**Module Introduction**

Hello dear students! Welcome to rehabilitation counseling course of department of special Needs and Inclusive Education, University of Gondar. Rehabilitation counseling is one of the most important courses in the Special Needs and Inclusive Education field of study. This module is an excellent introduction to the field of rehabilitation counseling but can also help update practicing professionals to new, cutting edge information.

As you know well, in different school settings in particular and in different environmental settings where you will go you will find a number of people with special needs. And, therefore, you need to have an ample and adequate knowledge and skills in rehabilitation counseling. That is why; this module was deliberately made to fulfill these all needs of yours. Thus the context of the profession is viewed in a holistic and comprehensive manner. To get well in to the module you need to go through the module thoroughly starting from chapter one to chapter three.

Dear students, as a matter of fact that your active involvement and engagement is needed in this course, you need to work out all the chapters` activities against the chapters. You can also further go to searching of other relevant reference materials and media outlets.

Finally, wishing you all the best to your stay with the material we will expect reach reading of yours on it.

**Module objectives**

**General Objective**

The general objective of the course is to equip students with the basic concepts, knowledge, skills and practices of rehabilitation counseling.

**The specific objectives**

After completing of the course students are expected to:

* Understand the basic concepts of rehabilitation counseling
* Know the essential elements of rehabilitation counseling
* Analyze the different theories of rehabilitation counseling
* Recognize the code of ethics of professionals of rehabilitation counselors
* Develop the basic knowledge and skills of rehabilitation counseling

**CHAPTER ONE**

1. **REHABILITATION COUNSELING**

**Chapter Introduction**

Dear students in the chapter of rehabilitation counseling you will learn about different points in rehabilitation counseling such as;concepts of rehabilitation andof rehabilitation counseling , history and background regarding the professionalization of rehabilitation counseling; and policy and legal bases, the philosophy of Rehabilitation Counseling, knowledge and skill required from rehabilitation counselor, different models of rehabilitation practice, Paradigms of rehabilitation practice, Practice the rehabilitation process and counselor functions and it also includes standards of practice and ethics.

Therefore if you exerted your effort as much as possible we would like to note you that you will get much more out of it.

**Chapter Learning Objectives:**

**At the end of this chapter students are expected to:**

* Define the rehabilitation concept;
* Understand the concept and paradigms of Rehabilitation Counseling;
* Identify the history and background regarding the professionalization of rehabilitation counseling;
* Value the philosophy of Rehabilitation Counseling
* Analyze thoroughly the knowledge and skill from rehabilitation counselor;
* Know the different models of rehabilitation practice;
* Paradigms of rehabilitation practice;
* Practice the rehabilitation process and counselor functions;
* Understand the law and policy of rehabilitation counseling;

**Chapter Activities**

1. Define rehabilitation in your own understanding and compare with the definitions given in this module?
2. Define rehabilitation counseling in your own understanding and compare with the definitions given in this module?
3. What do you think by models of disability mean?
4. Discuss the importance of disability models vis-a-vis the practice of rehabilitation counseling?
5. What international laws and policies of rehabilitation counseling do you know? List and discuss its practice in our country?
   1. **Concepts and Paradigms of Rehabilitation and Rehabilitation Counseling**

Dear students, rehabilitation is a robust concept, used in diverse contexts, referring to the restoration of persons, places, or things. In each of these varied contexts, there is an implied connotation of a return to a state of health or useful and constructive activity. As a concept, *rehabilitation* *counseling* is not as robust, nor is it as generally understood. This concept is, however, used to refer to a profession and to a scope of practice within health care and human service delivery systems. Beginning this discussion with definitions is critical in order to provide a language by which the concepts and paradigms of rehabilitation counseling may be articulated more clearly as both a profession and practice.

Definitions for the following terms are proposed. These terms provide an infrastructure for this and subsequent discussions. Therefore, it is important to first understand each definition independently, then to further consider each definition in relation to the others. There will then be better understanding of the direct, but complex, relationships linking the terms and of the importance of a shared language for the profession.

Rehabilitationis defined as “a holistic and integrated program of medical, physical, psychosocial, and vocational interventions that empower a person with disability to achieve a personally fulfilling, socially meaningful, and functionally effective interaction with the world” (Banja, 1990, p. 615). Rehabilitation within the context of the rehabilitation counseling process is “a comprehensive sequence of services, mutually planned by the consumer and rehabilitation counselor, to maximize employability, independence, integration, and participation of persons with disabilities in the workplace and the community” (Jenkins, Patterson, & Szymanski, 1991, p. 2).

Rehabilitation counselingis defined “as a profession that assists persons with disabilities in *adapting* to the environment, assists environments in *accommodating* the needs of the individual, and works toward full participation of persons with disabilities in all aspects of society, especially work” (Szymanski, 1985, p. 3). Rehabilitation counseling, as a *scope of* *practice*, is defined as: a systematic process which assists persons with physical, mental, developmental, cognitive, and emotional disabilities to achieve their personal, career, and independent living goals in the most integrated setting possible through the application of the counseling process. The counseling process involves communication, goal setting, and beneficial growth or change through self-advocacy, psychological, vocational, social, and behavioral interventions. The specific techniques and modalities utilized in the rehabilitation counseling process may include, but are not restricted to:

* Assessment and appraisal
* Diagnosis and treatment planning
* Career (vocational) planning
* Individual and group counseling treatment interventions
* Case management, referral, and service coordination
* Program evaluation and research
* Interventions to remove environmental, employment, and attitudinal barriers
* Consultation services
* Job analysis, job development, and placement services, including assistance with reasonable accommodations
* Provision of consultation about and access to rehabilitation technology (Commission on Rehabilitation Counselor Certification, 1994, pp. 1–2)

Dear students, the field of rehabilitation counseling is thus defined as a specialty within the rehabilitation professions, with counseling at its core, and is differentiated from other related counseling fields. Rehabilitation counseling is a profession, but it is also a practice that has evolved within the context of changing legislative mandates, societal perspectives, and technological and medical advances. Clearly defined terminology, and those concepts and paradigms that operationalize the terms, are critical to developing an understanding of this profession and its practice. Therefore, definitions of terms are provided throughout the text; Appendix A of the book provides a listing of acronyms commonly used in rehabilitation, as a reference to expand a shared language.

Once the rehabilitation counselor has a clear respect for and understanding of the philosophy of rehabilitation, the concept of disability, their own role and scope of practice, and a systematic paradigm to guide that practice, it is possible to revisit and further describe the rehabilitation concept. Maki (1986) operational zed the rehabilitation philosophy, defining the rehabilitation concept in terms of a comprehensive, individualized process, prescriptive in nature and directed toward the development or restoration of functional independence and QOL. Traditionally, VR defines functional independence in terms of economic self-sufficiency; independent living rehabilitation defines it in terms of community integration and autonomous living. Both VR and independent living rehabilitation programs increasingly include QOL indices in their definitions of successful outcome.

The following represent the key elements in understanding the concept of rehabilitation:

* ***It is comprehensive in scope and holistic in nature.***The rehabilitation process is an orderly sequence of activities related to the total needs of the individual. Although comprehensive services will differ from client to client, certain basic dimensions are relevant to understanding the total person. The most significant dimensions include the medical, psychological, personal–social, cultural, educational, vocational, and spiritual. To understand the client or to provide services relating to only one dimension of the person’s life functioning, without considering the other aspects and their interdependency, would be ineffective and could result in the ultimate failure of the rehabilitation effort. Effective rehabilitation thus often demands the coordinated efforts of a multidisciplinary or interdisciplinary team. The rehabilitation counselor is an integral member of this team.
* ***It is an individualized process.***Each person is unique in terms of skills, residual capacities, functional limitations, resources, and personality. The manifestations of disability present themselves differently in each individual, with varying meanings and implications for rehabilitation, depending on the environmental context. Rehabilitation is considered a process based on the needs and assets of each individual client. Rehabilitation counselors must continually be aware of the pitfalls of labeling and stereotyping. Various authors (Feist-Price, 1995; Nathanson, 1979) have noted that counseling professionals are not immune to bias or prejudice regarding disability and must be aware of their own attitudes and expectations.
* ***It is prescriptive in nature.***That is to say, a prescriptive course of action is developed with each individual. The type and number of services provided are based on the needs and characteristics of the individual. The services are selected that will remove, reduce, or compensate for the functional and societal limitations of the individual, so that they can achieve the goals established in the individualized plan. Environmental accommodations and modifications must be considered, as well as client development and adaptation.
* ***It functions to develop or restore*.** *Habilitation* is the term denoting the development or acquisition of skills and functions previously not attained. This term is used commonly to refer to the service of persons with disabilities who, because of lack of training or experience, are initially developing their functional independence. *Habilitation* refers to an initial learning of skills and roles that allow an individual to function in society. *Rehabilitation* refers to the restoration or reacquisition of skills and functions lost through injury, disease, or trauma; the term is used here, as well as throughout the text, to describe either process resulting in functional independence.
* ***Its goal is functional independence and a QOL*.** Functional independenceis the capacity of individuals to take care of their affairs to the extent that they are capable. Functional independence is a broad goal: Subsumed under the goal are economic self-sufficiency, as well as personal, social, and community living skills (Morris, 1973). It also reflects the individualized nature of the definition of success and functioning. Functional independence considers the total individual in all their environments.

A QOL (Quality of Life) perspective on rehabilitation counseling integrates competing program goals, such as client independence or employment, into a higher order, multidimensional rehabilitation outcome. Counselors committed to a QOL orientation work from a wellness and holistic position, which addresses both the development and adaptation of the individual and the accommodations that environments can achieve, where the person lives, learns, works, and recreates. QOL is directly applicable to the longstanding question of how to define successful outcomes in rehabilitation. Rehabilitation professionals continue to disagree about whether the primary goal of rehabilitation is promoting client independence or vocational placement. QOL offers a higher-order goal that subsumes both independence and employment as legitimate outcomes (Roessler, 1990).

**1.2. Historical Background of Rehabilitation Counseling**

Dear students everything has its own historical account. So does rehabilitation counseling. Hereafter we will be looking at the historical account of rehabilitation counseling. Truly, across a person’s lifespan, disability can happen at any time. Disabilities may be physical, sensory, cognitive, developmental, and/or related to mental health or other health related conditions. Disabilities may be present at birth or happen as a result of illness, disease, accident, military service, and/or ongoing stress.

People with disabilities often feel isolated from the world going on around them, whether injured in a motor vehicle or industrial accident, experiencing a debilitating condition resulting from a disease, or born with a birth defect. When someone is disabled, they need help overcoming certain barriers.

Rehabilitation counseling is the link between someone with a disabling condition and everyday functioning in the world. It focuseson helping people who have disabilities achieve their personal, career, and independent living goals through a counseling process. The service can be delivered at rehabilitation centers, hospitals, universities, schools, government agencies, insurance companies and other organizations where people are being treated for congenital or acquired disabilities.

The service encompasses every disabling situation, and works with every type of disability, including behavioral and emotional disabilities, disabilities caused by war, and those resulting from conditions such as muscular dystrophy, cerebral palsy, and Down syndrome, etc..

The rehabilitation counseling profession has undergone significant changes since its inception in the 1920’s. According to Rubin and Roessler (2001), rehabilitation counseling emerged as a distinct profession in 1920 with the passage of the Smith-Fess Vocational Rehabilitation Act, which deals with the establishment of the federal-state Vocational Rehabilitation (VR) program. Its main focus was civilians with physical disabilities. However, two or three years back, in 1917 and 1918, there were Smith Hughes Act – established for federal vocational education for dislocated industrial workers during World War I; and Soldier Rehabilitation Act for World War I veterans respectively. Accordingly, the US government has established Veteran’s Bureau in 1921.

Similarly, Commission on Rehabilitation Counselor Certification (2012) noted that early roots of the rehabilitation counseling profession date back to the 1920’s and are grounded in serving American veterans who returned from World War I with disabilities and injured agricultural/industrial workers. While rehabilitation professionals continued to serve individuals with disabilities through the 1930-40’s, rehabilitation counselingbegan to first establish its identity as a profession with the passing of the Vocational Rehabilitation Act of 1950 and the Vocational Rehabilitation (VR) Amendments of 1954. These important pieces of legislation underscored the importance of, and established the foundation for, service provision for individuals with disabilities. Specifically, they provided for the development and expansion of vocational rehabilitation services and established the availability of federal funding for critical rehabilitation counseling programs.

Historically, rehabilitation counselors primarily served working-age adults with disabilities. Today, the need for rehabilitation counseling services extends to persons of all age groups who have disabilities. Rehabilitation counselors also may provide general and specialized counseling to people with disabilities in public human service programs and private practice settings.

Initially, rehabilitation professionals were recruited from a variety of human service disciplines, including public health nursing, social work, and school counseling. Although educational programs began to appear in the 1940s, it was not until the availability of federal funding for rehabilitation counseling programs in 1954 that the profession began to grow and establish its own identity.

As indicated in Rubin and Roessler (2001), the training provision of the Vocational Rehabilitation Act Amendments of 1954 (PL 565) further spur the profession by allocating funding for the development of widespread master’s level rehabilitation counseling training programs. This training provision, along with the research and demonstration provision of PL 565 provided a strong foundation for the professionalization of rehabilitation counselors.

As a result of emerging service delivery trends, the expansion of knowledge areas, the counselor licensure movement, legislative mandates, and the growing diversity of settings in which the practice of rehabilitation counseling takes place, rehabilitation counselors must necessarily broaden the scope of their own knowledge in order to continue the provision of effective rehabilitation counseling services to their clients.

**1.3. Philosophy of Rehabilitation Counseling**

Dear students as you know very well every field of study has its own philosophy by which the professional working in it will be professionally guided by. Hence, as special needs educators when you are trying to help counseling people with special needs and others you need to know very well the philosophy of Rehabilitation Counseling.

Here after the points you are going to read is taken from <http://counseling.sfsu.edu/sites/sites7.sfsu.edu.counseling/files/Foundations%20of%20Rehabilitation%20Counseling.pdf>. If you develop an interest to read more you can click on the above website.

Philosophy of rehabilitation counseling: within the passage of the 1973 Rehabilitation Act Amendments emphasizing services to people with severe disabilities, the philosophy of rehabilitation has evolved from an economic \_return philosophy to a disability rights received considerable attention, particularly in recent years, in field of vocational rehabilitation. The demand for consumerism was first reflected in the legislative arena with the passage of the 1973 Rehabilitation Act Amendments, when consumer involvement was mandated in the rehabilitation planning process.

The traditional hierarchical counseling structure, where the counselor occupies the power position, is generally perceived by consumers as detrimental to the optimal rehabilitation of people with disabilities. Active participation by both consumers and counselors is viewed as the most viable alternative to the traditional helping relationship. This evolved philosophy of rehabilitation emphasizes consumer involvement and empowerment, which should lead consumers to take more responsibility and ownership in their vocational rehabilitation program.

Within the disability rights context, the goals of rehabilitation have been identified as: (a) inclusion, (b) opportunity, (c) independence, (d) empowerment, (e) rehabilitation, and (f) quality life. Both rehabilitation professionals and consumers generally accept the notion that the goals of the rehabilitation process can be better achieved when there is maximum consumer involvement in the development, implementation, and use of vocational rehabilitation services. The concept of consumer informed choice is intended to maximize the involvement of consumers in their vocational rehabilitation programs. Rehabilitation counselors assist consumers in exercising informed choice throughout the vocational rehabilitation process by (a) providing consumers with information pertaining to various options (e.g., job development service providers, vocational evaluation service providers, IPE development), (b) providing recommendations and professional opinions, and (c) providing consumers with information concerning the policies and procedures on service provision (e.g., comparable benefits, licensure and accreditation of service providers).

Let’s also see another extended elaboration on the philosophy of rehabilitation counseling on the following consecutive paragraphs:

The philosophy of rehabilitation is premised by a belief in the dignity and worth of all people. It values independence, integration and the inclusion of people, with and without disabilities, in employment and in their communities. Rehabilitation embodies the philosophy that, whenever possible, persons with disability will be integrated into the least restrictive environments. Inherent in this philosophy is a commitment to equalizing the opportunities for persons with disabilities to participate in all rights and privileges available to all people and to providing a sense of equal justice, based on a model of accommodation. In advocacy activities, in order to enable them to achieve independence and thus further empower themselves.

Simultaneously, with in this philosophy there is commitment to models of service delivery that emphasize integrated, comprehensive services that bare mutually planned by the consumer and the rehabilitation counselor. The philosophy of rehabilitation advocates consumer choice and empowerment. This emphasis service to define the philosophy of rehabilitation as one that is existential; that is, as people seek to make meaning out of their lives and become more self aware, they take on increased responsibility for, and ownership of , their choices and behaviors, in the face of an uncertain future. Full consideration must be given to the individual’s right to success as well as failure, as optional outcomes involved with choice, growth, and risk.

Embodied with this philosophy is the principle of informed consent. Informed consent has two central aspects: the first is disclosure and awareness of all pertinent information that the client needs to make a decision; the second aspect is possessing free consent engages in an activity or intervention, without coercion. Underlying the requirement of informed consent is the view of the client as autonomous being who is able to direct their own life (Welfel, 2002). The philosophy of rehabilitation embraces a person’s right to choose their relationships and goals, both personal and vocational.

The philosophy of rehabilitation is a solution focused and stresses the asset of the person and the resources of their environment. Individuals conceptualized as interacting within multiple contexts of life, especially within the contexts of their family and culture. The focus is on adaptation and accommodation, from an ecological perspective that is directed toward achieving a meaningful quality life (QOL) for the person with a disability. Disability and the philosophy of rehabilitation are different in various cultures. Therefore, each of these concepts must be defined and understood within the cultural context. Levers and Maki (1995) proposed the following definition of ethno rehabilitation and suggest the importance of this concept to a rehabilitation philosophy:

Ethno rehabilitation is an eco\_systemic, praxiological construct which acknowledges the comprehensive nature of persons with disabilities through functional relationship their respective cultures and in person /community appropriate interaction with their environments. It seeks to establish a holistic prescription for a quality of life that entails consideration of biomedical, psychological, personal, social, educational, and vocational dimensions through spiritual dialects at the individual, familial, community and cultural levels. This view simultaneously permits an existential, holistic, and ecological perspective, which is attentive to the spiritual dimensions of the person and the reflective of the environmental dialectic. It argues for a culturally specific sensitivity to the individual/environmental confluence. It is embedded in the temporal reality of the person’s existence and draws meaning from the multiple dimensions of the person/community interface. The ultimate measure of the attainment of this perspective is the ethical respect paid to the person at the personal, clinical, community, cultural, and metaphysical levels. It results in a philosophy of empowerment considerate of the feelings, rights, and behaviors of individuals their communities, and their environments, and mindful of their interactions.

