The Rehabilitation Professional, 21(1), pp. 29–44

Importance and Frequency Ratings of Ethical Dilemmas Experienced by Forensic Rehabilitation Counselors, Private Sector Rehabilitation Counselors and Public Sector Rehabilitation Counselors

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Forensic rehabilitation counseling is a field that has grown steadily over the last quarter century. However, little is known about the unique ethical dilemmas that professionals in this sector of counseling encounter. Rehabilitation counselors who practice in a forensic capacity perform a unique professional role that distinguishes them from a traditional rehabilitation counselor practicing in the public or private sectors. Until recently, little consideration was given to the specialized duty they perform in the litigation process. The CRC code of ethics did not have a section covering this area of practice until 2010. The aim of this study was two-fold. First, due to the paucity of research available on the types of ethical dilemmas that practitioners face across a number of different settings, the researchers here sought to examine the nature of ethical dilemmas experienced by these groups. Secondly, an attempt was made to determine if there were significant differences in how practitioners in these three settings (e.g., forensic, public, private) rate the frequency and importance of ethical dilemmas that they encounter. Findings and implications address both the need for more exploration into the unique dilemmas that those in the forensic field encounter as well as the importance of the newly created Section F of the CRC Code of Ethics.

Keywords: Ethical dilemmas, Ethics, Forensic Rehabilitation Counseling, Rehabilitation Counseling

Forensic rehabilitation has, over the past 50 years, developed into an established and fast-growing specialty area in rehabilitation counseling (Barros-Bailey, Carlisle, & Blackwell, 2010). As a result of the emergence of new knowledge and skill requirements for practitioners working within the forensic context, the profession of rehabilitation counseling must confront new ethical challenges specific to this specialty area. Identification and delineation of the ethical, contextual, and relational differences between forensic and non-forensic rehabilitation counseling is imperative in order to provide counselors with the appropriate ethical guidelines and decision-making models that are required when confronting the complex ethical issues that may arise when working in a forensic capacity.

The Need for Ethical Guidelines in Forensics

According to Barros-Bailey (2010) forensic practice by rehabilitation counselors has become increasingly recognized in both public and private sector disability and legal systems that require specific expertise and skills of a rehabilitation counselor (as cited in

Barros-Bailey, Carlisle & Blackwell, 2010, p. 43). As rehabilitation counseling in forensic settings became more common, the risks associated with working in this capacity became increasingly pronounced. Ethical complaints against forensic rehabilitation counselors increased (Saunders, Barros-Bailey, Rudman, Dew, & Garcia, 2007), along with requests for advisory opinions to the CRCC Ethics Committee (Shaw & Lane, 2008). It became increasingly evident that ethical guidelines needed to be established that would provide guidance and support for rehabilitation counselors working in a forensic capacity who, without any previously established ethical guidelines, were left vulnerable to liability and litigation.

Evolution of the Code

In 2006, the International Association of Rehabilitation Professionals (IARP) directed the first effort to independently examine issues specific to forensics (Barros-Bailey, Carlisle, & Blackwell, 2010). Barros-Bailey, Holloman, Berens, Taylor, & Lockhart (2005) clarified the limited value of this effort as it was initiated with the desired outcome of establishing a code that was consistent with all forensic practice, not just practices within rehabilitation counseling (as endorsed by Barros-Bailey, Carlisle, & Blackwell, 2010). As a result of having no universally applied ethical guidelines specific to rehabilitation counselors, a fundamental need for a thorough investigation of the ethical dilemmas present within the forensic context continued to exist despite the efforts of the IARP.

In 2007, The Forensic Ethics Workgroup, a taskforce entirely comprised of rehabilitation professionals with forensic experience, was created by the Commission on Rehabilitation Counselor Certification (CRCC) to review and recommend revisions to the Code that would establish much needed guidelines specific to forensics (Barros-Bailey, Carlisle, & Blackwell, 2010). After thorough discussion and debate, the workgroup produced a draft of the revisions that was released for public comment, where the comments that were received were then reviewed and integrated into the final recommendations. In 2009, the CRCC approved the recommendations which led to the creation of Section F, a new addition to the Code dedicated entirely to the practice of forensics and indirect service provisions by rehabilitation counselors (Barros-Bailey, Carlisle, & Blackwell, 2010).

Section F is one of the most significant changes found in the 2010 Code as the 2001 Code had only one standard specific to forensics. Within Section F, the CRCC has identified 17 standards specific to clients' and evaluee's rights, rehabilitation counselor's forensic competency and conduct, forensic practices, and forensic business practices (Barros-Bailey, Carlisle, & Blackwell, 2010). Standards mentioned in Section F include a unilaterally accepted definition of evaluee, primary obligations, informed consent, dual roles, indirect service provision, confidentiality, objectivity, qualification to provide expert testimony, conflict of interest, validity of resources consulted, foundation of knowledge, duty to confirm information, critique of opposing work product, case acceptance and independent opinion, termination and assignment transfer, payments and outcome, and fee disputes (Barros-Bailey, Carlisle, & Blackwell, 2010).

The Role of the Client

Forensic rehabilitation counselors mediate a counselor/client relationship that is different than the traditional, non-forensic, counselor/client dyad. In the provision of services to a client in both the private and public sectors, a client-counselor relationship is established, one in which the counselor is bound to an ethical code. In a forensic capacity, no such relationship is established and the client, according to Section F of the Code, is defined as an "evaluee" with no continuing client-counselor relationship. An evaluee is defined as "a person who is the subject of an objective and unbiased evaluation." However, in both forensic and non-forensic settings, the primary obligation of the rehabilitation counselor remains to the client or evaluee.

Perhaps the most significant contribution of the 2010 Code is a clarified definition of the role of the client in forensic rehabilitation counseling. The role of the client has been a point of contention within various professional organizations and professional bodies, all who did not ascribe to the same definition before the 2010 Code was published (Barros-Bailey, Carlisle, & Blackwell, 2010). Without a unilaterally ratified definition of the role of the client, rehabilitation counselors working in a forensic capacity had no standard clarifying and identifying client's rights. As a result of Section F, there are now guidelines that distinguish between the traditional role of a client, versus the role of the "evaluee" in forensic rehabilitation counseling.

