensic rehabilitation is a growing industry in the area of vocational rehabilitation. Ultimately, it is up to the rehabilitation provider to determine if their behavior is ethical or not. Practitioners are encouraged to develop extrinsic and intrinsic moral behavior. This article broadly reviews ethics, morals and values as they relate to forensic vocational rehabilitation. The Minnesota Department of Labor and Industry monitors professional conduct of Qualified Rehabilitation Consultants (QRC's). Ethical canons cited include the International Association of Rehabilitation Professionals (IARP), the American Board of Vocational Experts (ABVE) and the Commission on Rehabilitation Counselor Certification (CRCC). The author of the article also evaluates ethics versus morals and offers review of studies in which there could be mitigation for minor ethical infarctions. Self-examination and developing an action plan are the final steps in accepting responsibility for ethical violations.

"Often times the determination of what is deemed ethical is left to the individual rehabilitation practitioner" (Taylor & Lee, 1995, p. 3). In 2006, Curtis et al. published that, "[t]he vocational expert practitioner's [principle] client is the referring source," (p. 47). This was on the cusp of change; a work group met in 2007 to establish definitions regarding forensic evaluation. As noted by Barros-Bailey et al. (2009), there is no client in forensic rehabilitation evaluation. This was likely due to crossover of professionals between various organizations, such as ABVE, IARP and CRCC. Barros-Bailey et al. cites Blackwell et al., "The ultimate role of the expert is to communicate the truth of the matter" (2009, p. 32).

I decided to research morals and values as they relate to ethics and vocational rehabilitation because it is clear from review of ethics canons that organizations developed ethical and professional standards to encourage inherently good behavior. You will note that the organizations consistently decree the following ethical principles: respect the interest of the clients (beneficence), do no harm (nonmaleficence), respect freedom of choice (autonomy), act fairly (justice), be honest, loyal, and keep promises (fidelity).

Curtis et al. (2006) notes that Corey et al. (2003) added the principle ethic of veracity, which " . . . means being truthful . . . about the implications of a particular diagnosis, testing, confidentiality, or scope of practice of the practitioner" (p. 45). In addition to principle ethics, virtue ethics/ethics of care, " . . . relate to the personal characteristics of the practitioner" (Curtis et al., 2006, p. 45). Virtue ethics are described as prudence, integrity, respectfulness, and benevolence. I have included the ethical standards for practitioners within the Minnesota Department of Labor and Industry, IARP, ABVE and CRCC. It is apparent the practitioners associated with the organizations are encouraged to develop extrinsic and intrinsic moral behavior. While we try to walk the walk and talk the talk based on our own values and morals, I offer suggestions and remedies when the expert slips in their principle or virtuous ethical behavior(s).

"Values act as standards or beliefs that guide actions and judgments across situations and time . . . [p]rofessional values . . . are values that do not necessarily involve interaction with others. Personal values are expressed by an individual's behavior that generally brings about the value satisfaction" (Curtis et al., 2006, p. 43). A value is something that is held in high esteem and considered to be worthy, useful and important.[1] Morals pertain to, or are concerned with, the principles or rules of right conduct or the distinction between right and wrong; ethical.[2] Both ethics and morals relate to conduct, but morals refer to an individual's own principles regarding right and wrong.

Ethics is the discipline dealing with what is good and bad and with moral duty and obligation; a set of moral principles: a theory or system or moral values; the principle of conduct governing an individual or group;

Table 1
Comparison Chart [6]

	Ethics	Morals
What are they?	The rules of conduct in respect to a particular class of human actions or a particular group or culture.	Principles or habits with respect to right or wrong conduct. While morals also prescribe do's and don't's, morality is ultimately a personal compass of right and wrong.
Where do they come from?	Social System – External	Individual – Internal
Why we do it?	Because society says it's the right thing to do.	Because we believe in something being right or wrong.
Flexibility	Ethics are dependent on others for definition. They tend to be consistent within a certain context, but can vary between contexts.	Usually consistent, although can change if an individual's belief change.
The "Gray"	A person strictly following Ethical Principles may not have any Morals at all. Likewise, one could violate Ethical Principles within a given system of rules in order to maintain Moral integrity.	A Moral Person although perhaps bound by a higher covenant, may choose to follow a code of ethics as it would apply to a system. "Make it fit"
Origin	Greek word "ethos" meaning "character"	Latin word "mos" meaning "custom"
Acceptability	Ethics are governed by professional and legal guidelines within a particular time and place.	Morality transcends cultural norms.

a guiding philosophy; a consciousness of moral importance; a set of moral issues or aspects. [3]

The organizations rehabilitation professionals belong adhere to professional standards and codes of conduct. According to Curtis et al., "The attitudes and behaviors of rehabilitation practitioners almost always reflect on the profession to which he or she is a member" (2006, p. 45).

The Minnesota Department of Labor and Industry monitors the Qualified Rehabilitation Consultant's professional conduct. We refer to Statute 5220.1801. The QRC must provide prompt provision of service and assessment of progress, maintain objectivity, engage in a separate role and function from claims activity, maintain professional competence, and must not have impaired objectivity.[4]

The International Association of Rehabilitation Professionals published a code of ethics, adopted in 2007[5], and are by far the most detailed with regard to the forensic code.

> The term Forensic Rehabilitation Experts/Consultants is used to describe rehabilitation professionals who provide services in a forensic or litigation setting. Where applicable, statements differentiate between rules that apply for the Forensic Rehabilitation Expert versus rules for the Forensic Rehabilitation Consultant and the ethical responsibilities inherent in each role. Forensic Rehabilitation Experts/Consultants who are initially retained as primary service providers will adhere to the tenets of confidentiality and appropriate disclosure, as well as to other rules outlined in this Forensic Code.
>
> B1) Confidentiality
>
> a) Clients have the right to expect confidentiality and will be provided with an explanation of its limitations, including disclosure to others, at the onset of service delivery. Forensic Rehabilitation Experts will discuss these limitations, as well as pertinent benefits available to clients they serve, in order to facilitate open, honest communication and avoid unrealistic expectations.
>
> B2) Objectivity

a) So that justice is served by accurate determination of the facts involved, Forensic Rehabilitation Experts/Consultants use their abilities in an objective, unbiased, nonpartisan, impartial, and fair manner in arriving at findings, conclusions, and/or opinions.

b) Forensic Rehabilitation Experts/Consultants are to use appropriate methods and techniques, carefully research and analyze the evidence in a case, and render opinions or conclusions that are demonstrably objective and reasonable.

c) When testifying, Forensic Rehabilitation Experts have an obligation to present their findings, conclusions, evidence, or opinions in a fair and objective manner.

B3) Competence

a) Forensic Rehabilitation Experts/Consultants have an obligation to provide services in a manner consistent with the highest quality standards of their profession. They are responsible for their own professional and ethical conduct and the conduct of those individuals under their direct supervision.

b) Forensic Rehabilitation Experts/Consultants will not claim to possess any depth or scope of expertise greater than that demonstrated by professional achievement, knowledge, skill, experience, education, training, or credential.

c) Forensic Rehabilitation Experts/Consultants recognize that their own personal values, moral beliefs, or personal and professional relationships with parties to a legal proceeding may interfere with their ability to practice competently. Under such circumstances, Forensic Rehabilitation Experts/Consultants are obligated to decline participation or to limit their assistance in a manner consistent with professional obligations.

d) Forensic Rehabilitation Experts/Consultants will refer clients to other colleagues if the intended assignment is beyond their competence.

e) Forensic Rehabilitation Experts/Consultants will not represent their membership status as bestowing any specialized expertise.

f) Forensic Rehabilitation Experts/Consultants will practice in specialty areas new to them only after appropriate education, training, and/or supervised experience has been obtained. While developing skills in new specialty areas, Forensic Rehabilitation Experts/Consultants will take steps to ensure the competence of their work and to protect clients from possible harm.

g) Because of their special status as persons qualified as experts to the Court, Forensic Rehabilitation Experts/Consultants have an obligation to maintain current knowledge of scientific, professional, and legal developments within their area of claimed competence. They are obligated to use that knowledge, consistent with accepted clinical and scientific standards, in selected data collection methods and procedures for an evaluation, treatment, consultation, conclusion, finding, opinion and/or scholarly/empirical investigation.

h) Forensic Rehabilitation Experts/Consultants will take steps to maintain competence in the skills they use, will be open to exploring new and emerging techniques, seek consultation if deemed necessary, and develop and maintain competence for practice with the diverse and/or special populations with whom they work in order to provide the highest quality of services within their abilities.

i) Forensic Rehabilitation Experts/Consultants avoid offering information from their evaluations that does not bear directly upon the legal purpose of their professional services. The submissions of written and/or oral reports will present data germane to the purposes of the referral.

j) When Forensic Rehabilitation Experts/Consultants rely upon data or information gathered by others, the origins of those data are clarified in any professional product. Forensic Rehabilitation Experts/Consultants bear a special responsibility to ensure that such data, if relied upon, are gathered in a manner standard for the profession. Forensic Rehabilitation Experts/ Consultants will ensure that the resources used or accessed in supporting an opinion are credible and valid.