1.4. **Paradigms of Rehabilitation Counseling**

Dear students while you get yourself into the body of literatures about paradigms of rehabilitation counseling for sure you will get a number of paradigms. However, in this module we have tried to present you some of these paradigms. Enjoy reading. A conceptual model proposed by Hershenson (1990) provides a rationale for distinguishing rehabilitation counseling from the other helping disciplines involved in rehabilitation, such as medicine or psychology. This system of categories considers rehabilitation from the perspective of primary, secondary, and tertiary prevention of disability:

* ***Primary prevention***is characterized by the provision of interventions directed toward preventing the onset of disease or disability. Professionals from such fields as public health and occupational health and safety have traditionally provided primary prevention.
* ***Secondary prevention***is characterized by the provision of interventions directed toward preventing or, when that is not possible, limiting the effects of the disease or disability in persons, when primary prevention has failed. Professionals from medicine, psychology, and similar curative fields have traditionally provided this level of prevention.
* ***Tertiary prevention***is characterized by activities directed toward preventing long-term residual conditions from having any greater disabling effects than necessary, once the secondary prevention fields have done all they can do to cure or limit the disease/disabling process. Professionals from rehabilitation counseling and allied fields have traditionally provided tertiary prevention.

Hershenson (1990) described how the attention given to the individual and to the environment differs at each level. Primary prevention, for example, is heavily weighted toward the environment (e.g., drinking water supply, worksite safety, automobile seat belts) and considers individuals only insofar as that environment affects them. Secondary prevention is heavily weighted toward the individual (e.g., curing or limiting the pathology that exists within the individual) and examines the environment only insofar as it facilitates or impedes the curative process within the individual. Tertiary prevention differs from both of the other categories of prevention, in that it requires an equally balanced focus on both the environment and the individual. This dual focus is necessary, because disability may stem as much from environmental barriers as from individual limitations.

Rehabilitation as a tertiary intervention can be viewed as a process of addressing specific goals with therapeutic interventions. The tripartite model of intervention (Livneh, 1995) builds on Hershenson’s earlier work, and identifies three phases or components of rehabilitation intervention. Embedded within the broader model of therapeutic interventions, these three components are 1) disability minimization, as an effort to reduce its impact upon life activities; 2) skill development, as an attempt to compensate for limitations caused by permanent losses; and 3) environmental manipulations to promote physical, psychosocial, and social-attitudinal accessibility.

The paradigms derived from the three categories of prevention provide a basis for understanding and distinguishing the roles of the multiple disciplines that are part of the interdisciplinary rehabilitation process. Each level is represented by a discipline such as public health, medicine/ psychology, and rehabilitation counseling. Each discipline and each level is different from the others in its basic science, focus, strategy for intervention, and goals. All disciplines have a unique and important contribution to make in the rehabilitation endeavor.

**1.5. The Rehabilitation Process and Counselor Functions**

Historically, persons with disabilities have received services through a delivery system containing the following ordered components: intake, assessment, services, and outcomes. This generic model accommodates the interdisciplinary nature of rehabilitation. A model presented by Maki et al. (1979) provides a framework for describing this rehabilitation process. This sequence does not represent the delivery of supported employment and disability management services. In addition, these services must be provided ethically by qualified rehabilitation counselors.

Dear students, the client’s entry into the rehabilitation service delivery system typically begins with intake. Here, administrative decisions are made regarding the client’s eligibility for services, based on predetermined criteria, such as age, qualifying disability, location of primary residence, or financial status. If the client is determined to be ineligible or does not qualify for the program, there is an appeal process available to the client, such as the Client Assistance Program (CAP) in the state–federal VR program. If the client is determined to be eligible, the client begins an individualized assessment. Accurate and effective assessment is a prerequisite to successful rehabilitation planning. Assessment is designed to determine the client’s current level of functioning, the goal of rehabilitation, and what services are required to achieve the goal(s). The assessment results in the Individual Written Rehabilitation Plan (IWRP).

The client and rehabilitation counselor work together in assessment and plan development, using the skills of problem solving and resource analysis. Included in the plan are the necessary services to assist the client in attaining the specified outcomes, along with a listing of who will provide these services and a timeline for completion or review. The counselor and client must mutually establish the goals to be accomplished within the parameters of the practice setting, which may occur in a public agency, a nonprofit program, or a private for-profit organization. The practice setting will also affect the range of functions and tasks that are to be performed by the rehabilitation counselor.

The rehabilitation counselor performs four essential functions in the delivery of services to persons with disability: counseling and case management in working with the client, and consultation and advocacy in working with their significant others and environments impacting the person. Technology is a strategy for working with both the individual and the environment. Services are selected that will allow the client to achieve their goals, such as acquiring skills and behaviors appropriate for the designed outcomes.

Services provided to the individual by the rehabilitation counselor are generally either in the area of case management or counseling services. *Case management* has been defined by Moxley (1989) as a client-level strategy for promoting the coordination of human services. He refers to a case manager as “a designated person (or team) who organizes, coordinates, and sustains a network of formal and informal supports and activities designed to optimize the well-being and functioning of people with multiple needs” (p. 17). The case manager identifies appropriate providers and facilities, while ensuring that the resources are being used in a timely and cost-effective manner. Mullahy (1995) refers to case management as a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services to meet an individual’s health needs, using communication and available resources to promote quality, cost-effective outcomes (p. 9).

Two typical areas case-managed by the rehabilitation counselor are education and restoration services. Education is usually a service for clients who lack the skills or knowledge necessary to reach their longor short-term goal(s) and the objectives outlined in their individual rehabilitation plan. Education may be formal or informal and generally lies outside the scope of practice of the rehabilitation counselor. Restoration services are usually prescribed when the counselor sees that there is a need for enhancing the physical functioning of an individual: Prosthetics, work hardening, or speech therapy are examples of these services. As with education, these services are often coordinated or managed by the rehabilitation counselor, because they lie outside the counselor’s scope of practice.

*Counseling* is a therapeutic or psycho educational service. This service is provided by the rehabilitation counselor within the relationship and parameters of the agency, organization, or facility in which a particular counselor functions. In the performance of this function, the rehabilitation counselor selects an individual, group, or family counseling theory to guide this aspect of their practice. In chapter 8, Chan et al. discuss the importance of evidenced based best practices, based on research in the provision of effective, accountable counseling services. No matter where or what other functions and responsibilities are engaged in by the rehabilitation counselor, counseling is the central function that is provided continuously throughout the rehabilitation process. G. N. Wright (1980) stated that counseling is: A non-transferable obligation of the rehabilitation counselor. Consultant and Rehabilitation services of other kinds may/should be purchased, but the ultimate professional responsibility for the function of counseling cannot be delegated. Professional counseling is indispensable to the proper selection provision, and utilization of the other rehabilitation services. (p. 55)

Herbert, in chapter 16 discusses the importance of clinical supervision, both in the pre-service development of counseling competence and in the maintenance of counseling competency over the course of a rehabilitation counselor’s career.

Services provided by the rehabilitation counselor directed toward the environment are consultation and advocacy, when those environments and persons in them are relevant to the success of the client’s plan. Moxley (1989) describes both of these functions as environmental interventions and indirect services, because they do not involve direct contact with the client. As such, they involve activities and interventions that are implemented with persons and systems external to the client. These serve as a means to achieve the plan, build the capacities of the systems to respond to the needs of the client, and provide access to resources (Steinberg & Carter, 1983).

*Consultation* is a function through which the counselor engages in “the process of environmental restructuring and requires consultation with the client’s family, employer, and community” (Hershenson, 1990, p. 275). Lynch, Habeck, and Sebastian (1995) discuss the key skills, knowledge, and ethical and professional issues relevant to consultation by rehabilitation counselors. The following discussion of consultation is based on their work. Brown, Pryzwansky, and Schulte (1995) conceptualize consultation as an indirect service provided to a consultee. This service may be formal, with a contract, or more informal in nature. Consultation is frequently interdisciplinary, with the consultant either being internal to the organization or external from it. External consultants are more often readily viewed as experts, but may lack important background information that would be more accessible to an internal consultant. Consultation may occur as *expert consultation* or *process consultation*. Kurpius and Fuqua (1993) distinguish these two forms of consultation. In expert consultation, the consultant is responsible for the design, implementation, and success of the intervention. In process consultation, the consultant works in active partnership with the consultee, to design and implement change. Here the success of the intervention is shared between the consultant and the consultee.

Consultation may focus on primary, secondary, or tertiary prevention.Each of these foci may be targeted to individuals, groups, organizations, or communities. Primary prevention consultation focuses on such areas as enhanced communication, decision making, and coping. Secondary prevention consultation occurs in areas such as job-enrichment programs or remediation of learning disabilities. Tertiary prevention focuses on reducing the impact of functional limitations (Brown et al., 1995). *Advocacy*, as discussed in chapter 10 by Liu and Toperek, is the action a counselor takes in assisting clients to achieve their goals through participating in their environments. They discuss how advocacy has a role in the other functions (counseling, case management, and consultation). Teaching clients to become self-advocates is another important aspect of this process. In all cases, changing environments for growth and development is the goal. Sosin and Caulum (1983) argue that advocacy involves the use of influence or confrontation to get a third party to make a decision regarding the welfare of the client, who has less power than the decision maker. The rehabilitation counselor, in this way, represents the client to the decision makers.

The final component of the service delivery system is *outcome*. During this stage, placement and follow-up occur. As discussed in chapter 12, “Placement,” the rehabilitation counselor may perform these activities, or the client may be referred to a professional who specializes in these functions. In addition to the state–federal VR program’s employment criterion of success coded as Status 26 or successfully placed in a job for 90 days, other outcomes related to independent living and QOL are valued criteria of success in contemporary rehabilitation practice.

Counselors are both direct and indirect service providers, and the manner in which they manage their time and activities contributes significantly to the efficiency and effectiveness of the rehabilitation process. As discussed by Cassell and Mulkey in chapter 14, counselors need to develop caseload management practices that result in effective allocation of time and services across all their client and work responsibilities. Finally, Crimando, in chapter 17, describes the role of administration in the service delivery system.

**1.6. Knowledge and Skill Domain of Rehabilitation Counseling**

Students who are preparing to work as rehabilitation counselors are expected to demonstrate a body of different professional knowledge and skills necessary to address a wide variety of circumstances within the rehabilitation counseling context.

The below points on knowledge and skills were taken from <http://www.cacrep.org/wp-content/uploads/2014/01/Clinical-Rehabilitation-Counseling-Standards.pdf>.

Dear students now let’s see those bodies of knowledge and skills expected from a rehabilitation counselor as put here in below:

**A. Knowledge**

1. Understands the history, philosophy, and trends in rehabilitation counseling.

2. Understands ethical and legal considerations specifically related to the practice of rehabilitation counseling.

3. Understands the roles and functions of rehabilitation counselors in various practice settings and the importance of relationships between counselors and other professionals (e.g., medical and allied health professionals), including interdisciplinary treatment teams.

4. Understands the implications of environmental, attitudinal, and individual barriers for people with disabilities.

5. Knows the professional organizations, preparation standards, and credentials relevant to the practice of rehabilitation counseling.

6. Understands a variety of models and theories related to rehabilitation counseling.

7. Understands methods, models, and principles of clinical supervision.

8. Is aware of professional issues that affect rehabilitation counselors (e.g., independent provider status, expert witness status, forensic rehabilitation, access to and practice privileges within managed care systems).

9. Understands a wide range of rehabilitation service delivery systems (e.g., housing, independent living, case management, public benefits programs, educational programs, public/proprietary vocational rehabilitation programs).

10. Understands the management of rehabilitation services and programs, including areas such as administration, finance, benefit systems, and accountability.

11. Understands the impact of crises, disasters, and other trauma-causing events on people with disabilities.

112. Understands the operation of an emergency management system within rehabilitation agencies and in the community.

**B. Skills and Practices**

1. Demonstrates the ability to apply and adhere to ethical and legal standards in rehabilitation counseling.

2. Applies knowledge of disability policy, financing, and regulatory processes to improve service delivery opportunities in rehabilitation counseling.

3. Demonstrates an integrated personal theory of rehabilitation counseling.

The knowledge and skills that are expected from the RC could be in specific areas of customers needing different counseling service. Such as follows:

1. **Medical and Psychosocial Aspects of Disability Required Knowledge**

1. Understands how disability affects the human body, including relevant medical terminology.

2. Understands the onset, progression, expected duration, and functional limitations specific to the client’s disability from a holistic perspective (i.e., physical, spiritual, sexual, vocational, social, relational, and recreational).

3. Understands how assistive technology can reduce or eliminate barriers and functional limitations.

4. Knows relevant social science theory that addresses psychosocial aspects of disability.

**Required Skills**

1. Applies the principles and practices of rehabilitation counseling concerning issues such as etiology, diagnosis, treatment, and referral for clients with disabilities, including clients with co-occurring disabilities.

2. Demonstrates appropriate use of assistive technology principles to enhance client quality of life.

**B. Counseling, Prevention and Intervention**

**Required Knowledge**

1. Describes the principles of rehabilitation, including prevention, intervention, consultation, education, and advocacy, as well as the operation of programs and networks that promote wellness in a multicultural society.

2. Knows the models, methods, and principles of program development and service delivery (e.g., support groups, peer facilitation training, parent education, self-help).

3. Understands the range of rehabilitation service delivery—such as inpatient, outpatient, community-based care—and the rehabilitation counseling services network.

4. Understands the principles of crisis intervention for people with disabilities during crises, disasters, and other trauma-causing events.

5. Knows the principles, models, and documentation formats of bio psychosocial case conceptualization and treatment planning.

6. Recognizes the importance of family, social networks, and community in the provision of services for and treatment of people with disabilities.

7. Understands professional issues relevant to the practice of rehabilitation counseling.

**Required Skills**

1. Uses disability-related principles and practices of diagnosis, treatment, referral, and wellness to initiate, maintain, and terminate counseling.

2. Applies multicultural competencies to rehabilitation counseling.

3. Applies effective strategies to promote client understanding of and access to a variety of community-based resources.

4. Demonstrates the ability to use procedures for assessing dangerousness and developing a safety plan.

5. Applies current record-keeping standards related to rehabilitation counseling.

6. Demonstrates the ability to recognize his or her own limitations as a rehabilitation counselor and to seek supervision or refer clients when appropriate.

**C. Diversity, Advocacy and Accommodation**

**Required Knowledge**

1. Understands how living in a multicultural society affects clients seeking rehabilitation counseling services.

2. Understands the implications of concepts such as internalized oppression and institutional racism, as well as the historical and current political climate regarding immigration and socioeconomic status for people with disabilities.

3. Understands the effects of discrimination—such as handicapism, ablism, racism, sexism—and power, privilege, and oppression on one’s own life and career and those of clients.

4. Understands current literature that outlines approaches, strategies, and techniques shown to be effective when working with specific populations of clients with disabilities.

5. Understands effective strategies to support client advocacy and influence public policy and government relations on local, state, and national levels to enhance equity, increase funding, and promote programs that affect the practice of rehabilitation counseling.

6. Knows public policies on the local, state, and national levels that affect the quality and accessibility of rehabilitation services.

**Required Skills**

1. Maintains information regarding community resources to make appropriate referrals for clients with disabilities.

2. Advocates for policies, programs, and services that are equitable and responsive to the unique needs of clients with disabilities.

3. Demonstrates the ability to modify counseling systems, theories, techniques, and interventions to make them culturally appropriate for people with disabilities.

4. Consults with and educates employers, educators, and families regarding accessibility, and accommodations.

5. Provides community education to increase awareness and understanding of rehabilitation counseling and disability culture.

**D. Assessment and Diagnosis**

**Required Knowledge**

1. Knows the principles and models of assessment, case conceptualization, theories of human development, and concepts of wellness and pathology leading to diagnoses and appropriate counseling treatment plans.

2. Understands various models and approaches to clinical evaluation and their appropriate uses with clients with disabilities, including diagnostic interviews, mental status examinations, symptom inventories, psycho educational and personality assessments, career assessments, and assessment for assistive technology needs.

3. Understands basic classifications, indications, and contraindications of commonly prescribed medications so that appropriate referrals can be made for medication evaluations and so that the side effects of such medications can be identified.

4. Identifies standard screening and assessment instruments that are psychometrically appropriate for people with disabilities.

5. Knows the principles of the diagnostic process, including differential diagnosis, and the use of diagnostic tools, such as the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD).

6. Understands the established diagnostic criteria and describes treatment modalities and placement criteria within the continuum of care.

7. Knows the effect of co-occurring disabilities on the client and family.

8. Understands the relevance and potential biases of commonly used diagnostic and assessment tools with multicultural populations.

**E. Research and Evaluation**

**Required Knowledge**

1. Understands how to critically evaluate research relevant to the practice of rehabilitation counseling.

2. Knows models of program evaluation for rehabilitation programs.

3. Knows evidence-based treatments and basic strategies for evaluating counseling outcomes in rehabilitation counseling.

**Required Skills**

1. Applies relevant research findings to inform the practice of rehabilitation counseling.

2. Develops measurable outcomes for rehabilitation counseling programs, interventions, and treatments.

3. Analyzes and uses data to increase the effectiveness of rehabilitation counseling interventions and programs.

**F. Career/Vocational**

**Required Knowledge**

1. Understands career theory and labor market information for people with disabilities across the lifespan.

2. Knows the importance of career exploration and use of job placement strategies for people with disabilities.

3. Knows the importance of transferable skills and functional assessments in achieving successful employment and retention for people with disabilities.

4. Understands work-related supports to help people with disabilities obtain and maintain employment.

**Required Skills**

1. Applies career theory and labor market information when working with people with disabilities across the lifespan.

2. Demonstrates skill in conducting career exploration and job placement for people with disabilities.

3. Applies transferable skills and functional assessments based on client work history to obtain and maintain successful employment.

When summarizing those necessary knowledge and skills expected from a rehabilitation counselor the below points were found worthwhile to be taken from <http://www.mymajors.com/career/rehabilitation-counselors/skills/>

**Important knowledge expected from Rehabilitation Counselor**

* Psychology: knowledge of human behavior and performance; individual differences in ability, personality and interests; learning and motivation; psychological research methods; and the assessment and treatment of behavioral and affective disorders
* Therapy and counseling: knowledge of principles, methods and procedures, treatment and rehabilitation of physical and mental dysfunctions. and for career counseling and guidance
* Education and training: knowledge of principles and methods for curriculum and training design, teaching and instruction for individuals and groups, and the measurement of training effects.
* Customer and personal service: knowledge of principles and process for providing customer and personal service. This includes customer needs assessment, meeting quality standards for services and evaluation of customer satisfaction
* Personal and human resources: knowledge of principles and procedures for personnel recruitment, selection, training, compensation and benefits, labor relations and negotiation, and personnel information systems.
* English language: Knowledge of the structure and content of the English language including the meaning and spelling of words, roles and composition and grammar.
* Administration and management: Knowledge of business and management principles involved in strategic planning, resource allocation, human resource modeling, leadership technique, production methods and coordination of people and resources
* Sociology and anthropology: Knowledge of Group behavior and dynamics, societal trends and influences, human migrations, ethnicity, cultures and their history and origins.
* Public safety and security: Knowledge of relevant equipment, policies, procedures, and strategies to promote effective local, state, or national security operations for the protection of people, data, property and institutions.
* Law and government : knowledge of Laws, legal codes, court procedures, precedents, government, regulations, executive order, agency roles and the democratic political process.
* Transportation: Knowledge of principles and methods for moving people or goods by air, rail, sea, or road, including the relative costs and benefits.
* Clerical: Knowledge of administrative and clerical procedures and system such as word processing, managing files and records, stenography and transcription, designing forms and other office procedures and terminology.
* Medicine and Dentistry: Knowledge of the information and techniques needed to diagnose and treat human injuries, diseases, and deformities. This includes systems, treatment alternatives, drug properties and interactions and preventive health care measures.
* Philosophy and theology: Knowledge of different philosophical systems and religions. This includes their basic principles, values, ethics, ways of thinking , customs, practices, and their impact on human culture
* Mathematics: Knowledge of arithmetic, algebra, geometry, calculus, statistics, and their applications.