Conflicts of Interest and Dual Roles

The Code states that forensic and private practices should be mindful of potential conflicts of interest that "may interfere with their ability to practice competently" (F.2.b). The Code recognizes that dual roles should be avoided, though this becomes difficult based upon the jurisdiction in which rehabilitation counselors practice. More research needs to be completed in examining the various ethical issues that occur in the forensic context and how those ethical dilemmas change if and when rehabilitation counselors work concurrently in forensic and non-forensic sectors.

Section F makes a clear distinction between the traditional role of counselor and the role of the forensic evaluator and stresses the avoidance of dual roles

(Barros-Bailey, Blackwell, & Carlisle, 2010). Rehabilitation counselors are directed to not evaluate current or former clients for forensic purposes (except under the conditions stipulated by government statute or as noted in A.5.f) and are also directed to not provide direct services to past evaluees (F.1.c). Although dual roles should be avoided, the Code states that there may be circumstances where dual roles are inherent in the jurisdiction in which rehabilitation counselors practice, or there may be situations where those dual roles are beneficial to the evaluee.

Disclosure and Informed Consent

The requirement that rehabilitation counselors provide a professional disclosure statement is another change within the 2010 CRCC Code of Ethics. The importance of written professional disclosure is reinforced in the new code, where it's stated that a counselor must communicate the following to the consumer, both orally and in writing: qualifications, credentials, purposes, goals, techniques, limitations, the nature of potential risks and benefits of services, frequency and length of services, confidentiality and limitations regarding confidentiality, contingencies for continuation of services upon incapacitation or death of counselor, fees and billing arrangements, record preservation and release policies, risks associated with electronic communication and legal issues affecting forensic services (Bailey, Carlisle, & Blackwell, 2010; Shaw & Lane, 2008).

Manoogian (2007) explained that vocational rehabilitation counselors are faced with "multidimensional ethical issues relating to client definition, dual relationships, and competency when they act in the role of an expert witness" (p. 35). As a result of the complexity of these issues, Manoogian (2007) strongly recommended using a professional disclosure form, such as the "Professional Disclosure Form-Private Sector Example-Forensic" (CRCC, 2006) when addressing ethical concerns in vocational expert counseling witness work (as cited by Reid and McReynolds, 2007).

Another issue addressed in the 2010 Code of Ethics was that of informed consent. 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 (Blackwell & Patterson, 2003). At a minimum, the informed consent provided to the client must include the nature and purpose of services provided, along with the risks, benefits and available alternatives upon initiating services with a rehabilitation counselor.

Consultation

Consultation is a central theme in most ethical decision-making models across all disciplines of counseling. These ethical decision making models are designed to provide a framework for working through ethical dilemmas in a systematic and thorough manner. Consultation and seeking assistance from other professionals when confronted with an ethical dilemma is crucial (Remely & Herlihy, 2001; Welfel, 2002). Shaw (2004) concluded that consultation is essential to demonstrate that the counselor has sought input from the professional community where it's important for counselors to carefully document these activities in case of future legal action. This form of consultation is universal amongst both the private and public sectors, although no uniformly agreed upon standard exists regarding the context in which consultation should take place, or how to formalize the process (Shaw & Lane, 2008).

Ethical Dilemmas

According to Davis & Jahner (2010) an ethical dilemma is a situation in which more than one option is available and ethical cannons are in conflict. Investigating and researching ethical dilemmas is a highly valued and often studied topic in rehabilitation counseling. The most recent study of ethical decision-making conducted by Tarvydas & Barros-Bailey (2010) utilized a survey of participants from the CRCC database of certified rehabilitation counselors. A stratified random sample of 998 certified rehabilitation counselors and 118 Canadian certified rehabilitation counselors were selected for a sample that contained a 95% confidence level and an estimated 3% sampling error. The purpose of the study was to gather information regarding ethical dilemmas to inform the Code's review and revision process (Tarvydas & Barros-Bailey, 2010).

Tarvydas & Barros-Bailey (2010) also examined third-party referral and indirect services to determine how they could be clarified in order to assist counselors. The high levels of concern regarding conflicts of interest and the pressure to balance the primary responsibility to the client with the interests of the third party payer or referral source was identified as troublesome. According to this study, the most alarming finding involved the pressure on rehabilitation counselors from their employer or supervisors to disregard ethical best practices. This study however, did not distinguish between the public and private, nor the forensic and non-forensic sectors of rehabilitation counseling and only selected counselors through the CRCC's available email addresses (Tarvydas & Barros-Bailey, 2010). Tarvydas & Barros-Bailey's (2010) study included participants that were defined as rehabilitation counselors. No demographic details were offered as to what settings and capacities the participants operated in.

Summary

Future research should identify and define the significant ethical differences that are found within the Forensic area of rehabilitation counseling to guide future revisions of the CRCC Code of Ethics. In order to best serve our clients, there needs to be a continuing examination of the unique ethical dilemmas that may confront forensic rehabilitation counselors.

Purpose of Study

Because of insufficient research comparing ethical issues across rehabilitation practice sectors and the need to increase knowledge that could inform not only ethics education and research, but also practice, the purpose of this study was to compare the frequency and importance of specific ethical dilemmas faced by rehabilitation practitioners in both the private and public sector. The authors used a combination of quantitative and qualitative strategies to collect and analyze the data, using a sample of participants selected from public, federal vocational rehabilitation, agencies and private, for profit, rehabilitation companies.

The research questions of the study were the following, divided into quantitative and qualitative questions:

1. Quantitative Research Questions
   a) What is the mean frequency and importance ratings provided by public sector, private sector and forensic rehabilitation counselors to the ethical dilemmas presented?
   b) Is there a significant difference in the frequency and importance ratings between the public sector, private sector and forensic rehabilitation counselors by categories of ethical dilemmas and by specific items
2. Qualitative Research Questions
   a) What are the most common self-reported ethical dilemmas experienced by private, public and forensic rehabilitation practitioners?
   b) What are the main categories of self-reported ethical dilemmas experienced by each group of participants and how are these different across the three groups?