k) Reports will be thorough and include competent research.

l) Forensic Rehabilitation Experts/Consultants will not allow pursuit of financial gain or other personal benefit to interfere with the exercise of sound professional judgment and skills. They will not abuse their relationships with clients to promote personal or financial gain.

m) Forensic Rehabilitation Experts/Consultants understand and abide by the Code, demonstrate adherence to ethical standards, and ensure that standards are enforced.

n) Forensic Rehabilitation Experts/Consultants will not advocate, sanction, participate in, accomplish or otherwise carry out, or condone any act which is prohibited by the Code.

o) Forensic Rehabilitation Experts/Consultants may choose to consult with any other professionally competent persons about their cases. Care should be taken not to place the individual who is being consulted in a conflict of interest situation.

p) Forensic Rehabilitation Experts have an obligation to present to the Court the boundaries of their competence, the factual bases for their qualifications as an expert, and the relevance to the specific matters at issue.

q) Forensic Rehabilitation Experts are aware that hearsay exceptions and other rules governing expert testimony place a special ethical burden upon them. When hearsay or otherwise inadmissible evidence forms the basis of their opinion, evidence, or professional product, they seek to minimize sole reliance upon such evidence. Where circumstances reasonably permit, Forensic Rehabilitation Experts seek to obtain independent and personal verification of data relied upon as part of their professional services to the Court or to a party in a legal proceeding.

B4) Disclosure

a) Forensic Rehabilitation Experts/Consultants will not intentionally withhold or omit any findings or opinions discovered during a forensic evaluation that would cause the facts of a case to be misinterpreted or distorted.

b) A clinical interview is an important part of the decision-making process and bears particular importance for the Forensic Rehabilitation Expert. When direct contact with the client is made, Forensic Rehabilitation Experts will generate written documentation, either in the form of case notes or a report, as to their involvement and/or conclusions or opinions. This is not required for Forensic Rehabilitation Consultants where there is no contact with the client and where the Consultant's role is not discoverable. In those cases where a Forensic Rehabilitation Consultant changes roles to a Forensic Rehabilitation Expert, the responsibility stipulated in this Code predominates. Forensic Rehabilitation Experts/Consultants will define the limits of their reports, testimony, or opinions, especially when an examination of the client has not been conducted.

c) During initial consultation with the referral source, Forensic Rehabilitation Experts/Consultants have an obligation to inform the party of factors that might reasonably affect the decision to contract with the rehabilitation expert/consultant.

d) Forensic Rehabilitation Experts/Consultants shall be honest, thorough, and open in their analyses and shall not provide the retaining or opposing attorney, referral source, client, the Court, or any other entity involved in the case with any information, through commission or omission, that they know to be false or misleading. They shall exert due diligence and at all times strive to use competent judgment to avoid the use of invalid or unreliable information in the formulation of their opinions.

e) Forensic Rehabilitation Experts/Consultants will not misrepresent their role or competence to clients and referral sources and will provide information about their credentials, if requested.

f) Forensic Rehabilitation Experts/Consultants will actively disclose the sources of information relied upon in formulating their opinions.

g) Forensic Rehabilitation Experts/Consultants will disclose the existence of, and their adherence to, ethical standards and principles to those retaining them and to other participants involved in the case.

B5) Consistency

a) Forensic Rehabilitation Experts/Consultants may be given a different assignment when retained in a forensic case by the plaintiff as opposed to the defense. For any given assignment, however, the basic assumptions, information sources, and methods should not change regardless of the party who retains the Forensic Rehabilitation Expert/Consultant to perform the assignment. There should be no change in methodology or process used to evaluate the case for purposes of favoring any party's claim. This tenet is not meant to preclude methodological changes as new knowledge becomes available.

B6) Informed Consent

a) Forensic Rehabilitation Experts/Consultants shall inform clients and the retaining party with whom they have direct contact of the purposes, goals, techniques, procedures, limitations, potential risks, and/or benefits of services to be performed and other pertinent information, as well as the limits of the relationship between the evaluator and the client.

b) Forensic Rehabilitation Experts/Consultants provide clear and unbiased reports.

c) Unless Court ordered, Forensic Rehabilitation Experts will obtain the informed consent of the client or party, or their attorney or representative, before proceeding with their evaluation. If the client appears unwilling to proceed after receiving a thorough notification

of the purposes, methods, and intended uses of the forensic evaluation, the evaluation should be postponed and the Forensic Rehabilitation Expert should take steps to place the client in contact with his/her attorney or representative for the purpose of legal advice on the issue of participation.

d) In situations where the client or party may not have the capacity to provide informed consent for services or the evaluation is pursuant to a Court Order, the Forensic Rehabilitation Expert provides reasonable notice to the client's attorney or representative of the nature of the anticipated forensic service before proceeding. If the client's attorney or representative objects to the evaluation, the Forensic Rehabilitation Expert notifies the Court that issued the Order and responds as directed.

B7) Loyalty to Community and the Law

a) Forensic Rehabilitation Experts/Consultants will be familiar with and observe the legal limitations of the services they offer.

b) Forensic Rehabilitation Experts/Consultants will obey the laws and statutes of the legal jurisdiction in which they practice unless there is conflict with the Code, in which case they should seek immediate consultation and advice. When conflicts arise between professional standards and ethics and the requirements of legal standards, a particular court, or a directive by an officer of the court or legal authorities, the Forensic Rehabilitation Expert/Consultant has an obligation to make those legal authorities aware of the source of the conflict and to take reasonable steps to resolve it. Such steps may include, but are not limited to:

i. Obtaining the consultation of fellow rehabilitation experts;

ii. Obtaining the advice of independent counsel; and

iii. Conferring directly with the legal representative involved. In the absence of legal guidelines, the Code is binding.

B8) Loyalty to Colleagues (e.g., Professional Relationships)

a) Forensic Rehabilitation Experts/Consultants will not discuss in a disparaging way the competency of other professionals or agencies. Differences in opinions, findings, methods, or plan development should be made based on work product, not on the individual or agency.

b) When evaluating or commenting upon the professional work product or qualifications of another expert or party to a legal proceeding, Forensic Rehabilitation Experts/Consultants represent their professional disagreements with reference to a fair and accurate evaluation of the data, theories, standards, and opinions of the other expert or party.

c) Forensic Rehabilitation Experts/Consultants shall at all times strive to practice within the boundaries of professional and disciplinary honesty and fairness. To this end, they must assume the responsibility of holding their colleagues in the profession accountable to the ethical principles promulgated herein.

d) It is appropriate for Forensic Rehabilitation Experts/Consultants to offer criticism of breaches of these ethical principles, as long as such criticisms are not offered in a disparaging way.

e) Forensic Rehabilitation Experts/Consultants shall act with integrity in relationships with colleagues, other organizations, agencies, institutions, referral sources, and other professions so as to facilitate the contribution of all specialists toward achieving optimum service delivery.

f) When referring clients to other professional colleagues or cooperating agencies, Forensic Rehabilitation Experts/Consultants shall supply all relevant information necessary to begin service delivery in a prompt manner.

B9) Business Practices

Forensic Rehabilitation Experts/Consultants will neither give nor receive commissions, rebates, contingency fees, or any other form of remuneration when accepting a case or referring clients for professional services. Payment for services will not be contingent upon a case outcome or award.

b) Forensic Rehabilitation Experts/Consultants will not enter into financial commitments that may compromise the quality of their services.

c) Forensic Rehabilitation Experts/Consultants will not enter into fee arrangements that could influence their opinions in a case and otherwise raise questions as to their credibility.

d) While all Forensic Rehabilitation Experts/Consultants have the discretionary right to accept retention in any case or proceed within their area(s) of expertise, they should decline involvement in any case when asked to take or support a predetermined position, or where there are ethical concerns about the nature of the requested assignment.

e) Forensic Rehabilitation Experts/Consultants should decline involvement in any case when they are asked to assume invalid repre-

sentations of fact or alter their methodology or process without foundation or compelling reason.

f) Should a fee dispute arise during the course of evaluating a case and prior to trial, the Forensic Rehabilitation Expert/Consultant shall have the ability to discontinue his/her involvement in the case as long as no harm comes to the client.

g) If necessary to withdraw from a case after having been retained, the Forensic Rehabilitation Expert/Consultant will make a reasonable effort to assist the client and/or referral source in locating another Forensic Rehabilitation Expert/Consultant to take over the assignment.