**Important skills expected from Rehabilitation Counselor**

* Active listening: giving full attention to what other people are saying, taking time to understand the points being made, asking questions as appropriate, and not interrupting at inappropriate times.
* Speaking: Taking to others to convey information effectively
* Social perceptiveness Being aware of others’ reactions and understanding why they react as they do.
* Coordination : Adjusting actions in relation to others actions
* Monitoring: Monitoring/assessing performance of yourself, other individuals, or organizations to make improvements or take corrective actions
* Critical thinking: using logic and reasoning to identify the strengths and weaknesses of alternative solutions, conclusions or approaches to problems
* System analysis: determines how a system should work and how changes in conditions, operations and the environment will affect outcomes.
* Time management: managing one’s own time and the time of others
* Reading comprehension: understanding written sentences and paragraphs in work related documents
* Writing: communicating effectively in writing as appropriate for the needs of the audience
* Instructing: teaching others how to do something
* Service orientation: Actively looking for ways to help people
* Complex problem solving: identifying complex problems and reviewing related information to develop and evaluate options and implement solutions.
* Operations analysis: Analyzing needs and product requirements to create a design
* Judgment and decision making: considering the relative cost and benefits of operational actions to choose the most appropriate one
* Persuasion: persuading others to change their minds or behavior
* Negotiation: Bringing others together and trying to reconcile differences
* System evaluation: Identifying measures or indicators of system performance and the actions needed to improve or correct performances relative to the goals of the system
* Management of personnel resources: motivating, developing, and directing people as they work, identifying the best people for the job Science: using scientific roles and methods to solve problems.

**1.7. Policy and Law of Rehabilitation Counseling**

The practice of rehabilitation counseling has been influenced by numerous professionalism issues, rehabilitation agency priorities, federal legislation, and federal program initiatives. The priorities and mandates of federal disability legislation, and the implementation policies that have been established, have resulted in an implicit, yet significant impact on the professional practice of rehabilitation counseling.

Numerous articles discussing the role and functions (practice) of rehabilitation counselors in various work settings verify the diversity and uniqueness of rehabilitation counseling practice (Kuehn, 1991; Leahy, Szymanski, & Linkowski, 1993; Parker&Syzmanski, 1998; Rubin&Roessler, 2001; Smart, 2001). These articles frequently identify new skill and knowledge competencies or expanding responsibilities for counselors, and generally reflect the functions that counselors perform and the employment settings in which they work. This chapter, however, focuses on the general factors that influence rehabilitation counseling practice, which are related to agency priorities and policies, the problems in defining the term *disability*, professionalization issues, mandated legislation versus roles and functions per se, and challenges for rehabilitation counseling practice in the future. It is important to understand how changing legislative priorities and political issues have determined the various parameters that impact the scope of rehabilitation services, employment settings, populations to be served, advocacy efforts, and intervention strategies to be utilized. Further, influences on professional practice must be examined from the perspective of the events and decisions that have occurred over time, that is, a series of transitional factors involving change, rather than discrete priorities or laws that suggest simple directions and parameters for rehabilitation counseling practice.

Earlier chapters reviewed the history and philosophies that have formed the foundation of the profession of rehabilitation counseling; however, some important historical influences and service delivery priorities need to be revisited briefly, to understand the issues and limitations that policies and laws have created for service provision. Evidence of these influences on rehabilitation counseling practice can be seen most clearly in the differing interpretations of the term *disability*, the types and purposes of different government agencies and programs, and the emphases identified in federal legislation (E. Berkowitz, 1992; Sales, 2002; Scotch, 2000). These factors have all had an indirect and implied impact on rehabilitation counseling practice, although the broad scope and intent of both public and not-for-profit vocational rehabilitation (VR) services have been clearly articulated and addressed in the professional literature.

**1.8. Work Settings and Areas of Specialty of Rehabilitation Counseling**

Dear, students’ rehabilitation counselors are legally permitted to work in a certain specified work areas. The following ones are the lists of these areas.

Rehabilitation counselors work across many employment settings, both in the public and private sectors.

* Business & Industry
* Centers for Individuals with Developmental Disabilities
* Colleges & Universities
* Community Rehabilitation Programs
* Corrections Facilities
* Independent Living Facilities
* Insurance Companies
* Schools
* Medical Centers
* Mental Health Centers/Psychiatric Facilities
* Native American & Alaskan Community Work Programs
* Rehabilitation Hospitals
* Private Rehabilitation Companies *(for-profit and not-for-profit)*
* Private Practice/Self-Employed
* State Rehabilitation Agencies
* Veterans Benefits Administration
* Veterans Health Administration
* Workers’ Compensation Agencies

According to Commission on Rehabilitation Counselor Certification (2012, 4), given the broad range of expert services needed to facilitate independent living, there are many areas of specialty within the field of rehabilitation counseling. Though they are not exhaustively listed and universally agreed, the following are some of the **areas of specialty** of rehabilitation counseling:

* **Business Relations**

Developing partnerships with business to meet employment needs with qualified candidates with disabilities, support retention of employees who acquire a disability, and provide disability awareness training overall.

* **Career Counseling**

It is counseling people with disabilities on career choices, accommodations, and their rights as employees. Many times, people feel stuck in their careers. perhaps their work may not be as satisfying as they once felt, or maybe they're too stressed and don't feel able to handle their busy lifestyles. Or maybe they're just looking to try something different.

For those undergoing career changes, or starting their first careers, this time of transition is often a challenging period where they must reexamine skills and abilities, and get in touch with what it really is they want to do in life.

Fortunately for those undergoing this transition, career counselors exist to assist these individuals to analyze their skills, evaluate potential careers, and develop decision-making abilities that will lead them to their new professions.

Career counselors help people to gain awareness of personal skills and values, generate career and educational options, clarify, set, and meet reasonable goals, and cope with career challenges and transitions.

To effectively meet the needs of clients, career counselors must express competency in 11 different areas:

1. **Career development theories** - Includes counseling techniques and theories related to the growth and development of human life.
2. **Individual and group counseling** - Includes working with clients to establish goals, and identifying methods of achieving those goals.
3. **Skills and personality assessment** - Includes assessing interests and personality, and interpreting that data into a career role.
4. **Job information and resources** - Includes knowledge of the job market, and advice and tips when searching for jobs.
5. **Career program management** - Includes designing career programs that meet the needs of clients.
6. **Coaching and consultation** - Includes mentoring and coaching employees at career centers.
7. **Working with diverse populations** - Includes developing programs that meet the needs of diverse populations, such as the handicapped or disabled.
8. **Supervision** - Includes monitoring other staff members or seeking supervision, recognizing limitations.
9. **Knowledge of ethical issues and laws** - Includes adherence to career counseling ethical codes provided by the National Board of Certified Counselors, National Career Development Association, and the American Counseling Association.
10. **Research and Evaluation** - Includes conducting research on effective career counseling methods.
11. **Usage of technology** - Includes helping the client use various computer-based systems for job searches.

* **Cognitive Rehabilitation**

Remediation of cognitive deficits and how best to manage in interpersonal situations. Cognitive disabilities include traumatic brain injuries (TBI), autism spectrum disorders, and learning disorders, and may cause impairments in the cognitive processes of attention, memory, self-awareness, and executive functioning.

* **Employee Assistance Program**

Partnering employees with community members to help solve work-life issues, from counseling services to financial services.

* **Forensics**

Developing cases that are based on injury, quality of life, and/or a person’s ability to return to work in any capacity and/or providing expert testimony in cases where injury or disability is in question.

* **Independent Living Services**

Providing a range of services that support an individual living as independently as possible within their community. This includes keeping someone in their home and transitioning them from an institutional setting or care facility into the community. Areas of service and support include advocacy, housing, transportation, medical support, finances, benefits planning, etc.

* **Job Development/Job Placement**

Assisting in finding appropriate work environments based on skills and interests; working with employers to understand an applicant’s strengths, and; working to eliminate barriers through accommodation and consultation.

* **Life Care Planning**

Working with medical professionals to recommend supports, treatment, and protocol, with associated costs, for disabled individuals with chronic or multiple severe disabilities so they may lead a productive life.

* **Marriage & Family Counseling**

Assisting individuals, couples, and families in improving or enhancing interpersonal relationships.

* **Mental Health Counseling**

Assisting individuals in achieving greater independence and better quality of life through psychiatric rehabilitation services.

* **Return-To-Work Coordination**

Supporting the transition and adjustment of employees as they return to work after injury or illness through accommodations and counseling.

* **Student Disability Services**

Removing accessibility and environmental barriers in school environments to promote student success.

* **Substance Abuse/Addictions Counseling**

Developing treatment plans to help individuals with abstinence, gain independence, and develop a sense of self-worth through employment.

* **Teaching, or Rehabilitation Counseling Education**

Training professional rehabilitation counselors to assist persons with disabilities using counseling, advocacy, and assistive technology to optimize individual functioning, self-direction, participation, economic self-sufficiency, and quality of life.

* **Transition from School to Work**

Working closely with the school, the student, and their family to provide vocational support to students who are leaving school supports and who might otherwise be unable to seek employment on their own. Services provided may include training programs, job tryouts, interest evaluations, counseling, and developing sustainability plans.

* **Veteran’s Vocational Rehabilitation**

Developing a comprehensive, holistic, individualized plan that reduces or eliminates disability-related barriers allowing veterans to achieve employment and independent living goals that support a smooth transition into the community and self-sufficiency.

* **Vocational Evaluation**

Assessing and administering appropriate assessment tools; evaluating interests, aptitudes and barriers, and; developing and summarizing action plans through work, housing, and medical recommendations.

* **Vocational Rehabilitation**

Developing a comprehensive, holistic, individualized plan that reduces or eliminates disability-related barriers allowing the individual to achieve employment and independent living goals that support self-sufficiency.

**1.9. Important Duties and Qualities of Rehabilitation Counselor**

Dear, students any profession needs quality rendering services to its customers. So does rehabilitation counseling. It is to mean that rehabilitation counselors are expected to give quality service to their clients. That is what you are going to read here. Through a comprehensive and unique counseling process, rehabilitation counselors help individuals with disabilities set and achieve their personal, career, and independent living goals. They are the bridge between the person and self-sufficiency, helping them to live on their own, which typically includes securing, or returning to, productive, meaningful work.

Given the breadth and depth of knowledge, skills, and services necessary to work towards independent living for individuals across a wide range of disabling conditions, rehabilitation counseling encompasses a broad range of highly-specialized services to evaluate, determine, coordinate, and manage any or all necessary services throughout the rehabilitation process.

Rehabilitation Counselors:

* Arrange for psychological, medical, and vocational assessments.
* Consult with medical and allied health professionals.
* Assess capacity for independent living and employment.
* Interpret diagnoses.
* Develop treatment plans.
* Recommend and arrange for rehabilitative services and assistive technology/accommodations.
* Provide counseling to help with social or personal problems.
* Facilitate career planning.
* Advocate modifying environmental, social, and/or attitudinal barriers.
* Work with employers and other rehabilitative professionals to identify and modify job and work tasks.
* Engage in job development and placement efforts.

The professional scope of rehabilitation counseling practice is also differentiated from an individual scope of practice, which may overlap, but is more specialized than the professional scope. An individual scope of practice is based on one's own knowledge of the abilities and skills that have been gained through a program of education and professional experience. A person is ethically bound to limit his/her practice to that individual scope of practice.

Since rehabilitation counseling is a systematic process which assists persons with disabilities to achieve their personal, career, and independent living goals in the most integrated setting possible through the application of the **counseling process**, the counseling process involves communication, **goal setting**, and beneficial growth or change through **self-advocacy,** psychological, vocational, social, and behavioral **interventions**.

Rehabilitation counseling is a specialized segment of the counseling profession which focuses on working with persons with disability.  This specialized knowledge of disabilities, chronic illness and environmental factors differentiates rehabilitation counselors (RCs) from other types of counselors. RCs work directly with persons with a disability to support the movement from medical, psychological, educational, social and economic dependence to independence.  RCs often collaborate with a variety of health and human service professionals, including, physicians, nurses, therapists, attorneys, case managers, social workers, and employers, to help persons with disability reach independent living goals and improve the quality of life.

***1.10. Work Settings and Job Titles of Rehabilitation Counseling***

 Traditionally, Rehabilitation Counselors (RCs) worked in state rehabilitation agencies and community rehabilitation programs or vendors of the state rehabilitation agency.  Today, RCs are using their expertise to work in a variety of settings to assist persons with disability. As mentioned earlier, they can be found working in: the state vocational rehabilitation agency, community rehabilitation programs, public and private not-for-profit community agencies, hospitals, private rehabilitation firms, residential and outpatient rehabilitation facilities, independent living centers, elementary and secondary school settings, colleges and universities, correctional facilities & half-way houses.

 Depending on the setting, RCs may have different **job titles**:

* Vocational rehabilitation counselor
* Case manager
* Disability advocate
* Transition specialist
* Substance abuse counselor
* School counselor
* College counselor/advisor

The specific **techniques** and **modalities** utilized within this rehabilitation counseling process may include, but are not limited to:

* assessment and appraisal
* diagnosis and treatment planning
* career (vocational) counseling
* individual and group counseling treatment interventions focused on facilitating adjustments to the medical and psychosocial impact of disability
* case management, referral, and service coordination
* program evaluation and research
* interventions to remove environmental, employment, and attitudinal barriers
* consultation services among multiple parties and regulatory systems
* job analysis, job development, and placement services, including assistance with employment and job accommodations
* the provision of consultation about and access to rehabilitation technology

The following definitions are provided to increase the understanding of certain key terms and concepts used in the Scope of Practice Statement for Rehabilitation Counseling.  
**Appraisal:** Selecting, administering, scoring, and interpreting instruments designed to assess an individual's aptitudes, abilities, achievements, interests, personal characteristics, disabilities, and mental, emotional, or behavioral disorders as well as the use of methods and techniques for understanding human behavior in relation to coping with, adapting to, or changing life situations.

**Diagnosis and Treatment Planning:** Assessing, analyzing, and providing diagnostic descriptions of mental, emotional, or behavioral conditions or disabilities; exploring possible solutions; and developing and implementing a treatment plan for mental, emotional, and psychosocial adjustment or development. Diagnosis and treatment planning shall not be construed to permit the performance of any act which rehabilitation counselors are not educated and trained to perform.

Sometimes employees feel overwhelmed by the amount of work they must tackle, or develop irrational beliefs like, “Everything I do seem to be wrong. No matter how much I try, I just can't seem to do anything right.”

In order to gain a better picture of how a person reacts to certain situations, for example, and provide an overall view of a person's strengths and weaknesses, counselors often use different assessments and tests.

Personality tests are one form of assessment that gathers information on how clients work with others, and what they value in life. Two major personality assessments counselors employ include the Myers-Briggs Type Indicator and the Strong Interest Inventory.

The Myers-Briggs is useful for counselors wishing to gain an expansive insight into the interests and personality traits of clients. Clients answer a series of questions, and then counselors score their answers, assigning them one of 16 different personality types.

#### The Myers-Briggs Type Indicator

How a person answers questions on the Myers-Briggs Type Indicator reveals insight on his or her personality. The test focuses on four main areas that each has two dichotomous personality types. The following is an explanation of each area:

##### Where people focus their attention

* **Extraversion** - These people prefer to focus on people and interpersonal skills.
* **Introversion** - These people prefer to focus on inner thoughts and ideas.

##### How people take in information

* **Sensing** - These people prefer to focus on immediate concerns.
* **Intuition** - These people look toward future possibilities and see things in the “big picture.”

##### How people make decisions

* **Thinking** - These people make decisions based on logic and analysis of cause and effect.
* **Feeling** - These people tend to make decisions based on values and subjective evaluation.

##### How people deal with the outside world

* **Judging** - These people prefer an organized approach to life.
* **Perceiving** - These people prefer flexibility and spontaneity, and like to keep their options open.

**Counseling Treatment Intervention:** The application of cognitive, affective, behavioral, and systemic counseling strategies which include developmental, wellness, pathologic, and multicultural principles of human behavior. Such interventions are specifically implemented in the context of a professional counseling relationship and may include, but are not limited to: appraisal; individual, group, marriage, and family counseling and psychotherapy; the diagnostic description and treatment of persons with mental, emotional, and behavioral disorders or disabilities; guidance and consulting to facilitate normal growth and development, including educational and career development; the utilization of functional assessments and career counseling for persons requesting assistance in adjusting to a disability or handicapping condition; referrals; consulting; and research

**Referral:** Evaluating and identifying the needs of a client to determine the advisability of referrals to other specialists, advising the client of such judgments, and communicating as requested or deemed appropriate to such referral sources.

**Case Management:** A systematic process merging counseling and managerial concepts and skills through the application of techniques derived from intuitive and researched methods, thereby advancing efficient and effective decision-making for functional control of self, client, setting, and other relevant factors for anchoring a proactive practice. In case management, the counselor's role is focused on interviewing, counseling, planning rehabilitation programs, coordinating services, are interacting with significant others, placing clients and following up with them, monitoring progress, and solving problems

**Program Evaluation:** The effort to determine what changes occur as a result of a planned program by comparing actual changes (results) with desired changes (stated goals), and by identifying the degree to which the activity (planned program) is responsible for those changes.

**Research:** A systematic effort to collect, analyze, and interpret quantitative or qualitative data that describe how social characteristics, behavior, emotions, cognition, disabilities, mental disorders, and interpersonal transactions among individuals and organizations interact.

**Consultation:** The application of scientific principles and procedures in counseling and human development to provide assistance in understanding and solving current or potential problems that the counselee may have in relation to a third party, be it an individual, group, or organization. Rehabilitation counseling is often referred to as a process because of the many facets involved for an individual to become self-reliant.