Method

Participants

The researchers recruited participants from public vocational rehabilitation (VR) agencies in three Mid-Atlantic States and private rehabilitation counselors across the country. This was done by (a) contacting training directors of three state VR divisions who in turn recruited rehabilitation counseling professionals working in those agencies via e-mail; (b) contacting the directors of private rehabilitation companies who in turn recruited rehabilitation counselors at those companies via e-mail (c) contacting individuals via telephone and email through a database of private rehabilitation counselors associated with the Maryland Workers' Compensation Commission, a state government entity that provides certification, training, and regulation of all private VR counselors in MD. This database was obtained through one researcher's prior association with the organization. A total of 400 rehabilitation professionals participated in the study, where 128 were from public sector, 148 were forensic rehabilitation counselors and 124 were from the private sector but worked in areas other than forensic rehabilitation. The total number of rehabilitation professionals who received the e-mail invitation was not determined, making it unfeasible for the researchers to calculate the return rate. Prior to sending the invitations and recruiting the participants, the state VR agencies and private companies approved the study via their formal procedures, and the researchers obtained IRB approval from The George Washington University. The only selection criterion was that participants currently work as rehabilitation professionals in the target institutions. Participation in the study consisted of providing answers to the different sections of the questionnaire.

Of the 272 individuals surveyed from the private sector, 123 identified themselves as working in a specialty other than forensic rehabilitation. Of these participants, 40 (32.3%) were males and 83 (67%) females. The age of participants ranged from 27-77 years old with the mean participant age at 53.66 years. 116 (93.5%) of the respondents identified as Caucasian, 3 (2.4%) African-American, 1 (.80%) Hispanic/Latino, 3 (2.4%) American Indian and 2 (1.6%) as Other. Experience of the participants ranged from 1-50 years, with the mean being 14.63 years. Of those surveyed, 5 (3.9%) had received their bachelor's degree, 102 (82.3%) had completed their master's degree, and 15 (11.8%) had doctorates and 6 (4.7%) had an alternative degree. In terms of their location of practice, 67 (54%) identified it as suburban, 74 (59.7%) urban and 35 (28.2%) rural (Note: Counselors were allowed to select more than one location of practice). 71 (57.3%) described their job role as involving disability management or workers compensation, 18 (14.5%) as life care planning and 49 (39.5%) responded other.

148 of the 275 individuals working in the private sector identified themselves as working in forensic rehabilitation. Of these 148 individuals, 75 (50.7%) were males and 73 (49.3%) were females. The age of participants ranged from 28-77 years old with the mean participant age of 55.67 years. 139 (93.9%) of the respondents identified as Caucasian, 1 (.006%) African-American, 5 (.033%) Hispanic/Latino, 1 (.006%) American Indian

and 3 (.020%) identified as other. Experience of the participants ranged from 1-58 years, with the mean being 21.63 years. Of those surveyed, 7 (4.7%) had received their bachelor's degree, 116 (78.4%) had completed their master's degree, 23 (15.5%) had doctorates and 5 (3.4%) had an alternative degree. In terms of their location of practice, 73 (49.3%) identified it as suburban, 95 (64.2%) urban and 51 (34.5%) as rural (Note: Counselors were allowed to select more than one location of practice).

Of the 128 individuals surveyed from the public sector, 39 (30.5%) were male and 89 (69.5%) were female. The age of participants ranged from 24-78 years old with the mean participant age at 48.22 years. 94 (73.4%) of the respondents identified as Caucasian, 20 (15.6%) African American, 7 (5.5%) Hispanic/Latino, 2 (1.6%) Asian American, 5 (3.9%) American Indian, and 4 (3.1%) identified as other. Experience of the participants ranged from 0-45 years, with the mean being 9.11 years. Of those surveyed, 2 (1.6%) had received their bachelor's degree, 117 (91.4%) had completed their master's degree, 8 (6.3%) had a doctorate and 2 (1.6%) had an alternative degree. In terms of the location of practice, 35 (27.3%) identified it as suburban, 64 (50 %) urban and 45 (35.2%) identified that they worked in a rural area (Note: Counselors were allowed to select more than one location of practice).

Data Collection and Measures

Rehabilitation counselors who agreed to participate in the study did so by clicking a survey link from an Internet-based survey website that was delivered via e-mail invitation. Following the initial dissemination, the training coordinators and directors sent a follow-up email two weeks later to potential participants in an effort to maximize the response rate. Participants need only click on the link provided (or copy and paste the link into a browser) to retrieve the survey. An alternative paper survey was available upon request. Prior to dissemination, the researchers tested the survey to ensure that it was properly compiling data. The data collected was automatically compiled from the web survey Surveygizmo.com into an Excel spreadsheet and was then modified into SPSS for Windows.

Along with the survey link, participants were also sent an informed consent electronically which informed participants that they could voluntarily withdraw from the study at any time, what would be done with the information they provide, the intent of the current study, limitations of confidentiality, and a statement about known risks and benefits associated with their participation. Participants were informed that the survey would take approximately 30 minutes to complete. The surveys did not collect any identifying information as a means of protecting the anonymity of participants.

The questionnaire used in this study was developed by the researchers and consisted of three sections: demographic information, a list of 42 potential ethical dilemmas, and a section allotted for open comments. The demographic information collected included gender, age, ethnicity, work location (rural, suburban, urban), highest degree achieved, years of professional experience, state of employment, setting of practice (public vs. private), current job title/area of work and nature of any ethical training previously received. In the second section of the questionnaire, participants were presented with 42 ethical dilemmas that paralleled the standards found in the Commission of Rehabilitation Counselor Certification (CRCC) Ethics Code. Participants were asked to provide the frequency and the importance for each example on a 5-point Likert rating scale, ranging from Very Low to Very High. At the beginning of the survey instrument, the researchers operationalized an ethical dilemma as when "an individual is faced with a situation that can lead to two feasible conflicting courses of action leading to an uncertainty of which option would be the most ethical." In the third section of the questionnaire, the researchers asked participants to "describe, in your own words, an ethical dilemma typically experienced in your professional work," based upon the provided definition of an ethical dilemma.

The ethical dilemmas in section two were validated through a two-fold process: First, each dilemma was derived from a particular standard found in the CRCC Ethics Code (e.g., Section A.1. Welfare of Those Served by Rehabilitation Counselors. Not all the standards in the sections included were converted into a dilemma due to similarities and subsequent redundancy of inclusion. Sections I, J, and L of the Code were not reflected in the questionnaire since the researchers did not find them relevant to the current study. Second, the wording of the dilemmas were validated by a pilot convenience sample of graduate-level counseling students at The George Washington University who were asked to provide input on the clarity of each item included in the questionnaire.