B10) Detrimental/Exploitive Relationships

a) Forensic Rehabilitation Experts/Consultants will recognize potential conflicts of interest in dual/multiple relationships that are detrimental/exploitive, and seek to minimize their effects.

b) Forensic Rehabilitation Experts/Consultants will avoid providing professional services to parties in a legal proceeding with whom they have had personal or professional relationships that are inconsistent with the anticipated business and professional relationship.

c) When necessary to provide both evaluation and treatment services to a client involved in a legal proceeding, the Forensic Rehabilitation Expert will recognize the potential negative effects of these circumstances on the rights of the client, confidentiality, and the process of treatment and evaluation.

d) Forensic Rehabilitation Experts/Consultants will avoid establishing dual/multiple relationships with clients that could impair their professional judgment or increase the risk of exploitation.

e) Sexual conduct with clients is unethical and will not be tolerated during the course of an evaluation until the litigation has been concluded, unless otherwise restricted by other professional codes that may apply.

f) Forensic Rehabilitation Experts/Consultants will not be involved in surveillance set up, scheduling, and monitoring. Any knowledge of surveillance-related items must be divulged when rendering an expert opinion.

The American Board of Vocational Experts published a Code of Ethics and General Guidelines (2006). The following is the Ethical Canons and related rules: (ABVE, 2006, pp. 51–55).

1. Behave in legal, ethical and moral manner . . . maintaining the integrity of the Ethics Code.
2. Respect the integrity of individuals . . . primary obligation is to provide a fair and reasonable evaluation of the individuals being assessed . . . to determine their vocational capacity.
3. Relationships with colleagues, agencies. *Referral Sources*, and other professions will be conducted in the highest professional manner.
4. Adhere to professional standards in establishing fair and reasonable fees in promoting the services that are offered.
5. Respect the confidentiality of information obtained from *Referral Sources* about an individual being evaluated, understanding that in litigation matters, the information may be in effect be discoverable, and this will be made known to the individual being evaluated.
6. Be sensitive to individual differences of the persons being evaluated in reference to the selection, utilization and interpretation of assessment instruments.
7. Participate in efforts to expand the knowledge needed to more effectively determine the vocational capacities of injured persons.
8. Maintain . . . professional competencies at a level that is consistent with the services that are being offered.
9. Honor the integrity and respect the limitations placed upon the designation of *Fellow* or *Diplomate* of the American Board of Vocational Experts.

The Commission on Rehabilitation Counselor Certification (CRCC) publishes a detailed document of ethics behavior relating to forensic rehabilitation. The Rehabilitation Counselor must have forensic competency and conduct (2010, pp. 16–17).

a. OBJECTIVITY. Rehabilitation counselors are aware of the standards governing their roles in performing forensic activities. Rehabilitation counselors are aware of the occasionally competing demands placed upon them by these standards and the requirements of the legal system, and attempt to resolve these conflicts by making known their commitment to this Code and taking steps to resolve conflicts in a responsible manner.

b. QUALIFICATION TO PROVIDE EXPERT TESTIMONY. Rehabilitation counselors have an obligation to present to the court, regarding specific matters to which they testify, the boundaries of their competence, the factual bases (knowledge, skill, experience, training, and education) for their qualifications as an expert, and the relevance of those factual bases to

their qualifications as an expert on the specific matters at issue.

c. AVOID POTENTIALLY HARMFUL RELATIONSHIPS. Rehabilitation counselors who provide forensic evaluations avoid potentially harmful professional or personal relationships with individuals being evaluated, family members, romantic partners, and close friends of individuals they are evaluating. There may be circumstances however where not entering into professional or personal relationships is potentially more detrimental than providing services. When such is the case, rehabilitation counselors perform and document a risk assessment via use of an ethical decision- making model in order to arrive at an informed decision.

d. CONFLICT OF INTEREST. Rehabilitation counselors recognize that their own personal values, moral beliefs, or personal and professional relationships with parties to a legal proceeding may interfere with their ability to practice competently. Under such circumstances, rehabilitation counselors are obligated to decline participation or to limit their assistance in a manner consistent with professional obligations.

e. VALIDITY OF RESOURCES CONSULTED. Rehabilitation counselors ensure that the resources used or accessed in supporting opinions are credible and valid.

f. FOUNDATION OF KNOWLEDGE. Because of their special status as persons qualified as experts to the court, rehabilitation counselors have an obligation to maintain current knowledge of scientific, professional, and legal developments within their area of claimed competence. They are obligated also to use that knowledge, consistent with accepted clinical and scientific standards, in selected data collection methods and procedures for evaluation, treatment, consultation, or scholarly/empirical investigations.

g. DUTY TO CONFIRM INFORMATION. Where circumstances reasonably permit, rehabilitation counselors seek to obtain independent and personal verification of data relied upon as part of their professional services to the court or to parties to the legal proceedings.

h. CRITIQUE OF OPPOSING WORK PRODUCT. When evaluating or commenting upon the professional work products or qualifications of other experts or parties to legal proceedings, rehabilitation counselors represent their professional disagreements with reference to a fair and accurate evaluation of the data, theories, standards, and opinions of other experts or parties.

What MN DOLI, IARP, ABVE and CRCC have in common with regard to ethics and professional integrity involve good behavior, respect toward others, professionalism, understanding limits, being truthful, and understanding the impact of the evaluation on an individual. "The practice of expert witness testimony is not restricted to members of any specific organization" (Barros-Bailey et al., 2009, p. 32).

The forensic expert should bear in mind that, " . . . professional ethics is not about avoiding discipline or learning rules but rather about acting in ways that are consistent with the fundamental values of the profession" (Welfel, 2005, p. 122). Welfel (2005) also indicates, "[t]he standard for responsible practice is competence, not excellence. The ethical obligation is to strive for excellence; no profession requires its constant presence. Ultimately . . . the [consultant] aims for a proportionate response to minor missteps, becoming aware of the infraction without exaggerating its importance, and understanding the misbehavior in the broader context of a career of generally responsible practice," (p. 124). The following is a list of ethical issues that can arise in forensic rehabilitation counseling. The dilemma is the words or actions could be considered a reflection of the forensic expert. The issues include making disparaging remarks about other experts and maintaining professional judgment, assessment overuse, inappropriate use of evaluation systems, inconsistencies between data represented in the test manual and interpretation of data, and not promoting choice.

Gutheil et al. (2000) conducted a pilot study regarding disclosure about opposing experts. Forensic psychiatrists and psychologists were surveyed about information they would disclose to their referral sources (attorneys) about the opposing experts. ". . . it is extremely common for one side's expert to offer the retaining attorney consultative assistance by pointing out weaknesses in the other expert's opinion, mistaken assumptions, flawed clinical reasoning, and unsupported conclusions," (Gutheil et al., 2000, p. 449). The following questions were relevant to the participants' expert function (p. 451).

- The other expert does cases only for one side (plaintiff/prosecution/defense
- The other expert's lecture last year on this very subject reveals a bias
- The other expert's recent article on subject matter related to this case reveals a bias.

Participants in the study indicated the following questions/comments were inappropriate:

- The other expert is a survivor of childhood sexual abuse and probably cannot be objective about this recovered memory case
- The other expert has been through a messy divorce and custody battle and is thus questionably objective about this custody case
- The other expert is known to me personally to be an alcoholic.

The authors suggested that, " . . . an impression formed about an opposing expert . . . if conveyed as if it were a known fact, represents a failure of the ethics of objectivity" (Gutheil et al., 2000, p. 453). Even in social set-

tings, vocational experts should be aware their how their comments about other professionals could be interpreted, and might be a reflection on professional character.

Vocational experts use assessment as a tool for plan development, or as reference for an expert opinion. Ethical issues occur in assessment. Taylor and Lee quote Early (1987) regarding test overuse and limited financial resources, "[i]nadequate funding may result in . . . inappropriate uses of commercial evaluation systems by untrained evaluators" (2005, p. 5). Also, perhaps the evaluator is required to use a particular assessment even after identifying a better battery for the evaluee (Taylor and Lee, 2005). Other ethical issues include not taking into account the need for test modification when the evaluee needs additional time. " . . . issues as client motivation, predicted successful outcome, and client needs may affect the evaluator's decision-making process" (Taylor and Lee, 1995, p. 5). And, "[t]he evaluator is faced with the dilemma between using existing facility assessment instruments and the knowledge that better techniques may provide a more comprehensive evaluation" (Taylor and Lee, 1995, p. 5). Therefore, it behooves the forensic vocational expert to be competent with the tools of the industry and not misrepresent facts, be familiar with assessment tools and what they are designed to measure, and to be clear to the evaluee that the results might affect their eligibility for a particular program they might be interested in pursuing.