The process begins with a series of consultations. Interviews are conducted with the disabled individual, and with his or her family. Rehabilitation counselors review and evaluate medical reports, any relevant school reports, and psychometric test results. Consultations are held with the patient’s psychologist, physicians, and other therapists who have been, or will need to be, involved. This includes occupational therapists, physical therapists and speech therapists, depending on the condition.

Rehabilitation counselors are also trained in referring patients to other therapists, and consulting with physicians and other health care providers. The goal of these consultations is to assess capabilities in order to develop a rehabilitation program. Sometimes mental health counseling must take place before rehabilitation counseling can begin. Teachers and employers are also brought into the discussion.

Rehabilitation counseling takes place in various settings as the process of rehabilitation progresses. Some counselors specialize in certain settings, such as inpatient care or home-based care. However, the counseling process generally begins in a hospital or other clinical setting. Counseling typically then moves to outpatient facilities, rehabilitation clinics, private offices, homes, and into a school or workplace.

#### Goals Setting

Once the initial consultations are complete and the counselor, along with any involved physicians and family members, has an understanding of the patient’s condition and potential limitations, goals are established.

The goal of rehabilitation counseling is to help these individuals overcome these barriers, assessing abilities and needs, setting goals, and helping them overcome physical, social, and emotional obstacles.

Goals are **physical**, such as being able to walk or climb stairs, or helping an individual find an accessible route to his or her job, the grocery store, doctor’s offices, and churches. They might involve helping individuals find suitable jobs, teaching them how to manage all the physical requirements of a job, or how to live independently in their own house or apartment.

Goals are also **social**, such as helping individuals facilitate friendships and developing a social life outside of family. And they are **psychological**, such as regaining a certain level of problem-solving abilities, returning to activities, or helping individuals overcome emotional obstacles.

All goals are designed to minimize impediments, and maximize opportunities for independent living, maintaining a desirable quality of life. The counselor also determines what interventions will be necessary to remove physical and social barriers for the patient’s integration back into the world. And when situations and conditions change, counselors help individuals re-establish and set new goals.

#### 1.11. Knowledge of Assistive Technology

A wide range of assistive or adaptive technologies are available in our modern society to help people with disabilities as they strive to live independently. Assistive technology, as it is commonly referred to in rehabilitation counseling, is any technology or piece of equipment used by people with disabilities to perform tasks that might not otherwise be possible.

It allows individuals with a variety of disabilities to function in the world and ideally to work, go to school, and lead independent and fulfilling lives. According to the Federation for Children with Special Needs: “Assistive technology is redefining what is possible for people with a wide range of cognitive and physical disabilities…enabling individuals with disabilities to be more independent, self-confident, productive, and better integrated into the mainstream.”

Assistive technology ranges in scope from mobility devices such as prosthetics and electric wheelchairs, to Braille scanners, telecommunication devices, or even homemade devices, and environmental adaptations such as curb ramps. It is any mechanical aid to enhance the physical or mental performance of someone with impairment, designed to facilitate independence and also general functioning, employment, communication and learning.

There is a movement by disability advocates for more universal design in technology that allows all people better access to the technologies that are so critical in our modern world. These include computerized communication devices such as text-to-speech and voice synthesis software, telecommunication devices for the deaf (TDD or TYY), keyboard adaptations including eye tracking screens, or a foot-controlled mouse.

Assistive technologies also include items such as adaptive eating utensils, wheelchair ramps, and beeping crosswalks for the visually impaired. Other types of assistive technology are specific to workplace and classroom adaptations.

To assist those with disabilities in the workplace, the landmark Americans with Disabilities Act, and more recently the 1998 Assistive Technology Act Amendment, mandated adaptations for those with disabilities in all public and federal facilities and for those employed by government agencies. The 1990 Individuals with Disabilities Education Act (IDEA) implemented similar mandates into the public education system.

One group has pointed out, however, that although the technology exists or is prescribed for a patient, research has shown that the technology may go unused or be used inappropriately if personal preference, psychosocial factors, and environmental factors are not considered. The Institute for Matching Person & Technology was formed to better match people with disabilities to the adaptive technology that is the most appropriate for them. The Institute promotes two-way learning between those affected by disabilities and rehabilitation counselors to maximize the benefits of assistive technology, including the development and selection of the technology. Through this process, disabled individuals feel more empowered and are more inclined to use the technology provided to them.

Technological adaptations might require counselors to help individuals and their families adapt to prosthetic limbs, electric wheelchairs, or adaptive computer technology, such as telecommunication devices for the deaf (TDD), or tactile maps and print enlargers for those with visual impairments.

#### 1.12. Establishing Trust between a Counselor and Client

Dear students everything has its own smooth transition. For example, people won’t converse all of a sudden at every issue. For example, they start from the greetings and go to the details. Like was the same thing works in rehabilitation counseling.

After a diagnosis has been established but before any therapy begins, the rehabilitation counselor must establish trust with his or her patient. One of the critical skills learned in a degree program in psychology is interpersonal communications.

#### Advocacy and Education

The goal of rehabilitation counseling is to help a person increase his or her capacity to live independently. Sometimes this involves serving as the patient’s advocate in the community. Recognizing barriers to independence is one of the roles of the rehabilitation counselor. Barriers can be environmental, such as a staircase in a home or other mobility issues; or attitudinal, such as a landlord’s reluctance to rent to an individual with Down syndrome.

Educating the community then becomes a part of the rehabilitation counselor’s process. This begins with the individual’s family, and spreads out to teachers, employers, neighbors, and others working in service industries. The counselor may accompany the client on his or her daily activities for weeks or months before full independence is gained.

#### Advocacy and Case Management

During the days, weeks or even months that rehabilitation takes place, the rehabilitation counselor becomes an advocate, and often a case manager. As an advocate, for example, someone living on his or her own after becoming blind or deaf will need help getting to work or the grocery store. The counselor helps bus or cab drivers become aware of the individual’s disability and needs. Employers or teachers may need to be educated about the needs of someone recovering from a brain injury or someone with a behavioral condition. Job modifications may be necessary. The patient may also need independent living assistance from a government or nonprofit social service agency. The counselor advocates for disabled individuals with the key institutions and organizations that directly interface with and provide services for the disabled individual.

Case management involves coordinating all the services, advocacy, and educational services needed to get the disabled individual living and working as independently as possible. Analogous to working as a personal assistant, the rehabilitation counselor ensures that the patient stays organized, makes and keeps appointments, and completes the required paperwork to receive any social services or financial assistance.

Rehabilitation counselors have a background in counseling theory and technique, assessment, an understanding of the psychosocial and medical aspects of disability, skills in case management and planning, knowledge of technological adaptations, and career counseling and training. They work in hospitals, private nonprofit agencies, educational settings, state and federal social assistance agencies, vocational rehabilitation agencies, correctional facilities, halfway houses, and in private practice. Besides what have been listed earlier, according to Commission on Rehabilitation Counselor Certification, the following are some of other **important qualities of rehabilitation counselors**:

* ***Communication skills.*** Rehabilitation counselors need to be able to communicate with clients effectively, expressing ideas and information in a way that is easily understood.
* ***Compassion.*** Counselors often work with people who are dealing with stressful and difficult situations, so they must be compassionate and empathize with their clients.
* ***Interpersonal skills.*** Being able to work with different types of people is essential for rehabilitation counselors, who spend most of their time working directly with clients, families, employers, or other professionals. They must be able to develop and maintain a good working relationship.
* ***Listening skills.*** Good listening skills are essential for rehabilitation counselors, who need to give their full attention to clients in order to understand their problems, concerns, and values.
* ***Patience.*** To help people learn new skills and strategies, rehabilitation counselors must have patience as clients struggle to learn about and address the impact of their disabilities.

## 1.13. Underlying Values in Rehabilitation Counseling Profession

As a profession, rehabilitation counseling demands the following values:

* Facilitation of independence, integration, and inclusion of people with disabilities in employment and the community.
* Belief in the dignity and worth of all people.
* Commitment to a sense of equal justice based on a model of accommodation to provide and equalize the opportunities to participate in all rights and privileges available to all people; and a commitment to supporting persons with disabilities in advocacy activities to achieve this status and empower themselves.
* Emphasis on the holistic nature of human function which is procedurally facilitated by the utilization of such techniques as:
  + interdisciplinary teamwork
  + counseling to assist in maintaining a holistic perspective
  + a commitment to considering individuals within the context of their family systems and communities
* Recognition of the importance of focusing on the assets of the person.
* Commitment to models of service delivery that emphasize integrated, comprehensive services which are mutually planned by the consumer and the rehabilitation counselor.

**1.14. Models of Rehabilitation Counseling**

Dear students while trying to help your clients in the first place you need to be scientific enough in terms of understanding and using the models of rehabilitation counseling. For the basic reason that models are the guiding principles as to how a professional counselor carry out his/her jobs to the best satisfaction of his/her clients.

For intentional, systematic practice to occur, rehabilitation counselors must have a conceptual model or paradigm to guide their work. It has been suggested that rehabilitation counselors have at least three orientations from which to conceptualize their teaching, research, and practice. These paradigms include the *psycho medical model*, the *systems model*, and the *ecological model* (Cottone &Emener, 1990). Each of these orientations has merit and distinguishes itself by the relative emphasis it places on the person, the environment, and the relationship between the two. After a brief discussion of the psycho medical and systems model, a more detailed description of the ecological model is presented.

**1.14.1.** **The Psycho-medical Model**

The psycho medical model looks within the individual for a diagnosis of the problem, placing the person in a one-down position, relative to the expert, typically a physician or psychiatrist. From this perspective, the person with a disability is considered a patient. The psycho-medical model represents a biomedical orientation toward the scientific representation of the person’s condition and uses diagnostic categories to administratively classify and subsequently treat the underlying cause of a person’s disability. This approach is valuable for understanding the medical and allied health professional’s contribution to the rehabilitation team. It underlies the restorative services offered in rehabilitation and is related to the secondary prevention model referred to earlier.

**1.14.2.** **The Systems Model**

Cottone and Cottone (1986) provided yet another perspective for conceptualizing rehabilitation counseling practice: the systems approach. This perspective suggests that neither the person nor the environment is the unit of analysis. The unit of analysis is in fact the relationship between the two. This perspective also suggests that focus on either the individual (psychomedical) or the individual–environment transaction (ecological) is inadequate, because the inherent nature of persons is systematic. Disability impacts all persons with a relationship to the person with disability. Focusing on and understanding these relationships with others in those environments in which persons with disabilities live, learn, work, and recreate are critical to this point of view. This perspective argues for the inclusion of family counseling and systems training in the curriculum for the development of competency in the rehabilitation counselor.

**1.14.3.** **The Ecological Model of Rehabilitation Counseling**

The Ecological Model of Rehabilitation Counseling proposed here in reflects a tertiary prevention model, with equal consideration being given to the person and to the environment (Fig. 1.1). Cottone and Emener (1990) suggested that such an approach represents an alternative to the psycho medical and systemic models. Historically, the ecological perspective on rehabilitation has emerged from a trait–factor tradition, which measures traits within the individual, as well as factors within the environment.

An evaluation is then made to determine the extent of match or congruence between traits and factors. Decisions about the probable success of a person placed in a vocational, independent living, or other environment would then be made, based on this information. This model is based on an existential philosophy. Empowered clients make meaning out of their experiences. They take responsibility and ownership for their decisions, given their increased awareness about their strengths and the demands of the options they are considering.

The Minnesota Theory of Work Adjustment (Dawis, 1996; Lofquist & Dawis, 1969) has provided an empirically valid version of the trait–factor model for VR practice. Maki, McCracken, Pape, and Scofield (1979) suggested that an ecological perspective, with a developmental orientation, transformed a trait–factor approach into a viable theoretical framework for VR. Kosciulek (1993) supported the continuing validity of this approach to contemporary practice. Lofquist and Dawis (2002) agree, describing a person–environment correspondence theory.

Basically, this Ecological Model, in consideration of individual traits and environmental factors, provides a conceptual infrastructure for the profession of rehabilitation counseling and its model of practice. The conceptual discussion that follows is assumed to apply to persons with or without disability. In addition, the model can be applied to tasks and environments other than vocational.

FIGURE 1.1. Ecological Model of Rehabilitation Counseling.



***Source: Maki and Riggar,***

A transactional approach seeking correspondence between an individual’s maximum and typical behaviors with the criterion-requirements and the reinforces and demands present in the environment. The rehabilitation counselor’s four essential functions are indicated within this model.

Instances, be compared to the environmental factors or the task criterion requirements and reinforces available in environments such as independent living, education, and recreation. Both traits and factors can be measured or assigned numbers, to indicate the extent to which each is present in the individual and the environment. To better understand this Model, this approach is briefly described.

Traits refer to the underlying characteristics that exist in people. Traits account for the observed behavioral consistencies within people and for the stable and enduring differences among people. All people are assumed to possess the same traits, but in differing amounts. Cronbach (1990) has differentiated between those traits that are indicators of *typical performance* and those that are indicators of *maximum performance*. In the process of measuring the traits of an individual, the rehabilitation counselor must infer their presence from samples of behavior, because traits cannot generally be measured directly, other than physical traits such as range of motion. The particular traits that the rehabilitation counselor decides to evaluate will depend on the purpose of the assessment.

Traits indicative of typical performance describe how a person typically behaves in situations. The behavioral consistency principle is applied here, with the assumption being made that past performance is the best indicator of future behavior. These traits include the individual’s interests, temperaments, values, and other indicators of personality. The typical behaviors are evaluated through interview, observation, and the occasional use of inventories, in other words, through the use of expressed, manifest, and test strategies. Evaluating these traits, and comparing their correspondence with potential environments, facilitates making more accurate predictions regarding a client’s probable satisfaction with the factors present in various environments. The rehabilitation counselor may predict with enhanced accuracy the person’s likelihood to remain in a particular environment, by evaluating this satisfaction. The factors against which a person’s typical behavior traits are evaluated include environmental reinforces, such as salary, advancement possibilities, and position prestige, as well as other social and interpersonal factors. Therefore, identifying the client’s needs, interests, and personality is critical, as well as the reinforces and the social/interpersonal factors that are present in environments under consideration. The extent to which factors meet specific needs will provide important data to the client for decision making.

Traits indicative of maximum performance describe a person’s capacities and capabilities. These traits include physical capacity, aptitude and achievement, and other indicators of ability. The maximum behaviors are evaluated through test, manifest, and expressed strategies. Evaluating these traits facilitates making more accurate predictions regarding the satisfactoriness of a person’s capacity to perform the essential functions and tasks required in education, employment, independent living, and other major life activities. The matching or congruence between the client’s performance and the job or task has been described as the “level of satisfactoriness.” The factors against which a person’s maximum behavior traits are evaluated include the environment’s essential and marginal functions, including physical, educational, and skill demands.

In evaluating persons’ traits, equal consideration must be made for what they want to do (typical behavior) and what they are capable of doing (maximum behaviors). Therefore, considering the person’s interests and the environment’s ability to meet these needs is critical, as is their ability to perform essential functions in the environment, in order to enhance their tenure in a given job. Although, in some instances, referral to psychologists and other professionals may be involved in this rehabilitation assessment and information gathering process, rehabilitation counselors themselves may secure this information through interview, observation, and the occasional use of inventories. The question of who secures what information is a matter of each individual professional’s scope of practice and of the available resources that define the functions performed by the staff in a particular human service or rehabilitation system.

**1.14.4.** **Ecological Adaptation Model**

The Ecological Model of Rehabilitation Counseling provides a framework for counselor practice and client decision making. This trait–factor approach does not address the psychosocial adaptation of persons with their disabilities. The rehabilitation counselor must also have a framework within which to consider the psychosocial impact of disability. The Ecological Adaptation Model (Fig. 1.2) provides such a framework and also, when considered with the Ecological Model of Rehabilitation Counseling, a more robust paradigm for understanding the profession and process of rehabilitation counseling emerges.

The Ecological Adaptation Model is informed by a social learning orientation respectful of the reciprocal nature of both persons and their environments. Scofield, Pape, McCracken, and Maki (1980) described

**FIGURE 1.2. The Ecological Adaptation Model.**



The Ecological Adaptation Model, which conceptualizes this reciprocal relationship, as (1) the nature of the individual with a disability as they interact and to various degrees adapt to various environments, and (2) the simultaneous ability of environments to accommodate persons with disability. This model highlights the importance of not only assessing traits and factors, but also the transactions that dynamically describe the interactive nature of person(s) and their environment(s). *Adaptation*, as a dynamic concept describing the extent to which a person accepts disability as one of their many characteristics, is a concept preferred to *adjustment*, because it infers a more enduring, static, and categorical description, when referring to a person’s acceptance of disability.

This Ecological Adaptation Model provides a framework for assessing the normative standards, frames of reference, and response tendencies of environments and persons within these environments, at various levels of intimacy to the person with a disability. The environmental and normative standards include cultural values, community moral code, and those policies and laws that set the standards for acceptable behavior in the environment. Persons within the environment develop frames of reference based on the normative standards by which they interpret the behavior of others. The model suggests that environmental response tendencies are based on frames of reference regarding the capacity of a person with disability to meet normative standards. The extent to which a person with disability deviates from these standards, as interpreted in the frame of reference, predisposes persons in that environment to respond to the person with disability in ways compatible with the standards. One such response tendency is *attitude*, defined as learned predisposition to respond in an evaluative manner, which is especially critical to assess, considering its potential impact. This model acknowledges that only verbal or nonverbal responses by the environment, that is, those messages and behaviors that are actually exhibited and observable, serve as stimuli to the person.

In addition to the environment, the model also requires assessment of the individual. Specifically needing to be assessed are the person with disability’s capacity to receive overt and covert messages provided by the environment, the person’s frame of reference, including self-concept and self-efficacy as a way to understand how meaning is made out of the messages received, and the person’s response tendencies, or typical interaction style in response to particular persons, environments, and the messages they send. Disability may interfere with the person’s ability to see or hear messages, to cognitively make meaning from the messages, or to establish response tendencies relative to their acceptance, or not, of disability. The manifestation of the response tendency is the actual behavior or message emitted by the person. This then serves as stimuli and sends a message to the environment that will either reinforce the normative standards or act as a catalyst for changing those standards that are inaccurate or inappropriate.

The Ecological Adaptation Model perspective also provides the rehabilitation counselor with a systematic framework for organizing and conceptualizing the complexities of their work with individuals with disabilities, in relation to those significant persons and environments, in which they live, learn, work, and recreate. This model can be considered in conjunction with self-efficacy theory, which is concerned with the personal self judgments that influence the environments that people choose, the activities in which they engage, and the effort and persistence they demonstrate at a task, in the face of obstacles.

The theory provides an overall framework to explain why some clients are successful in rehabilitation efforts and others are not. It also addresses how counselors can most effectively help clients maximize rehabilitation potential. Brodwin and Brodwin (1993) described the usefulness to the field of rehabilitation of Bandura’s work (1982) on self-efficacy. They suggest that this growing body of research related to individual response tendencies supports the hypothesis that self-efficacy beliefs are cognitive mediators of assured, purposeful, and persistent behavior. These are behaviors that need to be developed and/or increased in persons with disabilities, if they are to receive maximum benefit from the various rehabilitation systems.