Data Analysis

Using SPSS 16.0, the researchers compared the participant frequency and importance ratings across forensic, private and private settings through a MANOVA with two dependent measures. To reduce type one error, the Holm's Sequential Bonferroni Procedure was performed for all initial significant p values in Table 1A and 1B for both frequency ratings and importance ratings. Descriptive statistics to analyze the demographic information consisted of means and standard deviations for each of the demographic variables. Finally, the participants' comments about the most frequent and the most important ethical dilem-

mas they experience at work were analyzed by using descriptive statistics.

Results

Research Question 1.a.

What are the mean frequency and importance ratings provided by forensic rehabilitation counselors, private sector rehabilitation counselors and public sector rehabilitation counselors to the ethical dilemmas presented?

First, we examined the means for frequency and importance of ethical dilemmas by using descriptive statistics. Tables 1 and 2 show the means and standard deviations for each of the 42 items under frequency and importance of listed ethical dilemmas as rated by private, public and forensic professionals who responded to the questionnaire. Participants in the private (non-forensic) sector had a mean score of 2.44 for the frequency of the ethical dilemmas provided and a mean score of 3.91 for the importance of the ethical dilemmas provided. Forensic rehabilitation professionals had a mean score of 2.46 for the frequency of the ethical dilemmas provided and a mean score of 3.87 for the importance of the ethical dilemmas provided. Participants in the public sector had a mean score of 2.62 for the frequency of the ethical dilemmas provided and a mean score of 4.08 for the importance of the ethical dilemmas provided.

Private (non-forensic) sector participants gave the highest frequency rating to item f12: Respecting the dignity and promoting the welfare of clients (e.g., unsure as to what is best interest of client) (Mean 3.41, SD 1.28) and the lowest to item f25: Avoiding situations that may lead to romantic involvement with former clients or client's family members after a 5 year period (e.g., unclear as to how much time should elapse before involving oneself with a client, not knowing whether an individual is considered a former client) (Mean 1.52, SD 1.22). The highest importance rating was given to item i12: Respecting the dignity and promoting the welfare of clients (e.g., unsure as to what is best interest of client) (Mean 4.60, SD 0.76) and the lowest to item i53: Deal with fee disputes when terminating (e.g., unclear as to what the appropriate fees are, not knowing the proper process to solve fee disputes, unsure on whether to charge referral fees) (Mean 3.09, SD 1.47).

Forensic rehabilitation professionals gave the highest frequency rating to item f12: Respecting the dignity and promoting the welfare of clients (e.g., unsure as to what is best interest of client) (Mean 3.27, SD 1.25) and the lowest to item f25: Avoiding situations that may lead to romantic involvement with former clients or client's family member after a 5 year period (e.g., unclear as to how much time should elapse before involving oneself with a client, not knowing an individual is considered a former client (Mean 1.44, SD 1.17). They gave the highest importance rating to item i12: Respecting the dignity and promoting the welfare of clients (e.g., unsure as to what is best interest of client) (Mean 4.47, SD .684) and the lowest to i53: Deal with fee disputes when terminating (e.g., unclear as to what the appropriate fees are, not knowing the proper process to solve fee disputes, unsure on whether to charge referral fees) (Mean 3.04, SD 1.30).

Public sector participants gave the highest frequency rating to item f12: Respecting the dignity and promoting the welfare of clients (e.g., unsure as to what is best interest of client) (Mean 3.60, SD 1.17) and the lowest to item f53: Deal with fee disputes when terminating (e.g., unclear as to what the appropriate fees are, not knowing the proper process to solve fee disputes, unsure on whether to charge referral fees) (Mean 1.67, SD 1.17). They gave the highest importance rating to item i12: Respecting the dignity and promoting the welfare of clients (e.g., unsure as to what is best interest of client (Mean 4.64, SD 0.74) and the lowest to i42: Representing one's own personal credentials, degrees or levels of competency (e.g., unclear as to what credentials to present or include when providing services) (Mean 3.66, SD 1.24).

Research Question 1.b.

Is there a significant difference in the overall and item-by-item frequency and importance ratings between public sector participants, private (non-forensic) sector participants and the forensic rehabilitation professionals?

A second research question of the study was whether there were significant overall differences in the frequency and importance ratings between public, private and forensic rehabilitation professionals. Multivariate analysis (Hotelling's Trace) yielded overall significant differences for both frequency and importance (see Table 2). In terms of frequency ratings (Section A: The Counseling Relationship $F(2,384) = 3.316$, $p < .05$, Section B: Confidentiality, Privileged Communication and Privacy $F(2,348) = 15.386$, $p < .01$, Section C: Advocacy and Accessibility $F(2,348) = 5.865$, $p < .05$, Section D: Professional Responsibility $F(2,384) = 3.465$, $p < .05$ and Section H: Teaching, Supervision and Training $F(2,348) = 16.718$, $p < .01$ appeared to have statistically significant differences. In terms of importance ratings, Section A: $F(2,348) = 3.879$, $p < 0.05$, Section D: $F(2,384) = 3.038$, $p < .05$ and Section H: $F(2.348) = 7.980$, $p < .01$ appeared to have statistically significant differences.

Tables 1 and 2 also allow us to examine the frequency and importance ratings between the three groups by individual question. Here we can see significant differences, at the $p < .05$ level between groups for the following items by frequency rating: V20, V24, V25,

Table 1
Means and Standard Deviations Across Items by Frequency of Ethical Dilemmas and by Work Setting