While promoting choice is inherent in Rehabilitation Counseling, forensic evaluators have an obligation to be aware of their own values. Curtis (2002) quotes Herr and Niles (1989). " . . . persons are . . . expected 'to value work, to plan, to be purposeful, to be productive, to be serious about life's meaning, to be useful, and to be committed to growth and learning rather than to passively accept being unemployed or on welfare.' "[7] A forensic consultant must be aware their own values differ from the evaluee and it is important to not be tempted to label individuals disparagingly if they do not meet our definition of motivated. It is up to the consultant to be objective, to review all data available, and to be fair and reasonable. Forensic consultants, " . . . must identify what is valued in terms of consumer goals and outcomes . . . [forensic consultants] must assess if values guide [recommendations]."[8]

Vocational practitioners are faced with making responsible choices and recommendations. We can be front and center without being on the witness stand. As noted, a consultant cannot be perfect, but can strive for excellence by reading and understanding the current code(s) of ethics. What happens when there is an ethical dilemma? Bourgeois et al. suggest ethical decision-making models by Tarvydas, Cottone and Clause (2003). They outline the following steps:

- Interpret the situation through awareness and fact finding
- Formulate an ethical decision
- Select an action by weighing competing, non-moral values, personal blind spots or prejudices
- Plan and execute the selected courses

Another model cited by Bourgeois et al. was developed by Swartz, Martin, & Blackwell (1996), and involves seven steps:

1. Identify the problem or dilemma
2. Identify the potential issues involved
3. Review relevant ethical guidelines
4. Obtain consultation
5. Consider the possible courses of action
6. Enumerate the consequences of various decisions
7. Decide what appears to be the best course of action

Bourgeois et al. suggest self-assessment: "(a) seeking external peer consultation if working alone; (b) seeking internal peer consultation if working as part of a forensic practice; (c) team consultation; (d) formal clinical supervision . . . (e) formulating yearly 'Work Plans'; (f) conducting annual 'Self Evaluation'; (g) mentoring by another forensic professional; (h) seeking outside consultation/program review; (i) seeking feedback from 'Evaluees'; (j) seeking feedback from attorneys; (k) submitting questions to CRCC or other credentialing bodies; (l) reviewing archives of ethical dilemmas and how resolved; (m) attending conferences, workshops, and/or webinars; (n) completing self-study courses; and (o) enrollment in formal graduate courses, etc." (2011, pp. 54–55).

Welfel (2005) suggested that professionals consider the fact that we are not perfect, and suggests a four-element model when the professional realizes they violated an ethics code. She presents a principle-based model and indicates that, "[t]he only individuals with the ability to address . . . misconduct . . . are the [consultants] themselves . . . no professional career is free of ethical missteps . . . and professional ethics is not about avoiding discipline or learning rules, but rather about acting in ways that are fundamental ethical values of the profession" (p. 122). Briefly, Welfel suggests the following steps:

1. Element 1: Recognition of Error
2. Element 2: Experience of Regret and Remorse
3. Element 3: Evaluation of Possibilities of Restitution
4. Element 4: Rehabilitation to Prevent Recurrence

Welfel (2005) indicates that, "[o]nce the [consultant] has accepted responsibility for the violation and addressed the damage to the extent possible, the final

step in recovery involves self-examination and action to reduce the possibility that this problem with recur" (p. 128). She suggests consultation with another professional, licensing boards and ethics committee, and educate themselves about acceptable and unacceptable behavior. She indicates that perhaps ethical committees are under-utilized.

The role ethics plays in the profession of vocational counseling or forensic consulting cannot be minimalized. Welfel (2005) cites May (1984) regarding virtue ethics, " . . . the focus is not so much on how professionals behave as it is on who they ought to be," and Cohen & Cohen (1999), ". . . [ethics] centers on the qualities that professionals should develop and the habits of character they need to reach the profession's goals" (p. 122). It is hard not to think of my own practice when I review the various codes of ethics, pitfalls of our profession, and promises I make myself that I will be attentive to every aspect of my career. My own self-assessment consists of the following points, (a) Am I following the rules, (b) Am I following through on promises I have made, (c) Am I providing a timely service, (d) Am I avoiding making legal, claims, or medical recommendations, (e) Am I professional and on-time, (f) Am I participating in activities that promote character development, (g) Am I current on ethical guidelines and (h) Am I doing my best, and (i) Have I identified two to three mentors whom I rely for continued growth and development. While the list seems endless, research suggests that Rehabilitation professionals are self-aware of ethical behavior and continue to monitor behavior in order to provide the best service possible to all parties involved in a case.

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The Rehabilitation Professional, 23(1), pp. 59–68

A Literature Review of Mental Health Professionals Work Within LGBT Populations

Sharae Vicknair

Abstract. Professionals in the field of mental health have conducted research, as well as therapeutic treatments with sexual minority individuals. However, equal opportunity has not been allotted in the literature to those who identify themselves as lesbian, gay, bisexual, and transgender. This literature review offers a brief history of sexual orientation as it pertains to mental health and subsequent mental health treatment. A review of qualities that are essential towards working with LGBT populations and relevant ethical and moral guidelines are furthermore addressed. Finally, an overview of suggestions to improve the availability of educated and competent professionals able to successfully serve the LGBT community will also be forwarded.

Historically, the topic of sexual orientation has undergone many transitional phases in regards to societal acceptance and degree of normalcy. For example, between 1970 and 1984 about 70% of public opinions toward homosexuality were negative in nature. In 1996 this percentage had dropped to 56%. By 1999 there was a major shift toward more positive opinions with reports as high as 81% of heterosexual adults claiming to oppose discrimination of lesbian, gay, bisexual, and transgender (LGBT) individuals in the work place (Newman, Dannenfelser, & Benishek, 2002). Societal opinion has had an impact on the historical pathology of homosexual behavior.

In 1952, with little empirical research and much religious justification, homosexuality was defined as a "sociopathic personality disturbance" in the first compilation of the *Diagnostic and Statistical Manual* (DSM-I). In 1968, the manual of mental disorders was revised (DSM-II) to classify homosexuality as a "sexual deviation" (Drescher, 2009). In the early 1970's, scientific research and gay rights activists' actions aided the movement to remove homosexuality from the DSM. After much deliberation and debates held by the American Psychiatric Association, it was concluded that homosexuality and other 'sexual deviations' did not cause generalized impairment of social functioning and effectiveness, or subjective anguish. These attributes were present in all other mental disorders resulting in the conclusion that homosexuality does not meet the inclusion criteria. Thus its subsequent removal from the DSM was finalized in 1973 (American Psychiatric Association, 1973; Drescher, 2009).

Many articles concerning sexual minorities aided the 1973 removal of homosexuality as a final step in the APA's effort to normalize homosexuality (Grove, 2009; Meyer, 2007; Newman et al., 2002). However, Drescher (2009) gives a detailed account of the replacement of "homosexuality" in the DSM with a new diagnosis called Sexual Orientation Disturbance, and then with Ego Dystonic Homosexuality in 1980. It was not until the revision of the third DSM in 1987 that homosexuality was completely removed and APA accepted homosexuality as a normal variation as opposed to a deviation of sexuality. Other diagnostic systems followed, but still in 1992 Ego-Dystonic Homosexuality was listed in the International Classification of Diseases. This is crucial to address in order to demonstrate how recent this movement is and the existing effects it has on the everyday lives of sexual minorities.

Ramifications of the wavering opinions, societal pressures, and the pathological history of homosexuality are apparent in the prevalence of mental health issues for those who identify as LGBT (Meyer, 2007). The pathological diagnoses for homosexuality contributed to social stigma, discrimination, prejudice, hostility, and even physical violence (Davison, 2001; Drescher, 2009; Singh & Shelton, 2010) which are all risk factors for development of the specific mental health issues that arise in LGBT individuals. Much of the literature reviewed cites considerable research evidence suggesting that LGBT individuals are at higher risk for developing anxiety, depression, substance abuse, suicidal ideation, and other mental health disparities (Dopp, 2013; Israel, Gorcheva, Burnes, & Walther, 2007; Meyers, 2003; Rutherford, McIntyre, Daley, and

Ross, 2012). Other contributing factors to the mental health of LGBT individuals are the existence of homophobia and heterosexist environments (Rutherford et al., 2012).

It may be suggested based on the research that LGBT mental health suffering is not related to homosexuality itself, but the treatment of individuals who identify as such (Meyer, 2007). Since higher prevalence of mental health issues indicates greater need for mental health services, it is essential that competent, well educated, and prepared professionals are readily available for LGBT individuals. It is the duty of psychology as a profession to supply competent psychologists for vulnerable populations (Dopp, 2013). The American Psychological Association has even created *Guidelines for Psychotherapy with Lesbian, Gay and Bisexual Clients* to outline the type of conduct that is expected from professionals who are working with sexual minority clients (APA, 2011).

Characteristics of a Prepared Professional

Clinicians are instrumental in conceptualizing complaints of the patient, the origins of these complaints, and steps to address maladaptation and improved quality of life (Davison, 2001). It may be proposed that the identified mental stress LGBT clients endure may be due to exterior strains. This implies that clinicians have a vital role when working with LGBT clients. In the literature, there are a number of essential characteristics involved in working within the LGBT community. These characteristics may prevent personal and cultural biases from interfering with professional care (Davison, 2001). They represent characteristics that may be improved upon with proper education and further research within the area. Acceptance and competence are two of the most discussed in regards to providing successful services. These characteristics can allow for work that is in congruence with ethical codes and guidelines put forth by the various mental health associations. American Psychological Association (APA) ethical guidelines will be referred to most in this review.