Rehabilitation potential, as defined by those same authors, consists of three characteristics: (1) attaining increased functioning in the direction of maximum physical and emotional growth, (2) having a sense of wellbeing, and (3) facilitating development of a personally satisfying level of independence. Those authors also note that different rehabilitation systems (e.g., worker’s compensation, long-term disability, Social Security, state VR, independent living) define a client’s rehabilitation potential within the context of their specific organization’s parameters. Crimando and Riggar (1991) stress that counselors need to be aware of the differing requirements of each rehabilitation system providing services.

Chapter Summary

Dear students, we have now come to the end of the chapter. In the chapter as you have come through it, you have seen and hope so understood various important issues in rehabilitation counseling as an introductory portion of the course of rehabilitation counseling. Nevertheless, it was found paramount to give and explain some of the key points that you have already master in the chapter. And, therefore points that have been covered in this chapter will be highlighted in the bird’s eye view as put here next. The points were: concepts and paradigms of rehabilitation counseling, history and background of rehabilitation counseling, philosophy of rehabilitation counseling, the rehabilitation process and counselor functions, knowledge and skill domain of rehabilitation counselor, policy and law of rehabilitation counseling, work settings and areas of specialty of rehabilitation counseling, important duties and qualities of rehabilitation counseling, work settings and job titles of rehabilitation counseling, knowledge of assistive technology, establishing trust between counselor and client, underlying values in rehabilitation counseling profession and models of rehabilitation counseling.

In the end, we need to stress that, there might be points that have been missed in the chapter in terms of coverage. Despite of this fact, we would like to recommend you that to further go to other relevant reference materials which are present to your access. Thank you for doing so!

# CHAPTER TWO

**REHABILITATION COUNSELING THERAPIES**

* 1. **Chapter Introduction**

The primary goal of rehabilitation counseling is to assist clients gain or regain their wellbeing such as psychological, physical social, mental, health economical and the like. These can be manifested in clients` independence through employment or better performance in carrying out some form of meaningful activity. This goal is based on the fundamental assumption that securing meaningful wellbeing of clients helps those to become successful in their lives such as be productive members of society, establish social networks and interpersonal relations, and ultimately experience a good quality of life. While the goals of rehabilitation counseling are relatively unambiguous, the process by which rehabilitation counselors’ work with clients to achieve these goals has become increasingly diverse and complex due to the broadening scope of disability groups served, and the various settings in which rehabilitation counseling services are provided.

The rehabilitation counseling profession has undergone significant changes since its inception in the 1920’s. As a result of emerging service delivery trends, the expansion of knowledge areas, the counselor licensure movement, legislative mandates, and the growing diversity of settings in which the practice of rehabilitation counseling takes place, rehabilitation counselors must necessarily broaden the scope of their own knowledge in order to continue the provision of effective rehabilitation counseling services to their clients.

**Chapter objectives**

**General objective**

The general objective of the chapter is to develop students` comprehensive knowledge of rehabilitation counseling theories

**Specific objectives**

After the end of this chapter students will be able to:

* Understand the theories of rehabilitation counseling;
* Recognize the meaning of rehabilitation counselor;
* Know the meaning of an occupational therapist; and
* Analyze the relationship between counseling and psychotherapy

**Chapter activities**

* Define theories of rehabilitation counseling
* What is the similarity between rehabilitation counseling and occupational therapies?
* What is the difference between rehabilitation counseling and occupational therapies? and
* Elaborate the relationship between counseling and psychotherapy

**2.2. Theories of Psychotherapy and Counseling**

Dear students since the emergence of psychology as a field of study, there has been a number of issues treated with in it. As time goes psychology has shown huge progress in its branches and body of study. Now here after, we will see in detail on one aspect of psychology, i.e. theories of psychotherapy. Before, the 1950s there were relatively few theories of psychotherapy, and most were derived from Freud’s theory of psychoanalysis. Since that time there has been a marked increase in the number of theories that therapists have developed to help people with psychological dysfunctions. Corsini (2001) summarized 69 new and innovative therapies; now there may be a total of more than 400 (Corsini, 2008). Although most of these theories have relatively few proponents and little research to support their effectiveness, they do represent the creativity of psychotherapists in finding ways to provide relief for individual psychological discomfort. At the same time that there has been an increase in the development of theoretical approaches, there has been a move toward integrating theories, as well as a move toward eclecticism. Broadly, *integration* refers to the use of techniques and/or concepts from two or more theories.

Psychoanalytic theories (those closely related to the work of Freud and his Contemporaries) and psychodynamic theories (those having some resemblance to psychoanalytic theories) are a popular theoretical orientation that is subscribed to by therapists from a variety of fields. Cognitive, and to a lesser extent, behavioral methods are popular with a variety of mental health workers. There is some disagreement among studies of therapist preference for theory, due in part to ways in which questions are asked and to changing trends in theoretical preference.Including a number of significant theories provides a background from which students can develop or select their own theoretical approach. Some theories, such as psychoanalysis, have sub-theories that have been derived from the original theory. The following paragraphs present a brief, nontechnical summary of the chapters (and theories) in this book to give an overview of the many different and creative methods for helping individuals who are suffering because of psychological problems or difficulties.

* + 1. **Psychoanalysis**

Sigmund Freud stressed the importance of inborn drives (particularly sexual) in determining later personality development. Others who followed him emphasized the importance of the adaptation to the environment, early relationships between child and mother, and developmental changes in being absorbed with oneself at the expense of meaningful relationships with others. All of these views of development make use of Freud’s concepts of unconscious processes (portions of mental functioning that we are not aware of) and, in general, his structure of personality (ego, id, superego). Traditional psychoanalytic methods require several years of treatment. Because of this, moderate-length and brief therapy methods that use more direct, rather than indirect, techniques have been developed. New writings continue to explore the importance of childhood development on later personality as well as new uses of the therapist’s relationship.

* + 1. **Jungian Analysis and Therapy**

More than any other theorist, Jung placed great emphasis on the role of unconscious processes in human behavior. Jungians are particularly interested in dreams, fantasies, and other material that reflects unconscious processes. They are also interested in symbols of universal patterns that are reflected in the unconscious processes so that patients can better integrate unconscious processes

into conscious awareness.

* + 1. **Adlerian Therapy**

Alfred Adler believed that the personality of individuals was formed in their early years as a result of relationships within the family. He emphasized the importance of individuals’ contributions to their community and to society. Adlerians are interested in the ways that individuals approach living and family relationships. The Adlerian approach to therapy is practical, helping individuals to change dysfunctional beliefs and encouraging them to take new steps to change their lives. An emphasis on teaching and educating individuals about dealing with interpersonal problems is another characteristic of Adlerian therapy.

* + 1. **Existential Therapy**

A philosophical approach to people and problems relating to being human or existing, existential psychotherapy deals with life themes rather than techniques. Such themes include living and dying, freedom, responsibility to self and others, finding meaning in life, and dealing with a sense of meaninglessness. Becoming aware of oneself and developing the ability to look beyond immediate problems and daily events to deal with existential themes are goals of therapy, along with developing honest and intimate relationships with others. Although some techniques have been developed, the emphasis is on issues and themes, not method.

* + 1. **Person-Centered Therapy**

In his therapeutic work, Carl Rogers emphasized understanding and caring for the client, as opposed to diagnosis, advice, or persuasion. Characteristic of Rogers’s approach to therapy are therapeutic genuineness, through verbal and nonverbal behavior, and unconditionally accepting clients for who they are. Person-centered therapists are concerned about understanding the client’s experience and communicating their understanding to the client so that an atmosphere of trust can be developed that fosters change on the part of the client. Clients are given responsibility for making positive changes in their lives.

* + 1. **Gestalt Therapy**

Developed by Fritz Perls, gestalt therapy helps the individual to become more aware of self and others. Emphasis is on both bodily and psychological awareness. Therapeutic approaches deal with being responsible for oneself and attuned to one’s language, nonverbal behaviors, emotional feelings, and conflicts within oneself and with others. Therapeutic techniques include the development of creative experiments and exercises to facilitate self-awareness.

* + 1. **Behavior Therapy**

Based on scientific principles of behavior, such as classical and operant conditioning, as well as observational learning, behavior therapy applies principles of learning such as reinforcement, extinction, shaping of behavior, and modeling to help a wide variety of clients with different problems. Emphasis is on precision and detail in evaluating psychological concerns and then assigning treatment methods that may include relaxation, exposure to a feared object, copying a

behavior or role playing. Its many techniques include those that change observable behavior as well as those that deal with thought processes.

* + 1. **Rational Emotive Behavior Therapy**

Developed by Albert Ellis, Rational Emotive Behavior Therapy(REBT) focuses on irrational beliefs that individuals develop that lead to problems related to emotions (for example, fears and anxieties) and to behaviors (such as avoiding social interactions or giving speeches). Although Rational Emotive Behavior Therapyuses a wide variety of techniques, the most common method is to dispute irrational beliefs and to teach clients to challenge their own irrational beliefs so that they can reduce anxiety anddevelop a full range of ways to interact with others.

* + 1. **Cognitive Therapy**

Belief systems and thinking are seen as important in determining and affecting behavior and feelings. Aaron Beck developed an approach that helps individuals understand their own maladaptive thinking and how it may affect their feelings and actions. Cognitive therapists use a structured method to help their clients understand their own belief systems. By asking clients to record dysfunctional thoughts and using questionnaires to determine maladaptive thinking, cognitive therapists are then able to make use of a wide variety of techniques to change beliefs that interfere with successful functioning. They also make use of affective and behavioral strategies.

* + 1. **Reality Therapy**

Reality therapists assume that individuals are responsible for their own lives and for taking control over what they do, feel, and think. Developed by William Glasser, reality therapy uses a specific process to change behavior. A relationship is developed with clients so that they will commit to the therapeutic process. Emphasis is on changing behaviors that will lead to modifications in thinking and feeling. Making plans and sticking to them to bring about change while taking responsibility for oneself are important aspects of reality therapy.

In recent years, marriage counseling and family therapy have become a particular interest of William Glasser. Reality therapists often observe the choice systems of different family members and how they interact and connect with each other. Attention is paid not just to the shared feelings but also to the wants and values of each family member. After an assessment of wants and needs, suggestions are made to focus on doing things together to promote family harmony. However, reality therapists also recognize the need for family members to develop their life separately from other members of the family. Reality family therapists may ask the child what activities she likes and how much of the activity she is doing. This way, reality family therapists can assess how well the family relationship is meeting the child’s needs. Suggestions may be made to do activities that bring about interaction. For example, a father walking to the park with a daughter is a better activity than watching television together. Attention is paid to activities the family does as a group, as small groups, and separately so that these activities will meet needs of family members separately and together.

* + 1. **Constructivist Therapy**

Constructivist therapists see their clients as theorists and try to understand their clients’ views or the important constructs that clients use to understand their problems. Three types of constructivist theories are discussed: solution-focused, personal construct theory, and narrative. Solution-focused therapy centers on finding solutions to problems by looking at what has worked in the past and what is working now, as well as using active techniques to make therapeutic progress. Personal construct theory examines clients’ lives as stories and helps to change the story. Narrative therapies also view clients’ problems as stories but seek to externalize the problem, unlike personal construct theory. Frequently, they help clients re-author or change stories, thus finding a new ending for the story that leads to a solution to the problem.

* + 1. **Feminist Therapy**

Rather than focusing only on the individual’s psychological problems, feminist therapists emphasize the role of politics and society in creating problems for individuals. Particularly, they are concerned about gender and cultural roles and power differences between men and women and people from diverse cultural backgrounds. They have examined different ways that gender and culture affect development throughout the life span (including social and sexual development, child-raising practices, and work roles). Differences in moral decision making, relating to others, and roles in abuse and violence are issues of feminist therapists. By combining feminist therapy with other theories, feminist therapists take a sociological as well as a psychological view that focuses not only on gender but also on multicultural issues. Among the techniques they use are those that help individuals address gender and power inequalities not only by changing client behavior but also by changing societal groups or institutions.

The approach is not on how to help the unfortunate woman who has been mistreated by a “bad” man. Rather, feminist therapists look at political and social factors that provide insight into how family members react to each other. The focus is not on attaching blame or rescuing people but on how gender and power issues affect clients. Feminist therapists are aware of how their own gender can affect their work with different family members, depending on their gender-role expectations and stereotypes. Information may be given about gender role, language usage, and other related activities. Feminist therapists also attend to issues of cultural and racial identity. They may integrate gender-role and power interventions with other theoretical approaches. Approaches to family therapy are often quite different from each other. Psychoanalytic family therapists may emphasize early relationships of both children and parents in their work. Adlerians may focus on relationships of siblings and family members as well as the need to educate. In contrast, existential therapists focus on knowing oneself and being self-aware. Person-centered therapists are empathic with their clients, while gestalt therapists attend to events happening in the therapeutic hour and are likely to use enactment activities. More structured in approach are behavioral, rational emotive behavioral and cognitive therapists, whose assessments may be quite systematic along with their interventions into the behaviors and thoughts of families. Although emphasizing doing, as behavior therapists do, reality therapists focus on meeting individual needs and wants and on the different choices that family members make.

In contrast to all of these approaches, feminist family therapists look at the impact of society on the family and the internalization of gender and power roles. None of these approaches examines the family as a system in the way that Bowen, Minuchin, Haley, Whitaker, and Satir do. These therapists focus more on the family as one system than as a group of individuals. Brief family therapists also see the family as a system, but they may conduct fewer sessions than other family systems therapists and their interventions may be quite unusual or powerful. By attempting to make interventions in a short period of time, innovators of brief family systems therapy have developed approaches that are practical, clear as to method, and related to the presenting problem. However, they desire to produce not just temporary change in the family to solve a pressing problem, *first-order* *change*, but a lasting change in the family system, *second-order change*. Because these approaches use powerful interventions, they often use therapy teams, some members of which observe behind a one-way mirror and may enter the therapy room, on occasion, or confer with the therapist during a break in the session.

* + 1. **Family Therapy**

Whereas many theories focus on the problems of individuals, family therapists attend to interactions between family members and may view the entire family as a single unit or system. Treatment is designed to bring about change in functioning within the family rather than within a single individual. Several different approaches to family therapy have been developed. Some focus on the impact of the parents’ own families, others on how family members relate to each other in the therapy hour and yet others on changing symptoms. Some family systems therapists request that all the family members be available for therapy, whereas others may deal with parents or certain members only. Almost all of the theories in this book can be applied to families.

* + 1. **Integrative Therapy**

Integrative therapists combine two or more theories in different ways so that they can understand client problems. They may then use a wide variety of techniques to help clients make changes in their lives. Prochaska and Norcross’s transtheoretical approach examines many theories, selecting concepts, techniques, and other factors that effective psychotherapeutic approaches have in common. Their model for therapeutic change examines client readiness for change, level of problems that need changing, and techniques to bring about change. Paul Wachtel’s cyclical psychodynamics combines psychoanalysis and behavior therapy, as well as some other theories. Arnold Lazarus’s multimodal therapy uses techniques from many theories to bring about client change but uses social learning theory as a way to view personality.

# 2.3. The Difference and Similarities between Rehabilitation Counselor and an Occupational Therapist

The following discussions present only few points about the similarities and differences between rehabilitation counselor and an occupational therapist only in some contexts. It is not a comprehensive discussion on the issues.

As mentioned by Bolden, occupational therapists and rehabilitation counselors treat the same client population – people who are permanently or temporarily disabled through injury or illness. They also help clients cope with mental, emotional, social and physical problems, including substance abuse and depression. Their goal is to get clients with disabilities living as independently as possible. Occupational therapists and rehabilitation counselors evaluate clients' abilities and follow up with customized treatment plans. They're often members of a treatment team of physicians, nurses, social workers and psychologists.

Occupational therapists and rehabilitation counselors access resources and equipment for clients, including medical services, eating aids, wheelchairs, computers and others. Preparing clients for the workplace is one of their chief responsibilities. They often meet with employers to recommend appropriate accommodations and plan work schedules and activities for their clients.

Occupational therapists help disabled people gain or recover everyday life skills. Rehabilitation counselors help disabled people overcome physical and emotional impairments that interfere with daily functions, including the ability to work. These avocations perform functions that aren't always distinguishable. But based on the U.S. Bureau of Labor Statistics' job descriptions, rehabilitation counselors advise and advocate for the disabled, while occupational therapists teach practical, hands-on skills.

Occupational therapists teach clients how to handle daily activities, from budgeting finances and managing time to performing household tasks and taking public transportation. They work with clients on overcoming alcoholism, drug addiction, depression and mental disorders. Occupational therapists might teach computer skills to an older person with memory loss or show chronic-pain sufferers how to do stretching exercises to relieve their symptoms. Occupational therapists also show clients how to use wheelchairs, knee braces, eating aids and other devices. They work with adults and children in hospitals, mental health facilities and physicians' offices.

But rehabilitation counselors advise clients, families and employers on what to expect from, and how to adjust to, the challenges of living and working with a disability. Rehabilitation counselors give disabled students advice on how to make the transition from school to work. Some teach veterans coping skills for handling the physical and mental stresses of military life. Others help older people adapt to the physical or mental disabilities that occur later in life from illnesses or injuries. Since rehabilitation counselors focus on helping the disabled prepare for employment, they usually don't work with young children. Rehab counselors work for hospitals and mental health facilities, and others are in private practice.

Chapter Summary

There are different types of rehabilitation counseling theories. These include: psychoanalysis, Judean analysis and therapy, Adlerian therapy, Existential therapy, Person-centered therapy, Gestalt therapy, Behavior therapy, Rational Emotive Behavior Therapy, Cognitive therapy, Reality therapy, Constructivist therapy, Feminist therapy, Family therapy and Integrative therapy. Occupational therapists and rehabilitation counselors treat persons with special needs; those individuals may be people who have permanent or temporary social, economical, psychological, physical, behavioral and other disorders and disabilities through injury and illness. Occupational therapists help people with disability to gain or recover everyday life skills. Rehabilitation counselors help people with disability to overcome physical and emotional impairments that interfere with daily functions, including the ability to work.

**CHAPTER THREE**

**3. CODE OF PROFESSIONAL ETHICS FOR REHABLITATION COUNSELOR**

**Introduction**

Dear students as you know very well in any field of study there are professional code of conduct. For example, in business, law, teaching, sporting activities and so and so forth. Likewise, in the field of psychology mainly in the field of counseling there is professional code of ethics for rehabilitation counselors by which they will be governed and abided by. Hence, in this chapter you will be highly introduced with the professional code of ethics for rehabilitation counselors.