	Private		Forensic		Public		
Item	M	SD	M	SD	M	SD	*P*
12	3.419	1.275	3.270	1.248	3.593	1.166	
13	3.258	1.627	3.006	1.562	3.140	1.576	
14	2.983	1.304	3.047	1.189	3.312	1.296	
15	3.203	1.173	3.081	1.207	3.257	1.218	
16	2.983	1.259	3.047	1.267	3.257	1.293	
17	2.967	1.593	3.175	1.450	3.031	1.601	
18	3.032	1.419	3.142	1.433	2.976	1.400	
19	2.853	1.297	2.632	1.222	3.101	1.291	
20	1.911	1.223	1.763	1.174	2.492	1.380	*0.000*
21	2.814	1.245	2.675	1.196	3.133	1.329	
22	2.650	1.448	2.648	1.418	3.000	1.469	
23	2.935	1.435	2.770	1.375	3.046	1.385	
24	1.604	1.286	1.534	1.271	2.094	1.659	*0.026*
25	1.516	1.219	1.438	1.168	2.101	1.635	*0.000*
26	1.911	1.236	1.684	1.143	2.507	1.511	*0.000*
27	1.881	1.199	1.601	1.088	2.328	1.462	*0.000*
28	1.770	1.126	1.568	1.113	2.093	1.377	*0.024*
29	1.774	1.174	1.616	0.998	2.472	1.220	*0.000*
30	2.131	1.402	1.736	1.241	2.385	1.368	*0.000*
31	2.398	1.178	2.114	1.231	2.500	1.235	
32	2.585	1.311	2.381	1.218	2.690	1.299	
33	2.741	1.360	2.398	1.123	2.826	1.327	
34	2.365	1.338	2.162	1.245	2.585	1.354	*0.028*
35	2.927	1.350	2.770	1.350	3.226	1.311	
36	2.900	1.428	2.824	1.441	2.511	1.396	
37	2.836	1.313	2.693	1.337	2.716	1.320	
38	2.682	1.374	2.445	1.224	3.000	1.345	*0.022*
39	2.088	1.236	1.952	1.045	2.375	1.292	
40	2.427	1.176	2.231	1.085	2.625	1.190	
41	2.173	1.288	1.973	1.183	2.390	1.347	*0.050*
42	2.528	1.500	2.614	1.509	2.566	1.461	
43	1.588	1.074	1.479	1.020	1.812	1.326	
44	2.838	1.526	3.081	1.426	2.171	1.352	*0.000*
45	1.756	1.256	1.591	1.032	1.671	1.242	
46	2.764	1.437	2.809	1.366	2.601	1.376	
47	2.314	1.297	2.183	1.158	2.406	1.294	
48	2.631	1.286	2.244	1.225	2.732	1.281	*0.030*
49	2.300	1.325	2.585	1.374	2.420	1.364	
50	2.208	1.229	2.591	1.317	2.401	1.280	
51	2.400	1.398	1.863	1.166	2.803	1.391	*0.000*
52	2.059	1.347	1.789	1.160	2.398	1.370	*0.014*
53	1.731	1.132	1.684	1.008	1.666	1.166	

Table 1
Means and Standard Deviations Across Items by Importance of Ethical Dilemmas and by Work Setting

	Private		Forensic		Public		
Item	M	SD	M	SD	M	SD	*P*
12	4.598	0.759	4.480	0.685	4.647	0.721	
13	4.425	0.964	4.345	0.863	4.424	0.917	
14	4.144	0.989	4.184	0.899	4.281	0.925	
15	4.040	0.928	3.966	0.895	4.043	0.875	
16	3.959	1.112	4.020	0.947	4.138	0.937	
17	4.280	0.955	4.196	1.034	4.326	0.945	
18	4.031	1.015	4.109	0.930	4.079	0.986	
19	3.857	1.049	3.747	1.088	4.108	0.882	
20	3.811	1.355	3.493	1.348	4.000	1.198	
21	3.858	1.029	3.662	1.073	3.986	0.936	
22	4.349	0.974	4.216	0.966	4.565	0.810	
23	4.360	0.807	4.102	1.025	4.482	0.755	*0.014*
24	4.192	1.354	4.279	1.232	4.536	0.998	
25	3.944	1.433	4.027	1.359	4.273	1.122	
26	3.857	1.263	3.939	1.183	4.158	1.037	
27	3.675	1.354	3.771	1.250	4.037	1.091	
28	3.520	1.323	3.463	1.315	3.813	1.189	
29	3.591	1.353	3.572	1.268	3.935	1.062	
30	3.829	1.377	3.581	1.395	4.007	1.197	
31	3.685	1.185	3.608	1.153	3.777	1.123	
32	3.696	1.094	3.728	1.126	3.797	1.115	
33	3.882	1.096	3.709	1.090	3.971	1.077	
34	4.304	1.034	4.182	1.069	4.331	0.996	
35	4.236	0.971	4.020	1.091	4.295	0.981	
36	4.168	1.045	4.041	1.059	4.080	1.088	
37	4.144	0.989	3.878	1.059	4.094	1.053	
38	3.857	1.211	3.830	1.049	4.232	0.976	
39	3.825	1.259	3.959	1.085	4.180	1.030	*0.044*
40	3.690	1.084	3.574	1.149	4.000	1.032	*0.048*
41	3.659	1.253	3.592	1.254	3.878	1.170	
42	3.476	1.288	3.709	1.214	3.645	1.243	
43	3.937	1.407	3.973	1.267	4.201	1.235	
44	4.320	1.029	4.338	0.846	4.138	1.102	
45	3.536	1.506	3.610	1.361	3.964	1.332	
46	3.806	1.159	3.959	1.036	3.877	1.199	
47	3.992	1.067	3.808	1.097	4.086	1.032	
48	3.968	1.223	3.782	1.095	4.159	1.055	
49	3.852	1.251	4.027	1.085	4.022	1.149	
50	3.636	1.232	3.912	1.091	3.826	1.158	
51	3.697	1.360	3.503	1.344	4.191	1.015	*0.000*
52	3.592	1.338	3.473	1.319	3.891	1.182	
53	3.108	1.466	3.062	1.314	3.044	1.500	

V26, V27, V28, V29, V30, V34, V38, V41, V44, V48, V51 and V52, as well as by importance rating: V23, V39, V40 and V51.

Research Question 2.a.

What are the most common self-reported ethical dilemmas experienced by private, public and forensic practitioners?

The researchers looked at what actual dilemmas are typically experienced by each group, as reported by participants under the open question asking them to describe in their own words a dilemma they typically experience at work. A total of 104 (84%) private sector (non-forensic) professionals provided an example of a dilemma, while 127 (86%) of forensic rehabilitation professionals and 107 (84%) of the public sector participants provided one. Table 3 shows the nature and frequency of ethical standards related to each dilemma provided by each group of participants. In general, this data shows participants describing dilemmas that fell under five general sections of the code.