Acceptance

The process of acceptance refers the mechanism or means to recognize as true and normal (Webster, 2007). Recognition of variant sexual identities as true and normal represents a key component in becoming an integral part of creating healthier lives for LGBT individuals. A majority of society assumes heterosexual identity as the norm and appears to value it more than any other variation of sexuality (heterosexism). It is important then for mental health professionals to accept, and promote acceptance of LGBT to provide relief from societal alienation (Davison, 2001; Meyer, 2007). The *Ethical Principles of Psychologists and Code of Conduct* of the American Psychological Association has several standards and principles that include sexual orientation as an identifying factor. For example, Principle E: Respect for People's Rights and Dignity calls for awareness and respect of differences based on sexual orientation as well as gender, age, race, religion, and other identifying characteristics (APA Ethics Code, American Psychological Association, 2002). As such, the APA expresses acceptance of sexual orientation as a normal identifying characteristic. Ethically, mental health professionals such as counselors and psychologists should aim to understand and accept the normal occurrence of LGBT identity and the issues that accompany it.

Though there is a lack of research that articulates whether or not mental health professionals are accepting of LGBT, one study conducted by Newman et al. (2002) aimed to answer important questions concerning whether those who choose to enter the helping professions possess attitudes of acceptance and respect for diversity, and if their beliefs imitate the professional principles and ethics of acceptance. They surveyed 2,837 first year graduate-level counseling psychology and social work students using the Attitudes toward Lesbians and Gay Men *(*ATLG) scale. Their results indicated a relatively high number of positive attitudes toward lesbians and gay men with only 6.5% of respondents scoring in the negative attitude range. This study had many limitations, including no control or allowance for prior experience with gay men and lesbians, and possible differences in schools that responded and those that did not respond. The results from this study are insightful, but there is a need for further empirical research in order to accurately address the important questions of mental health professionals' and aspiring professionals' attitudes and acceptance toward LGBT individuals (Newman et al., 2002).

Competence

Among the characteristics that mental health professionals should possess in order to be effective practitioners for the LGBT community, the most mentioned is competence (Bauer & Wayne, 2005; Bergh & Crisp, 2004; Davison, 2001; Dopp, 2012; Grove, 2009; Israel, Gorcheva, Burnes, & Walther, 2007). In plain context, competence is defined as having the necessary ability and qualities (Webster, 2007). Section 2 of the APA Ethics Code is exclusively devoted to competence which implies that it is an integral part of becoming a successful and ethical psychologist (APA Ethics Code; American Psychological Association, 2002). At least some form of cultural competence in LGBT issues is especially important in the mental health professions because there may be instances in which the profes-

sional is not aware of the LGBT identity of the client (Israel, Gorcheva, Burnes, & Walther, 2007).

Bergh and Crisp (2004) review the psychologists' and counselors' definition of cultural competence in terms of belief/attitude, knowledge, and skills. Self-awareness represents a key concept in the attitude dimension such that personal biases and cultural roots should be known to the individual. A clinician should also be aware of one's sensitivity and comfort with clients of different cultures. To be culturally competent one must also be knowledgeable about group values, beliefs, and norms as well as the impact of dominant cultures in society on the treatment of minorities. Cultural knowledge may be especially crucial when working with sexual minorities in order to alleviate the feelings of being misunderstood. Conveying lack of understanding has potential to further alienate an already hesitant population from trusting those who claim to improve upon the health of their community (Bauer & Wayne, 2005). The skills dimension should allow one to send and receive verbal and nonverbal messages and use culturally applicable approaches for research and intervention. Although the three components of attitude, knowledge, and skills define competence, knowledge seems to be a key element.

The many facets of a culture make it difficult to synthesize the information into a cohesive representation. The greater knowledge one has of these facets, the more one's attitudes and skills will reflect that of a competent professional. The sexual minority culture consists of unique obstacles such as the extra energy that is expended examining reasons for sexuality and maintaining multiple identities, the process of coming out (publicly identifying as LGBT), familial issues, and lack of social support (Davison, 2001). There may also be unique issues for lesbians, gays, bisexuals, and transgender individuals specifically, although Davison (2001) contends that the damage is comparable. In order to stand up to ethical codes regarding equal opportunity and treatment, it is essential that psychologists and counselors possess attitudes, knowledge, and skills that allow for culturally competent practice for LGBT clients. The existing literature lacks insight on competence rates of LGBT issues among mental health professions. Jan Grove (2009) attributes this shortcoming to the extremely low number of scholarly articles concerning LGBT topics. In 1990-1999 only about 2.11% of articles published in eight mainstream counseling journals were focused on sexual minority issues. Though this number is sure to have risen, it is still indicative of the gap in literature on the topic.

Grove (2009) presented a qualitative and quantitative account of professional competence in relation to attitudes, skills, and knowledge. She measured competence and evaluated experiences that had an impact on the work of 58 counseling students who had been in her educational course concerning LGB matters. She analyzed the data to explore the association between number of years since start of training in her course and level of competence. Results indicated that skills and knowledge of participants increased significantly with number of years since training, but the average skills score was still barely above the half way marker to full competence as suggested by the Sexual Orientation Counselor Competence Scale given. Another compelling finding by Grove (2009) was that attitude scores were initially very high upon entering the course, and after the second year there was a reflected decrease in attitude scores. This finding suggests that students may have believed that they had accepting attitudes toward sexual minority issues and exposure to sexual minority content challenged these perceived attitudes. This study suggests a positive insight that the program may be successfully bringing about self-awareness through exposure to LGB content.

Grove's qualitative data revealed that there were specific experiences that shaped the attitudes of the students. These experiences included direct interaction with LGB persons, being prompted to reflect on their own sexual identity and its influences, evaluating their communication and how underlying opinions might be reflected in their communication. These conclusions are all suggestive that first-hand experience enhances the learning experience and challenges the existing views and assumptions of the students. These quantitative and qualitative findings provide useful insights, but due to the relatively small sample and lack of generalizability, there is a need for further research in the area (Grove, 2009).

Ethical Implications

Acceptance and competence of LGBT issues are important attributes to provide treatment in accordance with ethical guidelines presented to mental health professionals, including psychology. There are many pertinent principles and guidelines in the APA Ethics Code that psychologists must be aware of when providing services to LGBT individuals. As mentioned earlier, Principle E: Respect for People's Rights and Dignity states that sexual orientation is not a viable reason to be ignorant or disrespectful of cultural, individual, or role differences. Principle A: Beneficence and Nonmaleficence expresses that psychologists must not only strive to help others, but similarly not harm others. This principle reiterates that to provide beneficial services to vulnerable populations such as LGBT, competence must be achieved. Lastly, Principle D: Justice entitles all persons to not only have access but also potentially benefit from the contributions of psychology and similarly have equivalent or comparable access to the processes, procedures, and services typified of the profession. Thus the mere lack of LGBT focused research, educational opportunities,

and competent clinicians may suggests unintentional professional discrimination against LGBT individuals and is a direct denial of justice to those who identify as such (APA Ethics Code: American Psychological Association, 2002; Dopp, 2013)

There are also many standards that support and enforce the ideals presented in the above principles. Denial of sexual orientation as a normal identifying factor and lack of competence on the topic can lead to a violation of Standard 2.01, Boundaries of Competence. This standard states that "an understanding of factors associated with . . . sexual orientation . . . is essential for effective implementation of services." It is ethical to make a referral if a psychologist does not have the knowledge or training to provide services to LGBT individuals, but in order to meet Standard 2.02, Providing Services in Emergencies, a general awareness and understanding is a necessity. Standard 2.04, Bases for Scientific and Professional Judgments clarifies that it would be unethical to assume a position or provide therapeutic intervention that is not based on "scientific and professional knowledge of the discipline." A common example of a therapeutic intervention previously used on LGBT individuals that is not empirically supported, and is therefore a direct violation of Standard 2.04, is conversion or reparative therapy. This type of therapy has even been suggested to result in harm to the client which also violates Standard 3.04, Avoiding Harm (Davison, 2001; Dopp, 2013).

Standard 3.01, Unfair Discrimination prohibits "unfair discrimination in work-related activities based on . . . sexual orientation . . . " and Standard 3.03, Other Harassment expresses that one must not "knowingly engage in a behavior that is harassing or demeaning . . . based on . . . sexual orientation" (APA Ethics Code; American Psychological Association, 2002). Dopp (2013) expresses that these standards and principles are put forth by the APA as a guide for ethical action when working with sexual minority clients, but there is much room for interpretation. It is the professional psychologist's duty to be aware of their biases, be knowledgeable, accepting, and competent, and actively aim to reduce their prejudice toward LGBT individuals in order to avoid intentional or unintentional discrimination and harassment. Unfortunately, there is evidence, or lack thereof, that suggests a scarcity of competency and preparedness within the mental health professions to service these individuals (Israel, Gorcheva, Burnes, & Walther, 2007; Grove, 2009). Luckily there are ways to improve the current conditions of education, research and services concerning sexual minority matters.