**Chapter Objectives**

**General objective**

After the end of this unit students will be able to:

* Understand the code of professional ethics for rehabilitation counselor;
* Recognize the vital components of the code of professional ethics for rehabilitation counselor;
* Analyze well the conditions for the code of professional ethics for rehabilitation counselor; and
* Value the code of professional ethics while practicing rehabilitation counseling.

**Chapter Activities**

Dear students,

* What do you think is code of professional ethics for rehabilitation counselor? and
* What does think is the purpose of code of professional ethics for rehabilitation counselor?

Dear students now let’s see the code of ethics for professional counselors

Vilia M. and R. Rocco C. (2000) a code of ethics is the identifier that most directly and visibly defines a profession for its stakeholders. Scholars may point to an extensive body of academic literature, and practitioners may cling to particular clinical tools or practices. The public, legislators, and regulators, however, are most often concerned with the resolve of the profession to responsible practice and to regulation of its members as defined through a publicly presented code of ethics. This code-and the processes used to enforce it-serves as a manifesto for how the members of the profession define appropriate practice. The very act of setting down these concepts of proper and improper types of conduct creates a socially constructed understanding of the profession.

The current Code of Ethics for Professional Rehabilitation Counselors (Commission on Rehabilitation Counselor Certification, 1987; hereafter referred to as the Code) is unique historically because it performed an important function in contributing to the greater consolidation of the profession of rehabilitation counseling. it was introduced in 1987, it had been jointly developed and endorsed by the American Rehabilitation Counseling Association (ARCA). Mainly focuses on:

* Best possible level of ethical practice
* Seek out and personally adopt exemplary ethical practices of their own profession and other groups.
* Seeking to uphold the highest level of ethical practice by reflecting on the welfare of the clients served their needs, and the effects of the counselor's actions on the profession as a whole.
* rehabilitation counselors shall serve as advocates for individuals with disabilities with disabilities
* The following can be ethical violations, involving conflicts of business and professional interests, sexual misconduct with clients and/or students, fraudulent use of credentials, inappropriate personal financial gain, failure to act as a client advocate, disparaging remarks about a colleague, inappropriate billing practices, use of an illegal substance, and improper supervision techniques (Ibid)

Dear students we would like to take you in a broad and message full a code of ethics for rehabilitation counselors entitled **“**Code of Professional Ethics for Rehabilitation Counselors” developed by Commission on Rehabilitation Counselor Certification.

In this code of practice there are many sections ranging from Section A: the counseling relationship toSection B: Confidentiality, Privileged communication, and privacy**,** section C: Advocacy and accessibility , Section D: Professional responsibility **,** Section E: relationship with other professionals **,** Section F: Forensic and indirect services, Section G: evaluation, Assessment, and interpretation **,** Section H: Teaching, Supervision, and Training **,** Section I: Research and Publication **,** Section J: Technology and Distance Counseling **,** Section K: Business Practices and Section L: Resolving Ethical Issues.

Each of the sections is having their own sub titles with their own descriptions. You can get the points on <http://www.oregon.gov/dhs/vr/docs/crc-code-ethics.pdf>

Dear students now let’s see each of the sections one by one as follows:

**SECTION A: THE COUNSELING RELATIONSHIP**

**A.1. WELFARE OF THOSE SERVED BY REHABILITATION COUNSELORS**

**A. PRIMARY RESPONSIBILITY.** 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.

**B. REHABILITATION AND COUNSELING PLANS.** Rehabilitation counselors and clients work jointly in devising and revising integrated, individual, and mutually agreed upon rehabilitation and counseling plans that offer a reasonable promise of success and are consistent with the abilities and circumstances of clients. Rehabilitation counselors and clients regularly review rehabilitation and counseling plans to assess continued viability and effectiveness.

**C. EMPLOYMENT NEEDS.** Rehabilitation counselors work with clients to consider employment consistent with the overall abilities, functional capabilities and limitations, general temperament, interest and aptitude patterns, social skills, education, general qualifications, transferable skills, and other relevant characteristics and needs of clients. Rehabilitation counselors assist in the placement of clients in available positions that are consistent with the interest, culture, and the welfare of clients and/or employers.

**D. AUTONOMY.** Rehabilitation counselors respect the rights of clients to make decisions on their own behalf. On decisions that may limit or diminish the autonomy of clients, decision-making on behalf of clients is taken only after careful deliberation. Rehabilitation counselors advocate for the resumption of responsibility by clients as quickly as possible.

**A.2. RESPECTING DIVERSITY**

**A. RESPECTING CULTURE.** Rehabilitation counselors demonstrate respect for the cultural background of clients in developing and implementing rehabilitation and treatment plans, and providing and adapting interventions.

**B. NONDISCRIMINATION.** Rehabilitation counselors do not condone or engage in discrimination based on age, color, race, national origin, culture, disability, ethnicity, gender, gender identity, religion/spirituality, sexual orientation, marital status/partnership, language preference, socioeconomic status, or any basis proscribed by law.

**A.3. CLIENT RIGHTS IN THE COUNSELING RELATIONSHIP**

**A. PROFESSIONAL DISCLOSURE STATEMENT.** Rehabilitation counselors have an obligation to review with clients orally, in writing, and in a manner that best accommodates any of their limitation, the rights and responsibilities of both rehabilitation counselors and clients. Disclosure at the outset of the counseling relationship should minimally include: (1) the qualifications, credentials, and relevant experience of the rehabilitation counselor; (2) purposes, goals, techniques, limitations, and the nature of potential risks, and benefits of services; (3) frequency and length of services; (4) confidentiality and limitations regarding confidentiality (including how a supervisor and/or treatment team professional is involved); (5) contingencies for continuation of services upon the incapacitation or death of the rehabilitation counselor; (6) fees and billing arrangements; (7) record preservation and release policies; (8) risks associated with electronic communication; and, (9) legal issues affecting services. Rehabilitation counselors recognize that disclosure of these issues may need to be reiterated or expanded upon throughout the counseling relationship, and/or disclosure related to other matters may be required depending on the nature of services provided and matters that arise during the rehabilitation counseling relationship.

**B. INFORMED CONSENT.** Rehabilitation counselors recognize that clients have the freedom to choose whether to enter into or remain in a rehabilitation counseling relationship. Rehabilitation counselors respect the rights of clients to participate in ongoing rehabilitation counseling planning and to make decisions to refuse any services or modality changes, while also ensuring that clients are advised of the consequences of such refusal. Rehabilitation counselors recognize that clients need information to make an informed decision regarding services and that professional disclosure is required for informed consent to be an ongoing part of the rehabilitation counseling process. Rehabilitation counselors appropriately document discussions of disclosure and informed consent throughout the rehabilitation counseling relationship.

**C. DEVELOPMENTAL AND CULTURAL SENSITIVITY.** Rehabilitation counselors communicate information in ways that are both developmentally and culturally appropriate. Rehabilitation counselors provide services (e.g., arranging for a qualified interpreter or translator) when necessary to ensure comprehension by clients. In collaboration with clients, rehabilitation counselors consider cultural implications of informed consent procedures and, when possible, rehabilitation counselors adjust their practices accordingly.

**D. INABILITY TO GIVE CONSENT.** When counseling minors or persons unable to give voluntary consent, rehabilitation counselors seek the assent of clients and include clients in decision-making as appropriate. Rehabilitation counselors recognize the need to balance the ethical rights of clients to make choices, the mental or legal capacity of clients to give consent or assent, and parental, guardian, or familial legal rights and responsibilities to protect clients and make decisions on behalf of clients.

**E. SUPPORT NETWORK INVOLVEMENT.** Rehabilitation counselors recognize that support by others may be important to clients. Rehabilitation counselors consider enlisting the support, understanding, and involvement of others (e.g., religious/spiritual/community leaders, family members, friends, and guardians) as resources, when appropriate, with consent from clients.

**A.4. AVOIDING HARM AND AVOIDING VALUE IMPOSITION**

**A. AVOIDING HARM.** Rehabilitation counselors act to avoid harming clients, trainees, supervisees, and research participants and to minimize or to remedy unavoidable or unanticipated harm.

**B. PERSONAL VALUES.** Rehabilitation counselors are aware of their values, attitudes, beliefs, and behaviors and avoid imposing values that are inconsistent with rehabilitation counseling goals.

**A.5. ROLES AND RELATIONSHIPS WITH CLIENTS**

**A. PROHIBITION OF SEXUAL OR ROMANTIC RELATIONSHIPS WITH CURRENT CLIENTS.** Sexual or romantic rehabilitation counselor–client interactions or relationships with current clients, their romantic partners, or their immediate family members are prohibited.

**B. SEXUAL OR ROMANTIC RELATIONSHIPS WITH FORMER CLIENTS.** Sexual or romantic rehabilitation counselor–client interactions or relationships with former clients, their romantic partners, or their immediate family members are prohibited for a period of five years following the last professional contact. Even after five years, rehabilitation counselors give careful consideration to the potential for sexual or romantic relationships to cause harm to former clients. In cases of potential exploitation and/or harm, rehabilitation counselors avoid entering such interactions or relationships.

**C. PROHIBITION OF SEXUAL OR ROMANTIC RELATIONSHIPS WITH CERTAIN FORMER CLIENTS.** If clients have a history of physical, emotional, or sexual abuse or if clients have ever been diagnosed with any form of psychosis or personality disorder, mental retardation, marked cognitive impairment, or if clients are likely to remain in need of therapy due to the intensity or chronicity of a problem, rehabilitation counselors do not engage in sexual activities or sexual contact with former clients, regardless of the length of time elapsed since termination of the client relationship.

**D. NONPROFESSIONAL INTERACTIONS OR RELATIONSHIPS OTHER THAN SEXUAL OR ROMANTIC INTERACTIONS OR RELATIONSHIPS.** 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 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.

**E. COUNSELING RELATIONSHIPS WITH FORMER ROMANTIC PARTNERS PROHIBITED.** Rehabilitation counselors do not provide counseling services to individuals with whom they have had a prior sexual or romantic relationship.

**F. ROLE CHANGES IN THE PROFESSIONAL RELATIONSHIP.** When rehabilitation counselors change roles from the original or most recent contracted relationship, they obtain informed consent from clients or evaluees and explain the right to refuse services related to the change. Examples of role changes include: (1) changing from individual to group, relationship or family counseling, or vice versa; (2) changing from a forensic to a primary care role, or vice versa; (3) changing from a non forensic evaluative role to a rehabilitation or therapeutic role, or vice versa; (4) changing from a rehabilitation counselor to a researcher role (e.g., enlisting clients as research participants), or vice versa; and, (5) changing from a rehabilitation counselor to a mediator role, or vice versa. The clients or evaluees must be fully informed of any anticipated consequences (e.g., financial, legal, personal, or therapeutic) due to a role change by the rehabilitation counselor.

**G. RECEIVING GIFTS.** Rehabilitation counselors understand the challenges of accepting gifts from clients and recognize that in some cultures, small gifts are a token of respect and gratitude. When determining whether to accept gifts from clients, rehabilitation counselors take into account the cultural or community practice, therapeutic relationship, the monetary value of gifts, the motivation of the client for giving gifts, and the motivation of the rehabilitation counselor for accepting or declining gifts.

**A.6. MULTIPLE CLIENTS**

When rehabilitation counselors agree to provide counseling services to two or more persons who have a relationship (e.g., husband/wife; parent/child), rehabilitation counselors clarify at the outset which person is, or which persons are, to be served and the nature of the relationship rehabilitation counselors have with each involved person. If it becomes apparent that rehabilitation counselors may be called upon to perform potentially conflicting roles, rehabilitation counselors clarify, adjust, or withdraw from roles appropriately.

**A.7. GROUP WORK**

**A. SCREENING.** Rehabilitation counselors screen prospective group counseling/therapy participants. To the extent possible, rehabilitation counselors select members whose needs and goals are compatible with goals of the group, who do not impede the group process, and whose well-being is not jeopardized by the group experience.

**B. PROTECTING CLIENTS.** In a group setting, rehabilitation counselors take reasonable precautions to protect clients from harm or trauma.

**A.8. TERMINATION AND REFERRAL**

**A. ABANDONMENT PROHIBITED.** Rehabilitation counselors do not abandon or neglect clients in counseling. Rehabilitation counselors assist in making appropriate arrangements for the continuation of services when necessary (e.g., during interruptions such as vacations, illness, and following termination).

**B. INITIAL DETERMINATION OF INABILITY TO ASSIST CLIENTS.** If rehabilitation counselors determine they are unable to be of professional assistance to clients, rehabilitation counselors avoid entering such counseling relationships.

**C. APPROPRIATE TERMINATION AND REFERRAL.** Rehabilitation counselors terminate counseling relationships when it becomes reasonably apparent that clients no longer need assistance, are not likely to benefit, or are being harmed by continued counseling. Rehabilitation counselors may terminate counseling when in jeopardy of harm by clients or other persons with whom clients have a relationship, or when clients do not pay agreed-upon fees. Rehabilitation counselors provide pretermination counseling and recommend other clinically and culturally appropriate service sources when necessary.

**D. APPROPRIATE TRANSFER OF SERVICES.** When rehabilitation counselors transfer or refer clients to other practitioners, they ensure that appropriate counseling and administrative processes are completed in a timely manner and that open communication is maintained with both clients and practitioners. Rehabilitation counselors prepare and disseminate, to identified colleagues or records custodian, a plan for the transfer of clients and files in the case of their incapacitation, death, or termination of practice.

**A.9. END-OF-LIFE CARE FOR TERMINALLY ILL CLIENTS**

**A. QUALITY OF CARE.** Rehabilitation counselors take measures that enable clients to: (1) obtain high quality end-of-life care for their physical, emotional, social, and spiritual needs; (2) exercise the highest degree of self-determination possible; (3) be given every opportunity possible to engage in informed decision-making regarding their end-of-life care; and, (4) receive complete and adequate assessment regarding their ability to make competent, rational decisions on their own behalf from mental health professionals who are experienced in end-of-life care practice.

**B. REHABILITATION COUNSELOR COMPETENCE, CHOICE, AND REFERRAL.** Rehabilitation counselors may choose to work or not work with terminally ill clients who wish to explore their end-of-life options. Rehabilitation counselors provide appropriate referral information if they are not competent to address such concerns. **c. CONFIDENTIALITY.** Rehabilitation counselors who provide services to terminally ill individuals who are considering hastening their own deaths have the option of breaking or not breaking confidentiality on this matter, depending on applicable laws and the specific circumstances of the situation and after seeking consultation or supervision from appropriate professional and legal parties.

**SECTION B: CONFIDENTIALITY, PRIVILEGED COMMUNICATION,**

**AND PRIVACY**

**B.1. RESPECTING CLIENT RIGHTS**

**A. CULTURAL DIVERSITY CONSIDERATIONS.** Rehabilitation counselors maintain beliefs, attitudes, knowledge, and skills regarding cultural meanings of confidentiality and privacy. Rehabilitation counselors hold ongoing discussions with clients as to how, when, and with whom information is to be shared.

**B. RESPECT FOR PRIVACY.** Rehabilitation counselors respect privacy rights of clients. Rehabilitation counselors solicit private information from clients only when it is beneficial to the counseling process.

**C. RESPECT FOR CONFIDENTIALITY.** Rehabilitation counselors do not share confidential information without consent from clients or without sound legal or ethical justification.

**D. EXPLANATION OF LIMITATIONS.** At initiation and throughout the counseling process, rehabilitation counselors inform clients of the limitations of confidentiality and seek to identify foreseeable situations in which confidentiality must be breached*.*

**B.2. EXCEPTIONS**

**A. DANGER AND LEGAL REQUIREMENTS.** The general requirement that rehabilitation counselors keep information confidential does not apply when disclosure is required to protect clients or identified others from serious and foreseeable harm, or when legal requirements demand that confidential information must be revealed. Rehabilitation counselors consult with other professionals when in doubt as to the validity of an exception.

**B. CONTAGIOUS, LIFE-THREATENING DISEASES.** When clients disclose that they have a disease commonly known to be both communicable and life threatening, rehabilitation counselors may be justified in disclosing information to identifiable third parties, if they are known to be at demonstrable and high risk of contracting the disease. Prior to making a disclosure, rehabilitation counselors confirm that there is such a diagnosis and assess the intent of clients to inform the third parties about their disease or to engage in any behaviors that may be harmful to identifiable third parties.

C. **COURT-ORDERED DISCLOSURE.** When subpoenaed to release confidential or privileged information without permission from clients, rehabilitation counselors obtain written, informed consent from clients or take steps to prohibit the disclosure or have it limited as narrowly as possible due to potential harm to clients or the counseling relationship. Whenever reasonable, rehabilitation counselors obtain a court directive to clarify the nature and extent of the response to a subpoena.

**D. MINIMAL DISCLOSURE.** When circumstances require the disclosure of confidential information, only essential information is revealed.

**B.3. INFORMATION SHARED WITH OTHERS**

**A. WORK ENVIRONMENT.** Rehabilitation counselors make every effort to ensure that privacy and confidentiality of clients is maintained by employees, supervisees, students, clerical assistants, and volunteers.

**B. PROFESSIONAL COLLABORATION.** If rehabilitation of clients involves the sharing of their information among team members, clients are advised of this fact and are informed of the team’s existence and composition. Rehabilitation counselors carefully consider implications for clients in extending confidential information if participating in their service teams.

**C. CLIENTS SERVED BY OTHERS.** When rehabilitation counselors learn that clients have an ongoing professional relationship with another rehabilitation counselor or treating professional, they request release from clients to inform the other professionals and strive to establish a positive and collaborative professional relationship. File review, second-opinion services, and other indirect services are not considered an ongoing professional relationship.

**D. CLIENT ASSISTANTS.** When clients are accompanied by an individual providing assistance to clients (e.g., interpreter, personal care assistant), rehabilitation counselors ensure that the assistant is apprised of the need to maintain and document confidentiality. At all times, clients retain the right to decide who can be present as client assistants.

**E. CONFIDENTIAL SETTINGS.** Rehabilitation counselors discuss confidential information only in offices or settings in which they can reasonably ensure the privacy of clients.

**F. THIRD-PARTY PAYERS.** Rehabilitation counselors disclose information to third-party payers only when clients have authorized such disclosure, unless otherwise required by law or statute.

**G. DECEASED CLIENTS.** Rehabilitation counselors protect the confidentiality of deceased clients, consistent with legal requirements and agency policies.

**B.4. GROUPS AND FAMILIES**

**A. GROUP WORK.** In group work, rehabilitation counselors clearly explain the importance and parameters of confidentiality for the specific group being entered.

**B. COUPLES AND FAMILY COUNSELING.** In couples and family counseling, rehabilitation counselors clearly define who the clients are and discuss expectations and limitations of confidentiality. Rehabilitation counselors seek agreement and document in writing such agreement among all involved parties having capacity to give consent concerning each individual’s right to confidentiality. Rehabilitation counselors clearly define whether they share or do not share information with family members that is privately, individually communicated to rehabilitation counselors.