For private sector (non-forensic) professionals, a total of 40 (38%) described dilemmas fell under section F (Forensic and Indirect Services), while 23 (22%) fell under B (Confidentiality) and 15 (14%) fell under section A (Counseling Relationship). For the forensic rehabilitation professionals, a total of 61 (48%) of the identified ethical dilemmas fell under section F, while 16 (12.6%) fell under section A (The Counseling Relationship) and 13 (10.2%) fell under section D (Professional Responsibility). Lastly, in the public sector, 36 (34%) of the identified ethical dilemmas fell under section A, 20 (19%) fell under section B and14 (13%) fell under section F.

The most endorsed ethical dilemmas by public rehabilitation participants fell under standards A.5.d (10 or 9%) and F.1.a (10 or 9%). Standard A.5.d. involves the roles and responsibilities with clients (A.5), specifically nonprofessional interactions or relationships other than sexual or romantic interactions or relationships (A.5.d). This standard reads as follows: "Rehabilitation counselors avoid nonprofessional relationships with clients, former clients, their romantic partners, or their immediate family members, except when such interactions are potentially beneficial to clients or former clients. In cases where nonprofessional interactions may be potentially beneficial to clients or former clients, rehabilitation counselors must document in case records, prior to interactions (when feasible), the rationale for such interactions, the potential benefits, and anticipated consequences for the clients or former clients and other involved parties. Such interactions are initiated with appropriate consent from clients and are time-limited (e.g., extended free-standing friendships are prohibited) or context

Table 3
Multivariate Analysis Results

	F	*df*	*P*
Hotelling's Trace	3.812	41	.000
Frequency Section A	3.316	2	.040
Section B	15.386	2	.000
Section C	5.865	2	.004
Section D	3.465	2	.040
Section E	.923	2	.419
Section F	.128	2	.931
Section G	.435	2	.600
Section H	16.718	2	.000
Section K	.156	2	.895
Importance Section A	3.879	2	.021
Section B	3.038	2	.049
Section C	1.791	2	.168
Section D	2.897	2	.056
Section E	1.207	2	.300
Section F	.342	2	.710
Section G	.937	2	.393
Section H	7.980	2	.000
Section K	.079	2	.924

specific (e.g., constrained to an organizational or community setting). Where unintentional harm occurs to clients or former clients, or to other involved parties, due to nonprofessional interactions, rehabilitation counselors must show evidence of an attempt to remedy such harm. Examples of potentially beneficial interactions include, but are not limited to, attending a formal ceremony (e.g., a wedding/commitment ceremony or graduation); purchasing a service or product provided by clients or former clients (excepting unrestricted bartering); hospital visits to ill family members; or mutual membership in professional associations, organizations, or communities".

Standard F.1.a involves client or evaluee rights (F.1.), specifically a rehabilitation counselors primary obligations (F.1.a) pertaining to forensic of indirect services. This standard reads as follows: "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.

The most frequently cited ethical dilemmas by private sector (non-forensic) participants fell under standard F.1.a (27 or 26%), and C.1.b (7 or 7%). Standard F.1.a is found under the general forensic and indirect services section (F), particularly standards related to client or evaluee rights (F.1) that deal with primary obligations (a). This standard reads as follows: "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".

Standard C.1.b is found under the advocacy and accessibility section (C), particularly standards related to advocacy. This standard reads as follows: "Rehabilitation counselors provide clients with appropriate information to facilitate their self-advocacy actions whenever possible. They work with clients to help them understand their rights and responsibilities, speak for themselves, make decisions, and contribute to society. When appropriate and with the consent of clients, rehabilitation counselors act as advocates on behalf of their clients at the local, regional, and/or national level."

The most frequently cited ethical dilemmas by forensic rehabilitation participants fell under standard F.1.a (37 or 29%) and F.1.c (10 or 8.%) Standard F.1.a is found under the general forensic and indirect services section (F), particularly standards related to client or evaluee rights (F.1) that deal with primary obligations (a). This standard reads as follows: "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".

Standard F.2.d is found under the general forensic and indirect services section (F), particularly standards related rehabilitation counselor forensic competency and conduct (F.2) that deal with objectivity (a). This standard reads as follows: "Rehabilitation counselors are aware of the standards that govern their roles in performing forensic activities. Rehabilitation counselors are aware of the occasional competing demands placed upon them by these standards and the requirements of the legal system, and attempt to resolve these conflicts be making known their commitment to this Code and taking steps to resolve conflicts in a responsible manner."

Table 4 provides specific information about three examples of the actual dilemmas experienced by each group of participants under each of the most frequent ethical standards involved. These are A.5.d and F.1.a for the public group, F.1.a and C.1.b for the private group and F.1.a and F.1.c for the forensic group.

Research Question 2.b.

What are the main categories of self-reported ethical dilemmas experienced by each group of participants and how are these different across the three groups?

As is illustrated from the findings above, professionals working in the rehabilitation field seem to encounter different sorts of ethical dilemmas depending on the primary setting in which they work. The majority of

Table 4
Total Number & Percentages of Participant Reported Ethical Dilemmas by CRC Standard Section and Work Setting

	Forensic N (%)	Private N (%)	Public N (%)
Section A: Counseling Relationship	16 (13%)	15 (14%)	36 (34%)
Section B: Confidentiality	10 (8%)	23 (22%)	20 (19%)
Section C: Advocacy	4	9 (9%)	10 (9%)
Section D: Professional Responsibility	13 (10%)	4	2
Section E: Professional Relationships	2	0	6
Section F: Forensic and Indirect Services	61 (48%)	40 (38%)	14 (13%)
Section G: Evaluation/Assessment	5	3	1
Section H: Supervision/Training	1	0	7
Section I: Research	1	1	0
Section J: Technology	1	0	0
Section K: Business Practice	2	2	1
Section L: Resolving Ethical Issues	11 (9%)	7 (7%)	10 (9%)

the ethical dilemmas identified by public sector participants fell under sections A and B of the ethical code, while the vast majority of identified ethical dilemmas for the private sector participants fell under sections F, B, and A. For the forensic rehabilitation professionals the overwhelming majority of the identified ethical dilemmas fell under section F of the ethical code.