Future Suggestions for Improvement

Education

Educators. In an attempt to discover factors contributing towards expertise in providing services for LGBT individuals, Rutherford and colleagues (2012) was only able to identify and contact eight mental health service providers that specialize in work within the LGBT population. Every participant reported a lack of available resources and professional training opportunities within their formal education, representing a potential factor contributing to the lack of competent professionals available to LGBT individuals. As mentioned earlier, Grove (2009) found significant increase in skills and knowledge after taking her interactive course focusing on LGBT. It may be suggested that mental health and other allied health professionals should seek opportunities to improve upon their individualized educational processes and opportunities to better inform and prepare themselves for work within the LGBT community. Moreover, these individuals may consider prospective, future impact their own attitudes and beliefs emerge in their teaching and applicable counseling practices.

Mathison (1998) listed the following questions that educators can ask that allow for reflection upon attitudes and beliefs that are held toward LGBT individuals, particularly in educational settings:

- Do I assume that all my teacher education students and colleagues are heterosexual?
- Do I believe that it is appropriate for gay men and lesbians to become teachers?
- As I discuss historians, philosophers, theorists, and practitioners with teacher education students, do I ever identify individuals as homosexual in the same manner that I might mention ethnicity, gender, or other cultural attributes?
- Do the examples I use in class assume that everyone is heterosexual?
- Have I ever said anything in or out of class that would let the students know how I feel about homosexuality?
- If someone were to look at my course syllabi or any other aspect of my teaching activities, would that person see any evidence that preparing teachers to serve gay and lesbian students was important to me? (p. 153)

Though this article was written for teacher educators, replacing "teacher" with "psychology" or "counselor," it becomes clear that these questions may be particularly relevant for educators in mental health fields.

After educators become aware of the implications of their attitudes and beliefs through self-reflection, awareness may be similarly facilitated by actual ac-

tion. There are many steps that educators may take to convey positivity, normalcy, competence, knowledge, and respect about LGBT issues in the classroom. The environment of the classroom should feel safe for those who identify as LGBT. It is important that sexual orientation disclosure is not met with or threatened by humiliation and rejection. Not only does this action benefit the LGBT students, but allows for heterosexual students to gain first-hand experience with the normalcy and presence of those with variant sexual identities. Providing positive role models by way of guest speakers, being aware of and making reference to important LGBT figures and their positive contributions, including interactive LGBT panel discussions, and selecting LGBT supportive materials for class assignments can aid in creating an accepting educational environment (Mathison, 1998).

Curriculum content. It has been reported that students often feel as though they were not adequately exposed to LGBT content in the course of their educational training (Grove, 2009; Rutherford et al., 2012). The clear-cut solution to this problem is to incorporate more LGBT focused material, activities, and exercises in every curriculum. Exposure to this material provides knowledge, awareness, and opportunity. It challenges students' self-awareness and personal biases, as well as prepares them for real world interactions because LGBT identity is universally present across all cultures, economies, genders, ethnicities, and geographic locations (Mathison, 1998). It is inevitable that they will cross paths with an LGBT individual at some point in their professional career and being knowledgeable will benefit both parties involved.

The eight LGBT experts interviewed by Rutherford and colleagues (2012) all had suggestions on how to improve training programs in order to ensure basic understanding and sensitive, effective care for LGBT individuals. Among their suggestions, some of the most recommended ideas were to include LGBT content that consists of basic knowledge about general terminology and the distinction between sexual orientation, sexual behavior, and sexual identity, and explain how to address each of these in a manner that expresses cultural competence. On developing cultural competence, successful curriculums may include content that addresses the skills, knowledge, and attitudes components by offering interactive learning experiences that exemplify communication skills, understanding of others, awareness of social and political contexts, and self-evaluation (Grove, 2009). In accordance with basic knowledge and cultural competence, the impacts of social stigma, heterosexism, and homophobia should also be addressed in great detail while refraining from stereotypical depictions of LGBT individuals (Rutherford et al., 2009). As LGBT content is fully integrated into ongoing mental health curriculums, a greater number competent professionals may prospectively emerge prepared to provide equal opportunity for LGBT individuals, independent of whether or not this may be representative of the population they intend to serve.

Research

Principle D: Justice in the APA Ethics Code entitles benefit from the contributions of psychology to all persons. It goes further saying that these contributions provide "equal quality in the processes, procedures, and services being conducted by psychologists" (APA Ethics Code: American Psychological Association, 2002). Psychologists contribute to research in an innumerable amount of ways and the dearth of research concerning LGBT issues represents an area of concern. As such, the research community must make an increased effort to include focus on sexual minorities and obtain more knowledge about the human experience (Bauer & Wayne, 2005). One ambitious suggestion to advance psychological research concerning sexual minorities was to include questions about sexual orientation identity, sexual attraction and behaviors across all studies (Moradi, Mohr, Worthington, & Fassinger, 2009). Baring this measure, there are many ways researchers can contribute high-quality LGBT research, several of which will be discussed.

Since sexual identity represents a culturally sensitive topic, there have been reports of institutional review board lack of knowledge on this topic, lack of federal funding, and little support from various institutions (Bauer & Wayne, 2005; Rutherford et al., 2012). Also, institutional review boards often lack competence concerning LGBT matters, thus potential problems in procedure should be carefully examined by those conducting the research in order to ensure protection of sexual minority participants (Moradi et al., 2009). Researchers should also expect at least some negative reactions as a standard part of conducting sexual minority research. Pilot studies are a useful way of testing procedures to make sure they are sensitive to the needs and perspectives of the participants. Procedural issues are especially important when working with a sensitive population such as LGBT.

Recruiting participants for sexual minority research has its own unique challenges. It may be proposed that researchers should aim to repair and rebuild the trust of LGBT individuals (Bauer & Wayne, 2005). It is important to express and disseminate specific benefits identified research studies may have for the sexual minority individual and for society as a whole. One suggestion has been proposed to increase trust and convey true concern for the LGBT community is to offer the participant an option to receive payment personally or have the payment donated to an organization dedicated to LGBT human rights (Moradi et al., 2009). However, a concern about this process will be both anonymity for the research participant, and dif-

ferential treatment for other participants of individual studies.

It is also important to design experiments that have optimal benefits, employing benefits for persons of various sexual orientations. Quantitative research may potentially be useful in many ways, but qualitative research may allow for a more intimate understanding of the everyday lives and experiences of sexual minorities. A content analysis of qualitative LGBT research articles published in four counseling journals found only 12 studies from 1998-2008 (Singh & Shelton, 2011). It is proposed that this is an underrepresentation of this minority and Singh and Shelton (2011) concluded their content analysis with ways to encourage more qualitative LGBT research. They advised that previous studies be expanded on with consistent reporting standards, sexual minorities of color be investigated more thoroughly, and attention to transgender and bisexual issues to be improved (Singh & Shelton, 2011). The literature that exists provides a reasonable, but developing foundation to build upon this important issue.

Therapy

Proper education and research in LGBT issues both potentially can have significant influence on the therapy offered by professionals. It is recommended that therapist be educated about how to be aware of personal biases and address these potential biases in their professional practices (Davison, 2001). It may be proposed that ineffective interactions with LGBT clients can be a result of unintentional bias and cultural inattention. For these reasons it is important for practitioners to develop cultural sensitivity within their services by avoiding language, images, and interactions that have potential to be perceived as problematic. It is also suggested that sexual minority staff, pictures of same-sex couples in materials, and familiar locations can increase the cultural sensitivity (Bauer & Wayne, 2005).

Asking about sexual health may be uncomfortable, but LGBT individuals may find relief in uncovering this hidden part of their identity, particularly as a component of the therapeutic process (Bauer & Wayne, 2005). It has been suggested that the therapist should assume a gay affirmative attitude and actively advocate for affirmative psychotherapy (Dopp, 2013). Applicable support and affirmation of the client's sexual identity exhibits the value of the characteristics of the client in regards to sexual identity as well as his or her affective abilities. In a study on helpful and unhelpful therapy experiences of LGBT clients the practioner's knowledge, helpfulness, trustworthiness, and affirmation were among the top characteristics listed as helpful (Israel, Gorcheva, Burnes, & Walther, 2008). The same study revealed that thirty-one percent of the unhelpful situations reported the therapist enforcing personal morals, judgments, or choices on the client.

To provide equal mental health service opportunities, the basic counseling skills such as warmth, openness, appropriate intervention, and others should facilitate the therapeutic process. Knowledge of specific LGBT issues again may be useful and cultural sensitivity may also contribute to helpful therapy with sexual minority clients. The use of larger LGBT communities may enhance therapeutic outcomes by providing extra social support (Israel et al., 2008). Dopp (2013) suggests that in order to keep improving the mental health services there should be continued updates to professional guidelines and training resources and constant strife toward the "best treatments, training programs, and ethical decision making models that will serve to address this population's unmet mental health needs" (p. 27).