**B.5. RESPONSIBILITY TO MINORS OR CLIENTS LACKING CAPACITY TO CONSENT**

**A. RESPONSIBILITY TO CLIENTS.** When counseling minor clients or adult clients who lack the capacity to give voluntary, informed consent, rehabilitation counselors protect the confidentiality of information received in the counseling relationship as specified by national or local laws, written policies, and applicable ethical standards.

**B. RESPONSIBILITY TO PARENTS AND LEGAL GUARDIANS.** Rehabilitation counselors inform parents and legal guardians about the role of rehabilitation counselors and the confidential nature of the counseling relationship. Rehabilitation counselors are sensitive to the cultural diversity of families and respect the inherent rights and responsibilities of parents/guardians over the welfare of their children/charges according to law. Rehabilitation counselors work to establish, as appropriate, collaborative relationships with parents/guardians to best serve clients.

**C. RELEASE OF CONFIDENTIAL INFORMATION.** When minor clients or adult clients lack the capacity to give voluntary consent to release confidential information, rehabilitation counselors seek permission from parents or legal guardians to disclose information. In such instances, rehabilitation counselors inform clients consistent with their level of understanding and take culturally appropriate measures to safeguard the confidentiality of clients.

**B.6. RECORDS**

**A. REQUIREMENT OF RECORDS.** Rehabilitation counselors include sufficient and timely documentation in the records of their clients to facilitate the delivery and continuity of needed services. Rehabilitation counselors take reasonable steps to ensure that documentation in records accurately reflects progress and services provided to clients. If errors are made in records, rehabilitation counselors take steps to properly note the correction of such errors according to agency or institutional policies.

**B. CONFIDENTIALITY OF RECORDS.** Rehabilitation counselors ensure that records are kept in a secure location and that only authorized persons have access to records.

**C. CLIENT ACCESS.** Rehabilitation counselors recognize that counseling records are kept for the benefit of clients and therefore provide access to records and copies of records when requested by clients, unless prohibited by law. In instances where the records contain information that may be sensitive, confusing, or detrimental to clients, rehabilitation counselors have a responsibility to educate clients regarding such information. In situations involving multiple clients, access to records is limited to those parts of records that do not include confidential information related to other clients. When rehabilitation counselors are in possession of records from others sources, they refer clients back to the original source.

**D. DISCLOSURE OR TRANSFER.** Unless exceptions to confidentiality exist, rehabilitation counselors obtain written permission from clients to disclose or transfer records to legitimate third parties. Steps are taken to ensure that recipients of counseling records are sensitive to their confidential nature.

**E. STORAGE AND DISPOSAL AFTER TERMINATION.** Rehabilitation counselors store the records of their clients following termination of services to ensure reasonable future access, maintain records in accordance with national or local statutes governing records, and dispose of records and other sensitive materials in a manner that protects the confidentiality of clients.

**F. REASONABLE PRECAUTIONS.** Rehabilitation counselors take reasonable precautions to protect the confidentiality of clients in the event of disaster or termination of practice, incapacity, or death of the rehabilitation counselor*.*

**B.7. CONSULTATION**

**A. AGREEMENTS.** When acting as consultants, rehabilitation counselors seek agreement among parties involved concerning each individual’s right to confidentiality, the obligation of each individual to preserve confidential information, and the limits of confidentiality of information shared by others.

**B. RESPECT FOR PRIVACY.** Rehabilitation counselors discuss information obtained in consultation only with persons directly involved with the case. Written and oral reports presented by rehabilitation counselors contain only data germane to the purposes of the consultation, and every effort is made to protect the identity of clients and to avoid undue invasion of privacy.

**C. DISCLOSURE OF CONFIDENTIAL INFORMATION.** When consulting with colleagues, rehabilitation counselors do not disclose confidential information that reasonably could lead to the identification of clients or other persons or organizations with which they have a confidential relationship unless they have obtained the prior consent of the persons or organizations or the disclosure cannot be avoided. They disclose information only to the extent necessary to achieve the purpose of the consultation.

**SECTION C: ADVOCACY AND ACCESSIBILITY**

**C.1. ADVOCACY**

**A. ATTITUDINAL BARRIERS.** In direct service with clients, rehabilitation counselors address attitudinal barriers, including stereotyping and discrimination, toward individuals with disabilities. They increase their own awareness and sensitivity to individuals with disabilities.

**B. ADVOCACY.** 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 clients at the local, regional, and/or national levels*.*

**C. ADVOCACY IN OWN AGENCY AND WITH COOPERATING AGENCIES.** Rehabilitation counselors remain aware of actions taken by their own and cooperating agencies on behalf of clients and act as advocates for clients who cannot advocate for themselves to ensure effective service delivery.

**D. ADVOCACY AND CONFIDENTIALITY.** Rehabilitation counselors obtain the consent of clients prior to engaging in advocacy efforts on behalf of specific, identifiable clients to improve the provision of services and to work toward removal of systemic barriers or obstacles that inhibit access, growth, and development of clients.

**E. AREAS OF KNOWLEDGE AND COMPETENCY.** Rehabilitation counselors are knowledgeable about local, regional, and national systems and laws, and how they affect access to employment, education, transportation, housing, financial benefits, and medical services for people with disabilities. They obtain sufficient training in these systems in order to advocate effectively for clients and/or to facilitate self-advocacy of clients in these areas.

**F. KNOWLEDGE OF BENEFIT SYSTEMS.** Rehabilitation counselors are aware that disability benefit systems directly affect the quality of life of clients. They provide accurate and timely information or appropriate resources and referrals for these benefits.

**C.2. ACCESSIBILITY**

**A. COUNSELING PRACTICE.** Rehabilitation counselors facilitate the provision of necessary accommodations, including physically and programmatically accessible facilities and services to individuals with disabilities.

**B. BARRIERS TO ACCESS.** Rehabilitation counselors collaborate with clients and/or others to identify barriers based on the functional limitations of clients. They communicate information on barriers to public and private authorities to facilitate removal of barriers to access.

**C. REFERRAL ACCESSIBILITY.** Prior to referring clients to a program, facility, or employment setting, rehabilitation counselors assist clients in ensuring that these are appropriately accessible, and do not engage in discrimination based on age, color, race, national origin, culture, disability, ethnicity, gender, gender identity, religion/spirituality, sexual orientation, marital status/partnership, language preference, socioeconomic status, or any basis proscribed by law.

**SECTION D: PROFESSIONAL RESPONSIBILITY**

**D.1. PROFESSIONAL COMPETENCE**

**A. BOUNDARIES OF COMPETENCE.** Rehabilitation counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, professional credentials, and appropriate professional experience. Rehabilitation counselors demonstrate beliefs, attitudes, knowledge, and skills pertinent to working with diverse client populations. Rehabilitation counselors do not misrepresent their role or competence to clients.

**B. NEW SPECIALTY AREAS OF PRACTICE.** Rehabilitation counselors practice in specialty areas new to them only after having obtained appropriate education, training, and supervised experience.

While developing skills in new specialty areas, rehabilitation counselors take steps to ensure the competence of their work and to protect clients from possible harm.

**C. QUALIFIED FOR EMPLOYMENT.** Rehabilitation counselors accept employment for positions for which they are qualified by education, training, supervised experience, professional credentials, and appropriate professional experience. Rehabilitation counselors hire individuals for rehabilitation counseling positions who are qualified and competent for those positions.

**D. MONITOR EFFECTIVENESS.** Rehabilitation counselors continually monitor their effectiveness as professionals and take steps to improve when necessary. Rehabilitation counselors take reasonable steps to seek peer supervision as needed to evaluate their efficacy as rehabilitation counselors.

**E. CONTINUING EDUCATION.** Rehabilitation counselors recognize the need for continuing education to acquire and maintain a reasonable level of awareness of current scientific and professional information in their fields of activity. They take steps to maintain competence in the skills they use, are open to new procedures, and keep current with the diverse populations and specific populations with whom they work.

**D.2. CULTURAL COMPETENCE/DIVERSITY**

**A. INTERVENTIONS.** Rehabilitation counselors develop and adapt interventions and services to incorporate consideration of cultural perspective of clients and recognition of barriers external to clients that may interfere with achieving effective rehabilitation outcomes.

**B. NONDISCRIMINATION.** Rehabilitation counselors do not discriminate against clients, students, employees, supervisees, or research participants in a manner that has a negative effect on these persons*.*

**D.3. FUNCTIONAL COMPETENCE**

**A. IMPAIRMENT.** Rehabilitation counselors are alert to the signs of impairment from their own physical, mental, or emotional problems, and refrain from offering or providing professional services when such impairment is likely to harm clients or others. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until such time it is determined that they may safely resume their work. Rehabilitation counselors assist colleagues or supervisors in recognizing their own professional impairment and provide consultation and assistance when warranted with colleagues or supervisors showing signs of impairment and intervene as appropriate to prevent harm to clients.

**B. DISASTER PREPARATION AND RESPONSE.** Rehabilitation counselors make reasonable efforts to plan for facilitating continued services for clients in the event that rehabilitation counseling services are interrupted by disaster, such as acts of violence, terrorism, or a natural disaster.

**D.4. PROFESSIONAL CREDENTIALS**

**A. ACCURATE REPRESENTATION.** Rehabilitation counselors claim or imply only professional qualifications actually completed and correct any known misrepresentations of their qualifications by others. Rehabilitation counselors truthfully represent the qualifications of their professional colleagues. Rehabilitation counselors clearly distinguish between accredited and non-accredited degrees, paid and volunteer work experience, and accurately describe their continuing education and specialized training.

**B. CREDENTIALS.** Rehabilitation counselors claim only licenses or certifications that are current and in good standing.

**C. EDUCATIONAL DEGREES.** Rehabilitation counselors clearly differentiate between earned and honorary degrees.

**D. IMPLYING DOCTORAL-LEVEL COMPETENCE.** Rehabilitation counselors refer to themselves as “doctor” in a counseling context only when their doctorate is in counseling or a closely related field or is accredited by a recognized body.

**D.5. RESPONSIBILITY TO THE PUBLIC AND OTHER PROFESSIONALS**

**A. SEXUAL HARASSMENT.** Rehabilitation counselors do not condone or participate in sexual harassment.

**B. REPORTS TO THIRD PARTIES.** Rehabilitation counselors are accurate, honest, and objective in reporting their professional activities and judgments to appropriate third parties, including courts, health insurance companies, those who are the recipients of evaluation reports, and others.

**C. MEDIA PRESENTATIONS.** When rehabilitation counselors provide advice or comment by means of public lectures, demonstrations, radio or television programs, prerecorded tapes, technology based applications, printed articles, mailed materials, or other media, they take reasonable precautions to ensure that: (1) the statements are based on appropriate professional counseling literature and practice; (2) the statements are otherwise consistent with the Code; and, (3) the recipients of the information are not encouraged to infer that a professional rehabilitation counseling relationship has been established.

**D. EXPLOITATION OF OTHERS.** Rehabilitation counselors do not exploit others in their professional relationships to seek or receive unjustified personal gains, sexual favors, unfair advantages, or unearned goods or services.

**E. CONFLICT OF INTEREST.** Rehabilitation counselors recognize that their own personal values, moral beliefs, or personal and professional relationships 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.

**F. VERACITY.** Rehabilitation counselors do not engage in any act or omission of a dishonest, deceitful, or fraudulent nature in the conduct of their professional activities.

**G. DISPARAGING REMARKS.** Rehabilitation counselors do not disparage individuals or groups of individuals.

**H. PERSONAL PUBLIC STATEMENTS.** When making personal statements in a public context, rehabilitation counselors clarify that they are speaking from their personal perspective and that they are not speaking on behalf of all rehabilitation counselors, the profession, or any professional organizations with which they may be affiliated.

**D.6. SCIENTIFIC BASES FOR INTERVENTIONS**

**A. TECHNIQUES/PROCEDURES/MODALITIES.** Rehabilitation counselors use techniques/procedures/modalities that are grounded in theory and/or have an empirical or scientific foundation. When using techniques/procedures/modalities that are not grounded in theory and/or do not have an empirical or scientific foundation, rehabilitation counselors define the techniques/procedures/modalities as unproven or developing. They explain the potential risks and ethical considerations of using such techniques/procedures/modalities and take steps to protect clients from possible harm.

**B. CREDIBLE RESOURCES.** Rehabilitation counselors ensure that the resources used or accessed in counseling are credible and valid (e.g., Internet link, books used in bibliotherapy).

**SECTION E: RELATIONSHIPS WITH OTHER PROFESSIONALS**

**E.1. RELATIONSHIPS WITH COLLEAGUES, EMPLOYERS, AND EMPLOYEES**

**A. CULTURAL COMPETENCY CONSIDERATIONS.** Rehabilitation counselors maintain beliefs, attitudes, knowledge, and skills regarding their interactions with people across cultures. Rehabilitation counselors are respectful of approaches to counseling services that differ from their own and of traditions and practices of other professional groups with which they work*.*

**B. QUESTIONABLE CONDITIONS.** Rehabilitation counselors alert their employers to conditions or inappropriate policies or practices that may be potentially disruptive or damaging to the professional responsibilities of rehabilitation counselors or that may limit their effectiveness. In those instances where rehabilitation counselors are critical of policies, they attempt to affect changes in such policies or procedures through constructive action within the organization. Such action may include referral to appropriate certification, accreditation, or licensure organizations, or voluntary termination of employment.

**C. EMPLOYER POLICIES.** The acceptance of employment in an agency or institution implies that rehabilitation counselors are in agreement with its general policies and principles. Rehabilitation counselors strive to reach agreement with employers as to acceptable standards of conduct that allow for changes in employer policies conducive to the growth and development of clients.

**D. PROTECTION FROM PUNITIVE ACTION.** Rehabilitation counselors take care not to harass or dismiss employees who have acted in a responsible and ethical manner to expose inappropriate employer policies or practices.

**E. PERSONNEL SELECTION AND ASSIGNMENT.** Rehabilitation counselors select competent staff and assign responsibilities compatible with their skills and experiences.

**F. DISCRIMINATION.** Rehabilitation counselors, as either employers or employees, engage in fair practices with regard to hiring, promoting, and training.

**E.2. CONSULTATION**

**A. CONSULTATION AS AN OPTION.** Rehabilitation counselors may choose to consult with professionally competent persons about their clients. In choosing consultants, rehabilitation counselors avoid placing consultants in a conflict of interest situation that precludes the consultant from being a proper party to the efforts of rehabilitation counselors to help clients. If rehabilitation counselors are engaged in a work setting that compromises this consultation standard, they consult with other professionals whenever possible to consider justifiable alternatives.

**B. CONSULTANT COMPETENCY.** Rehabilitation counselors take reasonable steps to ensure that they have the appropriate resources and competencies when providing consultation services. Rehabilitation counselors provide appropriate referral resources when requested or needed.

**C. INFORMED CONSENT IN CONSULTATION.** When providing consultation, rehabilitation counselors have an obligation to review, in writing and verbally, the rights and responsibilities of both rehabilitation counselors and conseltees. Rehabilitation counselors use clear and understandable language to inform all parties involved about the purpose of the services to be provided, relevant costs, potential risks and benefits, and the limits of confidentiality. Working in conjunction with the consultees, rehabilitation counselors attempt to develop a clear definition of the problem, goals for change, and predicted consequences of interventions that are culturally responsive and appropriate to the needs of consultees.

**E.3. AGENCY AND TEAM RELATIONSHIPS**

**A. CLIENTS AS TEAM MEMBER.** Rehabilitation counselors ensure that clients and/or their legally recognized representatives are afforded the opportunity for full participation in decisions related to the services they receive. Only those with a need to know are allowed access to the information of clients, and only then upon a properly executed release of information request or upon receipt of a court order.

**B. INTERDISCIPLINARY TEAMWORK.** Rehabilitation counselors who are members of interdisciplinary teams delivering multifaceted services to clients must keep the focus on how to serve clients best. They participate in and contribute to decisions that affect the well-being of clients by drawing on the perspectives, values, and experiences of the counseling profession and those of colleagues from other disciplines.

**C. COMMUNICATION.** Rehabilitation counselors ensure that there is fair and mutual understanding of rehabilitation plans by all parties cooperating in the rehabilitation of clients.

**D. ESTABLISHING PROFESSIONAL AND ETHICAL OBLIGATIONS.** Rehabilitation counselors who are members of interdisciplinary teams clarify professional and ethical obligations of the team as a whole and of its individual members. Rehabilitation counselors implement team decisions in rehabilitation plans and procedures, even when not personally agreeing with such decisions, unless these decisions breach the Code. When team decisions raise ethical concerns, rehabilitation counselors first attempt to resolve the concerns within the team. If they cannot reach resolution among team members, rehabilitation counselors consider other approaches to address their concerns consistent with the well-being of clients.

**E. REPORTS.** Rehabilitation counselors secure from other specialists appropriate reports and evaluations when such reports are essential for rehabilitation planning and/or service delivery.

**SECTION F: FORENSIC AND INDIRECT SERVICES**

**F.1. CLIENT OR EVALUEE RIGHTS**

**A. 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.

**B. INFORMED CONSENT.** Individuals being evaluated are informed in writing that the relationship is for the purpose of an evaluation and that a report of findings may be produced. Written consent for evaluations are obtained from those being evaluated or the individuals’ legal representatives/guardians unless: (1) there is a clinical or cultural reason that this is not possible; (2) a court or legal jurisdiction orders evaluations to be conducted without the written consent of individuals being evaluated; and/or (3) deceased evaluees are the subject of evaluations. If written consent is not obtained, rehabilitation counselors document verbal consent and the reasons why obtaining written consent was not possible. When minors or vulnerable adults are evaluated, informed consent is obtained from parents or guardians.

**C. DUAL ROLES.** Rehabilitation counselors do not evaluate current or former clients for forensic purposes except under the conditions noted in A.5.f. Or government statute. Likewise, rehabilitation counselors do not provide direct services to evaluees whom they have previously provided forensic services in the past except under the conditions noted in A.5.f. or government statute. In a forensic setting, rehabilitation counselors who are engaged as expert witnesses have no clients. The persons who are the subject of objective and unbiased evaluations are considered to be evaluees.

**D. INDIRECT SERVICE PROVISION.** Rehabilitation counselors who are employed by third parties as case consultants or expert witnesses, and who engage in communication with clients or evaluees, fully disclose to individuals (and/or their designees) the role of the rehabilitation counselor and limits of the relationship. Communication includes all forms of written or oral interactions. When there is no intent to provide rehabilitation counseling services directly to clients or evaluees and when there is no in-person meeting or other communication, disclosure by rehabilitation counselors is not required.

**E. CONFIDENTIALITY.** When rehabilitation counselors are required by law, employers’ policies, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, they clarify role expectations and the parameters of confidentiality with their colleagues and with evaluees.