Rehabilitation counselors in the public sector encountered more ethical dilemmas that revolve around direct interactions and relationships with clients as well as those that bring up questions about confidentiality and client care. When and when not to disclose information to given parties and how best to establish and maintain appropriate expectations for the counseling relationship were common themes that arose from the ethical dilemmas identified by these individuals.

Participants from the forensic rehabilitation sector encountered more ethical dilemmas that revolved around how best to deal with pressures and influence from both attorneys and 3rd party payers as well as how best to go about addressing possible unethical behavior by others in their field. Providing your unbiased opinion in the face of pressure from the client's legal representation, dealing with referral sources/colleagues and addressing the perceived unprofessional/unethical behavior of others in the field were common themes that arose from ethical dilemmas identified by these participants.

Private (non-forensic) sector participants, seemed to fall somewhere in between with regards to the nature of the ethical dilemmas that they identified. Although the majority of the individual ethical dilemmas that they identified did fall under section F of the code, responses that fell under sections A and B when combined actually represented a larger percentage of their responses. These participants were not only faced with dilemmas that revolved around pressure when dealing with attorneys and 3rd party payers but were also faced with dilemmas that revolved around the counseling relationship with clients and limits of confidentiality as well.

Discussion

From the results of this study it can be asserted that there is a clear distinction between both the nature of ethical dilemmas encountered by practitioners in various rehabilitation counseling settings as well as the beliefs that these practitioners have concerning the dilemmas that they face. Counselors in the Forensic group as well as those in the Private Sector group reported more ethical dilemmas that fell under Section F (Forensic and Indirect Services) of the CRCC Code of Ethics where as counselors from the public sector reported more ethical dilemmas that feel under categories A (Counseling Relationship) and B (Confidentiality) of the Code. Additionally, This dichotomy in the nature of ethical dilemmas reported by counselors in these settings seems to address the different roles and expectations that rehabilitation counselors operate under in these different work settings.

Although item V12 (Respecting the dignity and promoting the welfare of clients) was endorsed by all three groups as both the most frequently encountered and the most important ethical dilemma that they face, participants from the private sector and forensic counselors differed from the public sector group on the least important and least encountered ethical dilemmas. The forensic and private sector groups both rec-

Table 5
Sample Ethical Dilemmas

Public
F.1.a
1. It is not uncommon to encounter clients who have employment goals that meet their interests, but appear to not be appropriate considering skills, training, history, and limitations. Common example; client wants to 'work with computers', but has relatively no practical knowledge or training pertaining to actual job-related skills.
2. I do forensic work in restoration to competency. My role is to restore someone to competency to stand trial. I have an individual, who would benefit from medication, but she is refusing and her attorney supports her. She is delusional, but does not see this and therefore doesn't want meds because of the side effects. Her attorney probably isn't vested in her becoming 'competent.' I have the authority to force medication because of her placement in my program.
3. In pushing counselors to produce numbers; my opinion is that this is at the expense of the client. We are inundated with marketing slogans and 'popular' (as opposed to peer reviewed) business practices that at times are not consistent with standards of practice or ethics.
A.5.d
1. Living in a small community, there are times when you will encounter clients at events. This can be awkward at least, and can present a conflict, if the person starts a conversation concerning their case, etc. The need to maintain a professional relationship can be difficult in a social situation. Also since this is a small rural community physicians that you see personally, are often the physicians for our clients. This can also present a dilemma, since I try to keep my personal opinions concerning physicians from reflecting to whom I refer a client to.
2. A typical ethical dilemma I experience is my own need to help people too much. I will say things regarding services before thinking it through. For example, a homeless client had found a job and housing and I assisted in providing tools through the usual process. But also gave him some tools I had for a long time. I'm trying to get better about telling the client this is a process and the first step is to determine eligibility. The other issue is not maintaining good contact with the client. I meet with them and then I may get distracted and forget to get back with them.
3. I live in a rural area and I often run into clients in a non-work situation. It is difficult to know what to say and how to approach people in this situation. I often will say Hello but let the client determine how they will react to me. I hold off on any other type of discussion.
Private
F.1.a
1. Defense attorney trying to use rehab counselors to make workers go back to work when they are not physically ready.
2. Ethical dilemmas include the request from a referral source to exclude medical information in your report when it can be damaging to the referral course's legal case.
3. I am a vocational case manager dealing with persons who are injured. Sometimes there is a mental health issue of an addictions issue that the insurance company does not want to address because it is not related to the accident. It is difficult sometimes to help the insurance company see the relevancy of addressing these issues in overall rehabilitation
C.1.b
1. In Workers Comp if a person has an unrelated condition and cannot participate, time loss is stopped. It is upsetting when this happens, because you do not know what is going to happen to the injured worker.
2. Not giving patients' referral or resource information that might benefit them due to their assignment in a particular research group that they have been randomized to.
3. Assisting the client with accessing a position within a company that is within the restrictions–trying to understand personal preferences, behavioral barriers, personal preferences compared with actual limitations provided by a treating physician.

Table 5 (Continued)
Sample Ethical Dilemmas

Forensic
F.1.a
1. Lack of proper disclosure. Failure to identify in a report if the counselor has met with the evaluee, if so through what means (in-person or telephonically) when and for how long.
2. Attorney chooses to disregard indications of brain injury for which injured worker may need treatment, but orthopedic injuries will secure big settlement for attorney and worker.
3. A client is participating in a physical rehabilitation program. The program suggests that the client shows traits associated w/ neurological deficits. The payor is informed. The payor refuses to authorize testing, as this is not related to the issue the client is being rehabilitated for. The CRC must address the client's work ability post rehabilitation program, knowing the above concerns.
F.1.c
1. Being asked to provide job leads or placement assistance to an evaluee in a forensic matter when I have been retained by the opposing party.
2. Changing roles from voc rehab counselor to forensics expert, particularly in Workers Compensation
3. Counselor attempting to serve two sources: evaluated claimant for insurance carrier, while providing services for claimant attorney. This counselor cannot represent two referral sources. This is a situation where the counselor said that because the referral sources knew about each other there was no conflict. This is a CRC.

ognized V25 (avoiding situations that may lead to romantic involvement) as the least frequent ethical dilemma encountered and V53 (dealing with fee disputes) as the least important ethical dilemma faced. The public sector group however endorsed V53 (dealing with fee disputes) as the least frequent ethical dilemma faced and V42 (representing one's own credentials or degrees) as the least important ethical dilemma encountered. These group differences in ratings regarding the least important ethical dilemmas experienced relates to the inherent difference in the duties of each group and what counselors in these various settings do and do not value in their professional roles. Further research is warranted to examine other factors that affect the values of counselors in the rehabilitation field.