Conclusion

It may be suggested that the historical pathology of homosexuality has put a significant strain on many individuals. For so many years society discriminated and oppressed those with a varying sexual identity and practitioners spent their time trying to convert them to heterosexual as a component of professional practice. Even after the APA code was modified to recognize variations of sexual identities as normal and conversion therapy was deemed an unethical practice, LGBT individuals are still reporting high numbers of unhelpful therapy and have less access to qualified, competent professionals (Israel et al., 2008). There is also a gap in the literature focusing specifically on sexual minority issues.

It is proposed that psychology and the other mental health professions go beyond simple measures to improve acceptance and competence among those aspiring to work in the mental health professions. There are multiple standards and principles within the APA Ethics Code that mandate understanding of social diversity and oppression as well as equal treatment, opportunity, rights, and equal services for all people including LGBT individuals. Educators can take lead roles in the movement by creating a safe, accepting environment. Furthermore, educational opportunities can provide an appropriate foundation of knowledge that prepares all students for interactions with LGBT individuals. There were many reports of students seeking out information on their own (Rutherford et al., 2012; Grove, 2009; Newman et al., 2002), but LGBT content with interactive and self-reflective lessons in all curriculums will benefit those who hold negative attitudes or do not consider seeking knowledge on their own (Mathison, 1998; Rutherford et al., 2012). All professionals must seek a solid foundation of knowledge on this topic because it is most

probable that they will work with an LGBT person at some point in their career.

Research and therapy should also be improved upon by competent and knowledgeable professionals. Respect for LGBT persons and the unique issues they face prospectively may make research and therapy more successful and similarly with greater application. Conveying this respect can be accomplished by using language that does not assume heterosexism, adopting gay affirmative attitudes, and being active within the LGBT communities. Although working within the LGBT populations presents difficulties and sensitivities, it is worth additional educational efforts. It also contributes to a deeper understanding of all human experience (Moradi et al., 2009) which remains a goal across all mental health professionals.

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The Rehabilitation Professional, 23(1), pp. 67–72

Multiculturalism Among Hispanics and Latinos: The Importance of Culture over Racial Identity

Benjamin Ramos

Abstract. Hispanics and Latinos are the fastest growing ethnic group in the United States. Based on this fact, it is clear that more research in psychology is necessary to adequately care for this expanding population. Yet the question remains: Can you objectively define and identify a Hispanic or Latino individual? Or do these labels exist for the sake of convenience in data collection? Through the perspective of cultural psychology, the lack of competency regarding intercultural variability in the Hispanic and Latino population is proposed as an oversight in the development of methods of psychotherapy and diagnostic criteria. With the increasing population of Hispanics and Latinos within the United States, multiculturalism competency should go beyond an ethical guideline and instead be considered required coursework in clinical psychology graduate programs.

In contemporary psychology, the phenomenological experience of the individual is a critical component in the therapeutic treatment. Although the primary goal of psychological research is to predict and alter behavior, there are far too many subgroups in the human population to account for every possible outcome. Quina and Bronstein (2003) noted that there are numerous factors that can attribute to an individual's self-identity and life experiences including locus of ethnic identity, socioeconomic status, location, country of origin, fluency in the local language, physical features, in addition to many other factors. As such, acknowledgement of the unique experiences of an individual is often accounted for in studies that attempt to generalize to a specific target population, which are commonly based on an individual's racial or ethnic identity.

Researchers of cultural psychology have defined ethnic identity as a dynamic multidimensional construct that may evolve over time (Phinney, 2003). The development of one's ethnic identity may involve one's subjective feelings toward a culture, heritage, the cultural labels an individual pragmatically applies to his or her identity, a sense of belongingness to the culture, the salience of the cultural perspective, and the majority population's opinion regarding the ethnic group (e.g., Costigan, Koryzma, Hua, & Chance, 2010; Phinney, 1992; Phinney & Ong, 2007).

A person's ethnic identity, especially if they self-identify with a cultural minority, is critical as a social construct as it may serve as a deictic frame through which one perceives the environment in which they live, one's concept of self, self-esteem, and how the person adjusts to the culture of the host nation (Costigan et al., 2010; Daha, 2011; Hayes & Gregg, 2000). Furthermore, Verkuyten and Lay (1998) identified ethnic identity as a critical variable in psychology as the aspect of the phenomenological experience serves as a nearly perfect mediator of psychological well-being separate from group status.

Within any group, individuals often seek out self-identifiers that emphasize their unique features to separate themselves from others. One's ethnic identity may become especially important in the United States where popular culture has unfortunately cultivated the use of archaic racial labels and obstructed the movement for cultural sensitivity, which has permeated into scientific research (Yee, Fairchild, Weizmann, & Wyatt, 1993). This is a troubling reality that must be addressed, as members of ethnic minority groups tend to develop a stronger ethnic identity than members of the ethnic majority (Pellebon, 2000). One principle example within the United States is the use of racial labels, which may not exist in other parts of the world including the designation of Hispanic and Latino. For instance, adolescents that had immigrated to the United States from a Hispanic nation

were not aware of the racial label applied to them until they arrived in the United States and were referred to as Latinos due to their physical attributes, cultural differences from their peers, and fluency in the Spanish language. When these adolescents faced discrimination, they often used the label as a tool for group cohesion and the development of their self-concept (Portes & Rumbaut, 2001).

Whether one's racial identity is requested on government documents, a standardized test, or a job application, Hispanics and Latinos are often grouped together as a single racial identity based solely on similar histories and the common language of Spanish. Generally, individuals who can trace their ancestry back to the nation of Spain are considered Hispanic, while Latino is considered a much broader term that includes anyone from the regions of Central America, South America, and the Caribbean. Collectively, these two terms could include people from more than 40 different nations and territories spread throughout the entire world including Spain, Cuba, Puerto Rico, Mexico, Argentina, Equatorial Guinea, the Philippines, even the Portuguese-speaking nation of Brazil, which had never been colonized by Spain. For many, especially immigrants, these labels represent a separation from their heritage and prefer to identify themselves by their nationality (Bernal & Enchautegui-de-Jesús, 1994).

From the broad perspective of census data collection, the terms Hispanic and Latino are on par with other racial identities such as White and Native American. Yet in spite of the U.S. Census Bureau's acknowledgement that race is a socio-political construct and historically has no biological, anthropological, or genetic evidence to support the use of a racial label in data collection (Public Information Office, 2001), the mental health community has continued to use the generalized labels of Hispanic and Latino in research and has lost potentially valuable data in this practice (Bernal & Enchautegui-de-Jesús, 1994). Even though generalizability across the target population and the use of the analysis of variance model is crucial to the scientific endeavors of psychology, the assumption that there are no individual or cultural differences within an arbitrarily applied racial group is a fatal flaw in psychological research (Hirsch, 1967). The assumption of heterogeneity among Hispanics and Latinos has strengthened the pervasiveness of stereotypes and diminished the utilization of mental health services (Roll, Millen, & Martinez, 1980).

Multiculturalism Among Hispanics and Latinos

To develop an accurate competency in multiculturalism among Hispanics and Latinos, an overall view of the cultures including similarities and differences is necessary. Although most Hispanics and Latinos share several cultural traits such as the rigidity of gender roles (*machismo* and *marianismo*), the importance of family, and being well-mannered (de las Fuentes, Barón, & Vásquez, 2003), these racial labels represent millions of people from a variety of ethnic and socioeconomic backgrounds that immigrated for different reasons from an assortment of nations around the world with different histories and cultures. Each of these similarities and differences may have a tremendous impact upon an individual's concept of self and as a result affect the person's ability to adapt, react, or function overall in a variety of scenarios. They may also have a direct effect upon a person's perception of their mental health. For example, even though many Hispanics and Latinos speak Spanish, each nation and region within the nation have altered the language over time to be more relevant to the residents' livelihood and culture including different terms for psychological distress (Weller, Baer, de Alba Garcia, & Rocha, 2008).

Gender Roles

The greatest misunderstanding in psychological literature regarding the Hispanic and Latino population is that of gender roles. Consider the two most well-known gender roles in psychological literature: *machismo* (men) and *marianismo* (women). According to these traditions, the *marianismo* female should mirror the example set by the Virgin Mary of the Roman Catholic Church. In other words, the woman is expected to be pure until marriage, forsake self-indulgence, be selfless, obedient to her husband, and devoted to her family. In contrast, the framework for male behavior is often described, as a chauvinistic disciplinarian that is would not hesitate to use physical violence against disobedient women and children (de las Fuentes et al., 2003). Although these gender roles have been thoroughly researched in psychology, much of the literature has neglected to account for intercultural variability (Vazquez-Nuttall, Romero-Garcia, & De Leon, 1987). In reality, these gender roles should be recognized as a cultural tradition, but rather as an issue of gender inequality as a relational framework in which these behaviors are cultivated and sustained by the dominant culture within each nation. For example, Ehlers (1991) argued that Guatemalan women often accepted their lower role in society due to social inequality perpetuated by a male-bias in the nation's economy. In Cuba, the socialist regime of Fidel Castro has promoted egalitarianism and increased the female role in society, but dedication to the family and motherhood has remained a primary value (Queralt, 1984). Among Mexican-Americans and Mexicans, the majority of Latino men, have rejected the machismo characteristics and instead aspire to be chivalrous, humble, and kind to others (Arciniega, Anderson, Tovar-Blank, & Tracey, 2008). Yet to understand the persistence of

gender inequality, one must understand the importance of family in Hispanic/Latino cultures.

Family

Similar to many other cultures, the individual develops a personal identity and derives many values from interaction and support with family members. Many Hispanic cultures emphasize that the family should take priority over the individual (Sabogal, Marín, Otero-Sabogal, Marín, & Perez-Stable, 1987). The culture within the family instills the values of responsibility, solidarity, and mutual selflessness among family members to the degree of the obfuscation of personal boundaries (Cuéllar, Arnold, & González, 1995). As this is in direct contrast from the United States and many other western cultures that emphasize the independent individual, the differing emphases many not translate well during the stages of acculturation as many Hispanic and Caribbean immigrant students described the American culture as selfish, aggressive, and competitive (Schwartz, Montgomery, & Briones, 2006).

The importance of family also has a tremendous impact on cognitive development and the person's self-concept and behaviors. Individuals within a collectivist society often develop an interdependent self that experiences the world with emphatic consideration for the thoughts and feelings of others rather than exclusively focused on one's own perception (Markus & Kitayama, 1991). As one's self-concept is considered essential aspect of one's mental health (Kálay & Rus, 2014), it is necessary for mental health professionals to be familiar with the conceptualizations of mental health among different cultures in the Hispanic and Latino communities.

Multiculturalism and Mental Health

Additionally, a majority of the research involving the maladaptive behaviors and symptomatology associated with disorders described in the DSM-5 (American Psychiatric Association [APA], 2013) was carried out in the United States and Western Europe (Ideus, 1994). This has led to many instruments and diagnostic measures designed to assess symptoms of mental illness with a bias toward American ideals and very little validity in other nations (Canino & Guarnaccia, 1997). What is considered pathologically maladaptive in one culture may be considered average in another culture. A variety of cultural factors including differences in spoken language as well as religious and spiritual beliefs may affect the results of testing and assessment and also may lead to the misinterpretation of reported experiences. A meta-analysis of cross-cultural studies using American diagnostic measures on more than 500 children revealed that 48% of participants in Mannheim, Germany and 49.5% of participants in Puerto Rico met diagnostic criteria for at least one mental illness in comparison to 22% of participants in Pittsburgh, Pennsylvania (Bird, 1996).

Culture is a primary predictor of how the individual or caregivers interpret and understand the symptoms of a mental disorder (Kirmayer, 2001). For example, consider the diagnostic criteria for attention-deficit hyperactivity disorder (ADHD). Many of the standardized scales designed to assess the severity of impulsive and inattentive behaviors related to ADHD rely on parent and teacher appraisals of these behaviors (e.g., Conners, Erhardt, & Sparrow, 1999) and do not account for intercultural variability. In fact, when Puerto Rican parents were prompted to rate the behavior of their school-aged children using the American diagnostic criteria for ADHD, the children were rated more severely than American standards and 45.3% of Puerto Rican children had a diagnosable case of ADHD (Bird et al., 1988). Some Hispanic cultures do not have a conceptualization for the behaviors associated with ADHD and require education to improve the environment in which these children live. Arcia and Fernández (1998) asked Cuban mothers to describe their experiences with their children diagnosed with ADHD. Common themes included perplexity and the search for familiar explanations of the behaviors including *retardado* (retardation), *malcriado* (spoiled, poorly raised), and *ñoño* (pampered). As a nurturing mother-child relationship is thought to be critical to positive outcomes in childhood development and socially acceptable behaviors (Anderson, Hinshaw, & Simmel, 1994), a lack of conceptualization may have a profound impact on how the child is treated and the prognosis of the mental disorder.

Proposed Graduate Coursework in Cultural Sensitivity

The racial label of Hispanic and Latino has resulted in an identity crisis for millions of immigrants and their descendants living in the United States (Bernal & Enchautegui-de-Jesús, 1994). Compounded with the fact that a majority of the psychological research used to develop instruments for assessment and treatment plans is carried out in the United States and Western Europe (Ideus, 1994), people that belong to a cultural minority are less likely than Caucasian people to seek out and receive mental health treatment (U.S. Department of Health and Human Services [USDHHS], 2008). As such, it is imperative that there should be an effort made to improve cultural competence among mental health professionals. Consider the following case.

Dr. Harrison, a psychiatrist, has agreed to help a Puerto Rican client suffering from an extended period of grief after the loss of her husband. Dr. Harrison felt confident about his ability to treat the client, because

he was experienced in the treatment of bereavement and had completed a minor in Spanish during his undergrad coursework. After the assessment, she clearly met the diagnostic criteria for Major Depressive Disorder, but Dr. Harrison felt that he could treat her without the use of medication. Over the next two sessions, some progress is made as the client reported at least the desire to visit her friends but still lacked the motivation. During the sixth session, he noticed a significant increase in the client's positivity and with a sense of pride in his work, he immediately asked about the change in mood. Ecstatic, the client excitedly told him that her husband had visited her the day before and spoke with her for several hours. Disapproving of this experience, Dr. Harrison immediately sat back in his chair, appeared concerned and asked for more details about the visitation. The client reported that she felt the warmth of his touch and that his words comforted her. Toward the end of the session, he wrote her a prescription for an antipsychotic and escorted her to the pharmacy.

Although Dr. Harrison had some knowledge of the Spanish language, he lacked the cultural awareness and sensitivity to treat the client. In the Puerto Rican culture, encounters with the spiritual world are considered a positive experience rather than symptomatic of schizophrenia (Rogler & Hollingshead, 1985). Meeting the cultural needs of a client can be the difference between a positive or negative treatment out come. When a mental health organization provides treatment that meets the cultural needs of the client, there is a significant reduction in the severity of depression, suicidality, and anxiety (Costantino, Malgady, & Primavera, 2009).

López (2002) designed a class for graduate students that adapted cultural sensitivity training into the lesson plan. He would first teach his students about the key principles of assessment, construct reliability and validity and the effects that cultural disparity may have upon them. He would then help the students develop culturally based critical thinking skills and understand how to shift cultural lenses to meet the needs of their clients. Thirdly, it is important to understand that culture exists on a spectrum that may shift on a daily basis, vary among individuals, and may not impact therapy at all.

Culturally competent therapists may be able to take a step back from their own culture and help the client based on their own. For example, if a Filipino man that is suffering from arachnophobia enters the therapist's office. The therapist would do well to get to know and understand the client's personal values and their orientation toward them. If the Filipino man closely associates himself with the machismo gender role then it may be evidence that the fear is so intense that he was willing to cast aside his self-perceived masculinity and admit that he needed help and suggest alterations to the treatment plan of systematic desensitization. A therapist that is culturally aware would be a valuable asset to any organization, especially in the United States.

Conclusion

With the acknowledgement of the increasing population of Latinos and Hispanics in the United States, multiculturalism competency and the awareness that one's cultural identity cannot be easily ascertained from an ethnic or racial label should be considered essential to cultivate empathy for these individuals and implement interventions to assist with the healthy development of a personal and cultural identity. For the greatest benefit to this growing population as well as other ethnic minorities, coursework to teach and foster multiculturalism competency or empathy should be integrated into required coursework in clinical psychology graduate programs. As research has demonstrated that a healthy ethnic identity is associated with greater life satisfaction in addition to lower risk of alcohol and substance abuse (Love, Yin, Codina, & Zapata, 2006), assignments should center around an emphasis on critical thinking, perspective taking, and the knowledge that the cultural identity of individuals is heterogeneous not only within their racial or ethnic label but within their ancestral nation of origin as well.

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The Rehabilitation Professional

The Rehabilitation Professional is published quarterly by the International Association of Rehabilitation Professionals (IARP). The Rehabilitation Professional is published to promote the profession and to inform the public about the activities of the organizations and their affiliates.

The Rehabilitation Professional is distributed to all IARP members as a benefit of membership and is available through subscription. Circulation of others is through various promotions.

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Manuscript Submission Deadlines: Deadlines are November 5, February 5, May 5, and August 5 with publication goal dates of February, May, August and November. There is no guaranteed publication date for an accepted article.

Credits:
Design & Production: Janet Field
Printing: Athens Printing Company, Athens, GA

Publication Guidelines

The Rehabilitation Professional (RehabPro) is the quarterly publication of the International Association of Rehabilitation Professionals (IARP). The articles are written with the rehabilitation professional in mind. Articles are suggested for, but not limited to, the following tracks: case management, disability management, forensic/life care planning, and business development. The articles are reviewed by the Managing Editor and may be reviewed by members of the Rehab Pro Committee.

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