Although ratings on importance and frequency of ethical dilemmas does increase our understanding of not only the nature of dilemmas that counselors in various settings face but also the way in which counselors' values perhaps differ across settings, an examination of the overall and item-by-item frequency and importance ratings between the three groups was also conducted. From this analysis we found that there were several statistically significant differences between the groups on both frequency and importance ratings by categories of the Code of Ethics. In terms of frequency ratings, there was a significant difference in how frequently the groups encountered dilemmas that fell into sections A (The Counseling Relationship), B (Confidentiality), C (Advocacy), D (Professional Responsibility) & H (Teaching, Supervision & Training) of the code. In terms of importance ratings, it was found that there is a statistically significant difference in the ratings between the three groups for dilemmas that fell under sections A, D and H of the code. Although it was outside of the scope of this study to conduct a more in-depth examination of the nature of these differences, further exploration is warranted with the goal of better understanding the nature of these group differences. Additionally, from further analysis examining the item-by-item differences in how the groups rated each question in terms of importance and frequency, we found that there were statistically significant between group differences for many of the items. These differences may speak to the vast difference in the types of ethical dilemmas faced by rehabilitation counselors and may also demonstrate a lack of consistency in perceived frequency and importance between the three groups of rehabilitation professionals. Additionally, these findings speak to the ambiguous nature of ethical decision making where similar situations can be interpreted quite differently by different people.

In terms of the actual dilemmas that were endorsed by the participants across the three groups, there was a vast difference in what sections of the CRCC Code of Ethics they came from. Not surprisingly, the forensic rehabilitation counselors seemed to encounter a significant percentage of dilemmas that fell under Section F (Forensic and Indirect Services) of the code. For both the private sector group and the forensic rehabilitation counselors more than 40% of their respective dilemmas fell under this section of the code, where the endorsed dilemmas fell most frequently un standard F.1.a (Client and Evaluee Rights). The highest percentage of endorsed dilemmas fell under section A for the public sector participants, with the highest percentage falling under standard A.5.d. (Roles and Rela-

tionships with Clients). Even though there were only a handful of reported dilemmas that fell under section F for the public sector participants, there were still just as many dilemmas that fell under standard F.1.a for this group than for any other singular standard in the entire code.

These break downs are not surprising however, as many counselors in the public sector tend to operate in more of a traditional counselor-client role than does someone in the private sector or a forensic practitioner therefore it is logical that the majority of their dilemmas involve this traditional working relationship. Additionally, participants in the forensic and private sector groups will more likely be engaged in work dealing with 3rd party payers and managing the interests and expectations of other involved parties and thus it's no surprise that the majority of their dilemmas fall under the section of the code that addressed their unique work environments.

Limitations

The findings from this study should be viewed and applied within the context of the following limitations. The first and perhaps most significant limitation is related to the instrumentation used in this study, specifically the measurement of the ethical dilemmas experienced by participants. Not all of the sections of the CRCC Code of Ethics were included in the instrument. Specifically, Section I- Research and Publication, Section J– Technology and Distance Counseling and Section L– Resolving Ethical Issues were not included in the ethical dilemmas survey. The first author recently developed the survey in collaboration with other faculty/researchers and therefore no psychometric data is available for this instrument. This was only the second time this instrument has been utilized for ethical dilemmas research.

A second limitation is low statistical power. When completing the item by item statistical analysis the authors noticed increase in Type I errors. Utilizing an instrument with 42 Likert-type questions resulted in low statistical power (less than .80). In order to mitigate this limitation the authors corrected the p values using the Holm-Bonferoni sequential method to reduce type I errors. Having a larger sample size in a future study would reduce the Type I error rate and improve item reliability.

An additional limitation is the lack of generalizeability inherent in the nature of qualitative research. This was an exploratory study and, therefore, qualitative methods served as a way to delve deeper into a topic that has had only a minimal amount of prior research. The data collected was obtained via self-report which is also understood as a potential threat to validity. It is widely acknowledged that individuals will respond in socially desirable ways when faced with self-report measures. As such, these types of measures are prone to response bias and inferences about correlational and causal relationships could potentially be inflated. According to Donaldson and Grant-Vallone (2002), participants tend to under-report behaviors deemed inappropriate by researchers or other observers, and they tend to over-report behaviors viewed as appropriate (p.247). Being that the current study is in regards to ethical dilemmas, the researchers must take into account the limitations of self-report.

Conclusion

The nature and frequency of ethical dilemmas experienced by rehabilitation counselors and, more specifically, those experienced by forensic rehabilitation counselors is a topic that is of paramount importance to the profession of rehabilitation counseling. Although it has been established that forensic rehabilitation counselors practice in a capacity that is different from traditional rehabilitation counselors, minimal consideration has been given to the diversity of ethical dilemmas that these practitioners encounter in their professional roles. The inclusion of Section F in the 2010 CRCC Code of Ethics was the rehabilitation counseling field's first attempt to address the differing nature of ethical dilemmas that forensic rehabilitation counselors are likely to face in their work.

This study was the first of its kind to specially examine the nature and frequency of ethical dilemmas experiences by both traditional rehabilitation counselors, in both the private and public sectors, and forensic rehabilitation counselors. Findings from this study revealed that there were significance differences for reported frequency and importance ratings between all three groups of rehabilitation counselors. Furthermore, a significant proportion of the ethical dilemmas experienced by rehabilitation counselors in the public and private sectors fell under sections A (The Counseling Relationship) and B (Confidentiality) of the Code while the vast majority of ethical dilemmas faced by forensic rehabilitation counselors fell under section F (Forensic and Indirect Services) of the Code. Although findings from this study speak to the fact that forensic rehabilitation counselors and traditional rehabilitation counselors both encounter and perceive ethical dilemmas in different fashions, further study is warranted to address the various dynamics that underlie this process as well as to further explore the applicability of section F of the CRCC Code.

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