**F.2. REHABILITATION COUNSELOR FORENSIC COMPETENCY AND CONDUCT**

**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.

**F.3. FORENSIC PRACTICES**

**A. CASE ACCEPTANCE AND INDEPENDENT OPINION.** 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.

**B. TERMINATION AND ASSIGNMENT TRANSFER.** If necessary to withdraw from a case after having been retained, rehabilitation counselors make reasonable efforts to assist evaluees and/or referral sources in locating another rehabilitation counselor to take over the assignment.

**F.4. FORENSIC BUSINESS PRACTICES**

**A. PAYMENTS AND OUTCOME.** 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.

**B. FEE DISPUTES.** Should fee disputes arise during the course of evaluating cases and prior to trial, rehabilitation counselors have the ability to discontinue their involvement in cases as long as no harm comes to evaluees.

**SECTION G: EVALUATION, ASSESSMENT, AND INTERPRETATION**

**G.1. INFORMED CONSENT**

**A. EXPLANATION TO CLIENTS.** Prior to assessment, rehabilitation counselors explain the nature and purposes of assessment and the specific use of results by potential recipients. The explanation is given in the language and/or developmental level of clients (or other legally authorized persons on behalf of clients), unless an explicit exception has been agreed upon in advance. Rehabilitation counselors consider personal or cultural context of clients, the level of their understanding of the results, and the impact of the results on clients. Regardless of whether scoring and interpretation are completed by rehabilitation counselors, by assistants, or by computer or other outside services, rehabilitation counselors take reasonable steps to ensure that appropriate explanations are given to clients.

**B. RECIPIENTS OF RESULTS.** Rehabilitation counselors consider the welfare of clients, explicit understandings, and prior agreements in determining who receives the assessment results. Rehabilitation counselors include accurate and appropriate interpretations with any release of individual or group assessment results. Issues of cultural diversity, when present, are taken into consideration when providing interpretations and releasing information.

**G.2. RELEASE OF INFORMATION TO COMPETENT PROFESSIONALS**

**A. MISUSE OF RESULTS.** Rehabilitation counselors do not misuse assessment results, including test results and interpretations, and take reasonable steps to prevent the misuse of such by others.

**B. RELEASE OF DATA TO QUALIFIED PROFESSIONALS.** Rehabilitation counselors release assessment data in which clients are identified only with the consent of clients or their legal representatives, or court order. Such data is released only to professionals recognized as qualified to interpret the data.

**G.3. PROPER DIAGNOSIS OF MENTAL DISORDERS**

**A. PROPER DIAGNOSIS.** If within their professional and individual scope of practice, rehabilitation counselors take special care to provide proper diagnosis of mental disorders. Assessment techniques (including personal interviews) used to determine care of clients (e.g., focus of treatment, types of treatment, or recommended follow-up) are carefully selected and appropriately used.

**B. CULTURAL SENSITIVITY.** Rehabilitation counselors recognize that culture affects the manner in which the disorders of clients are defined. The socioeconomic and cultural experiences of clients are considered when diagnosing.

**C. HISTORICAL AND SOCIAL PREJUDICES IN DIAGNOSIS AND THE DIAGNOSIS OF PATHOLOGY.**

Rehabilitation counselors recognize historical and social prejudices in the misdiagnosis and pathologizing of certain individuals and groups. Rehabilitation counselors may refrain from making and/or reporting a diagnosis if they believe it would cause harm to clients or others.

**G.4. COMPETENCE TO USE AND INTERPRET TESTS**

**A. LIMITS OF COMPETENCE.** Rehabilitation counselors utilize only those testing and assessment services for which they have been trained and are competent. Rehabilitation counselors take reasonable measures to ensure the proper use of psychological and career assessment techniques by persons under their supervision. The requirement to develop this competency applies regardless of whether tests are administered through standard or technology-based methods.

**B. APPROPRIATE USE.** Rehabilitation counselors are responsible for the appropriate applications, scoring, interpretations, and use of assessment instruments relevant to the needs of clients, whether they score and interpret such assessments themselves or use technology or other services. Generally new instruments are used within one year of publication, unless rehabilitation counselors document a valid reason why the normative data from previous versions are more applicable to clients.

**C. RECOMMENDATIONS BASED ON RESULTS.** Rehabilitation counselors are responsible for recommendations involving individuals that are based on assessment results, and have a thorough understanding of educational, psychological, and career measurements, including validation criteria, assessment research, and guidelines for assessment development and use. In addition to test results, rehabilitation counselors consider other factors present in the client’s situation (e.g., disability or cultural factors) before making any recommendations, when relevant.

**D. ACCURATE INFORMATION.** Rehabilitation counselors provide accurate information and avoid false claims or misconceptions when making statements about assessment instruments or techniques. Special efforts are made to avoid utilizing test results to make inappropriate diagnoses or inferences.

**G.5. TEST SELECTION**

**A. APPROPRIATENESS OF INSTRUMENTS.** Rehabilitation counselors carefully consider the validity, reliability, psychometric limitations, and appropriateness of instruments when selecting tests for use in given situations or with particular clients.

**B. REFERRAL INFORMATION.** If clients are referred to a third party for assessment, rehabilitation counselors provide specific referral questions and sufficient objective data about clients to ensure that appropriate assessment instruments are utilized.

**C. CULTURALLY DIVERSE POPULATIONS.** Rehabilitation counselors are cautious when selecting assessments for use with individuals from culturally diverse populations to avoid the use of instruments that lack appropriate psychometric properties for those client populations.

**G.6. CONDITIONS OF TEST ADMINISTRATION**

**A. ADMINISTRATION CONDITIONS.** Rehabilitation counselors administer assessments under the same conditions that were established in the standardized development of the instrument. When assessments are not administered under standard conditions, as may be necessary to accommodate clients with disabilities, or when unusual behavior or irregularities occur during the administration, those conditions are noted in interpretation, and the results may be designated as invalid or of questionable validity.

**B. TECHNOLOGICAL ADMINISTRATION.** When using technology or electronic methods to administer assessments, rehabilitation counselors ensure that the instruments are functioning properly and provide accurate results.

**C. UNSUPERVISED TEST-TAKING.** Rehabilitation counselors do not permit unsupervised or inadequately supervised use of tests or assessments unless the tests or assessments are designed, intended, and validated for self-administration and/or scoring.

**G.7. TEST SCORING AND INTERPRETATION**

**A. REPORTING RESERVATIONS.** In reporting assessment results, rehabilitation counselors indicate any reservations that exist regarding validity or reliability because of the circumstances of the assessments or the inappropriateness of the norms for persons tested.

**B. CULTURAL DIVERSITY ISSUES IN ASSESSMENT.** Rehabilitation counselors use caution with assessment techniques that were normed on populations other than that of the client. Rehabilitation counselors recognize the effects of age, color, race, national origin, culture, disability, ethnicity, gender, gender identity, religion/spirituality, sexual orientation, marital status/partnership, language preference, socioeconomic status, or any basis proscribed by law on test administrations and interpretations, and place test results in proper perspective with other relevant factors*.*

**C. RESEARCH INSTRUMENTS.** Rehabilitation counselors exercise caution when interpreting the results of research instruments not having sufficient technical data to support respondent results. The specific purposes for the use of such instruments are stated explicitly to examinees.

**G.8. ASSESSMENT CONSIDERATIONS**

**A. ASSESSMENT SECURITY.** Rehabilitation counselors maintain the integrity and security of tests and other assessment techniques consistent with legal and contractual obligations. Rehabilitation counselors do not appropriate, reproduce, or modify published assessments or parts thereof without acknowledgment and permission from the publisher.

**B. OBSOLETE ASSESSMENT AND OUTDATED RESULTS.** Rehabilitation counselors do not use data or results from assessments that are obsolete or outdated. Rehabilitation counselors make every effort to prevent the misuse of obsolete measures and assessment data by others.

**C. ASSESSMENT CONSTRUCTION.** Rehabilitation counselors use established scientific procedures, relevant standards, and current professional knowledge for assessment design in the development, publication, and utilization of educational and psychological assessment techniques.

**SECTION H: TEACHING, SUPERVISION, AND TRAINING**

**H.1. REHABILITATION COUNSELOR SUPERVISION AND CLIENT WELFARE**

**A. CLIENT WELFARE*.*** Rehabilitation counselor supervisors meet regularly with supervisees to review case notes, samples of clinical work, or live observations in order to ensure the welfare of clients. Supervisees have a responsibility to understand and follow the Code*.*

**B. REHABILITATION COUNSELOR CREDENTIALS.** Rehabilitation counselor supervisors work to ensure that clients are aware of the qualifications of the supervisees who render services to clients*.*

**C. INFORMED CONSENT AND CLIENT RIGHTS.** Rehabilitation counselor supervisors make supervisees aware of the rights of clients including the protection of their privacy and confidentiality in the counseling relationship. Supervisees provide clients with professional disclosure information and inform them of how the supervision process influences the limits of confidentiality. Supervisees make clients aware of who has access to records of the counseling relationship and how these records are used.

**H.2. REHABILITATION COUNSELOR SUPERVISION COMPETENCE**

**A. SUPERVISOR PREPARATION.** Rehabilitation counselors who offer supervision services regularly pursue continuing education activities, including both counseling and supervision topics and skills.

**B. CULTURAL DIVERSITY IN REHABILITATION COUNSELOR SUPERVISION.** Rehabilitation counselor supervisors are aware of and address the role of cultural diversity in the supervisory relationship.

**H.3. ROLES AND RELATIONSHIPS WITH SUPERVISEES OR TRAINEES**

**A. RELATIONSHIP BOUNDARIES WITH SUPERVISEES OR TRAINEES.** Rehabilitation counselor supervisors or educators clearly define and maintain ethical professional, personal, and social relationships with their supervisees or trainees. Rehabilitation counselor supervisors or educators avoid nonprofessional relationships with current supervisees or trainees. If rehabilitation counselor supervisors or educators must assume other professional roles (e.g., clinical and/or administrative supervisors, instructors) with supervisees or trainees, they work to minimize potential conflicts and explain to supervisees or trainees the expectations and responsibilities associated with each role.

They do not engage in any form of nonprofessional interactions that may compromise the supervisory relationship.

**B. SEXUAL OR ROMANTIC RELATIONSHIPS.** Rehabilitation counselors do not engage in sexual or romantic interactions or relationships with current supervisees or trainees.

**C. EXPLOITATIVE RELATIONSHIPS.** Rehabilitation counselors do not engage in exploitative relationships with individuals with whom they have supervisory, evaluative, or instructional control or authority.

**D. SEXUAL HARASSMENT.** Rehabilitation counselor supervisors or educators do not condone or subject supervisees or trainees to sexual harassment.

**E. RELATIONSHIPS WITH FORMER SUPERVISEES OR TRAINEES.** Rehabilitation counselor supervisors or educators are aware of the power differential in their relationships with supervisees or trainees. Rehabilitation counselor supervisors or educators foster open discussions with former supervisees or trainees when considering engaging in a social, sexual, or other intimate relationships. Rehabilitation counselor supervisors or educators discuss with the former supervisees or trainees how their former relationship may affect the change in relationship.

**F. NONPROFESSIONAL RELATIONSHIPS.** Rehabilitation counselor supervisors or educators avoid nonprofessional or ongoing professional relationships with supervisees or trainees in which there is a risk of potential harm to supervisees or trainees or that may compromise the training experience or grades assigned. In addition, rehabilitation counselor supervisors or educators do not accept any form of professional services, fees, commissions, reimbursement, or remuneration from a site for supervisee or trainee placements.

**G. CLOSE RELATIVES AND FRIENDS.** Rehabilitation counselor supervisors or educators avoid accepting close relatives, romantic partners, or friends as supervisees or trainees. When such circumstances cannot be avoided, rehabilitation counselor supervisors or educators utilize a formal review mechanism.

**H. POTENTIALLY BENEFICIAL RELATIONSHIPS.** Rehabilitation counselor supervisors or educators are aware of the power differential in their relationships with supervisees or trainees. If they believe nonprofessional relationships with supervisees or trainees may be potentially beneficial to supervisees or trainees, they take precautions similar to those taken by rehabilitation counselors when working with clients. Examples of potentially beneficial interactions or relationships include attending a formal ceremony; hospital visits; providing support during a stressful event; or mutual membership in professional associations, organizations, or communities. Rehabilitation counselor supervisors or educators engage in open discussions with supervisees or trainees when they consider entering into relationships with them outside of their role as clinical and/or administrative supervisors. Before engaging in nonprofessional relationships, rehabilitation counselor supervisors or educators discuss the rationale for such interactions, potential benefits or drawbacks, and anticipated consequences with supervisees or trainees. Rehabilitation counselor supervisors or educators clarify the specific nature and limitations of the additional role(s) they have with supervisees or trainees. Nonprofessional relationships with supervisees or trainees are time-limited or context specific and initiated with their consent.

**H.4. REHABILITATION COUNSELOR SUPERVISOR RESPONSIBILITIES**

**A. DISCLOSURE AND INFORMED CONSENT FOR SUPERVISION.** Rehabilitation counselor supervisors provide professional disclosure that, at a minimum, is consistent with the jurisdiction in which they practice. Rehabilitation counselor supervisors are responsible for incorporating into their supervision the principles of informed consent. Rehabilitation counselor supervisors inform supervisees of the policies and procedures to which they are to adhere and the mechanisms for due process appeal of individual supervisory actions.

**B. EMERGENCIES AND ABSENCES.** Rehabilitation counselor supervisors establish and communicate to supervisees the procedures for contacting them or, in their absence, alternative on-call supervisors to assist in handling crises.

**C. STANDARDS FOR REHABILITATION COUNSELOR SUPERVISEES.** Rehabilitation counselor supervisors make their supervisees aware of professional and ethical standards and legal responsibilities. Rehabilitation counselor supervisors of post-degree rehabilitation counselors encourage these rehabilitation counselors to adhere to professional standards of practice.

**D. RESOLVING DIFFERENCES.** When cultural, ethical, or professional issues are crucial to the viability of the supervisory relationship, both parties make efforts to resolve differences. When termination is warranted, rehabilitation counselor supervisors make appropriate referrals to possible alternative supervisors.

**H.5. REHABILITATION COUNSELOR SUPERVISOR EVALUATION, REMEDIATION, AND ENDORSEMENT**

**A. EVALUATION.** Rehabilitation counselor supervisors or educators clearly state to supervisees or trainees, prior to and throughout the training program, the levels of competency expected, appraisal methods, and timing of evaluations for both didactic and clinical competencies. Rehabilitation counselor supervisors or educators document and provide supervisees or trainees ongoing performance appraisal and evaluation feedback.

**B. LIMITATIONS.** Throughout ongoing evaluation and appraisal, rehabilitation counselor supervisors or educators are aware of and address the inability of some supervisees or trainees to achieve, improve, or maintain counseling competencies. Rehabilitation counselor supervisors or educators: (1) assist supervisees or trainees in securing remedial assistance when needed; (2) seek professional consultation and document their decision to dismiss or refer supervisees or trainees for assistance; (3) ensure that supervisees or trainees have recourse in a timely manner to address decisions that require them to seek assistance or to dismiss them; and (4) provide supervisees or trainees with due process according to organizational policies and procedures.

**C. COUNSELING FOR SUPERVISEES.** Rehabilitation counselor supervisors or educators address interpersonal competencies of supervisees or trainees in terms of the impact of these issues on clients, supervisory relationships, and professional functioning. With the exception of brief interventions to address situational distress, or as part of educational activities, rehabilitation counselor supervisors or educators do not provide counseling services to supervisees or trainees. If supervisees or trainees request counseling or if counseling is required as part of a remediation process, rehabilitation counselor supervisors or educators provides them with referrals.

**D. ENDORSEMENT.** Rehabilitation counselor supervisors or educators endorse supervisees or trainees for certification, licensure, employment, or completion of academic or training programs based on satisfactory progress and observations while under supervision or training. Regardless of qualifications, supervisors or educators do not endorse supervisees or trainees whom they believe to be impaired in any way that would interfere with the performance of the duties associated with the endorsement.

**H.6. RESPONSIBILITIES OF REHABILITATION COUNSELOR EDUCATORS**

**A. REHABILITATION COUNSELOR EDUCATORS.** Rehabilitation counselor educators who are responsible for developing, implementing, and supervising educational programs are skilled as teachers and practitioners. They are knowledgeable regarding the ethical, legal, and regulatory aspects of the profession, are skilled in applying that knowledge, and make students aware of their responsibilities. Rehabilitation counselor educators conduct rehabilitation counselor education and training programs in an ethical manner and serve as role models for professional behavior.

**B. INFUSING CULTURAL DIVERSITY.** Rehabilitation counselor educators infuse material related to cultural diversity into all courses and workshops for the development of professional rehabilitation counselors.

**C. INTEGRATION OF STUDY AND PRACTICE.** Rehabilitation counselor educators establish education and training programs that integrate academic study and supervised practice.

**D. TEACHING ETHICS.** Rehabilitation counselor educators make students aware of their ethical responsibilities, standards of the profession, and the ethical responsibilities of students to the profession. Rehabilitation counselor educators infuse ethical considerations throughout the curriculum.

**E. PEER RELATIONSHIPS.** Rehabilitation counselor educators make every effort to ensure that the rights of peers are not compromised when students lead counseling groups or provide clinical supervision. Rehabilitation counselor educators take steps to ensure that students understand they have the same ethical obligations as rehabilitation counselor educators, trainers, and supervisors.

**F. INNOVATIVE TECHNIQUES/PROCEDURES/MODALITIES.** When rehabilitation counselor educators teach counseling techniques/procedures/modalities that are innovative, without an empirical foundation or without a well-grounded theoretical foundation, they define the counseling techniques/procedures/modalities as unproven or developing and explain to students the potential risks and ethical considerations of using such techniques/procedures/modalities.

**G. FIELD PLACEMENTS.** Rehabilitation counselor educators develop clear policies within their training programs regarding field placement and other clinical experiences. Rehabilitation counselor educators provide clearly stated roles and responsibilities for students, site supervisors, and program supervisors. They confirm that site supervisors are qualified to provide supervision and inform site supervisors of their professional and ethical responsibilities in this role.

**H. PROFESSIONAL DISCLOSURE.** Before initiating counseling services, rehabilitation counselors-in training disclose their status as students and explain how this status affects the limits of confidentiality. Rehabilitation counselor educators ensure that clients at field placement are aware of the services rendered and the qualifications of the students and supervisees rendering those services. Students obtain permission from clients before they use any information concerning the counseling relationship in the training process.

**H.7. STUDENT WELFARE**

**A. ORIENTATION.** Rehabilitation counselor educators recognize that orientation is a developmental process that continues throughout the educational and clinical training of students. Rehabilitation counselor educators have an ethical responsibility to provide enough information to prospective or current students about program expectations for them to make informed decisions about entering into and continuing in a program.

**B. SELF-GROWTH EXPERIENCES.** Rehabilitation counselor education programs delineate requirements for self-disclosure as part of self-growth experiences in their admission and program materials. Rehabilitation counselor educators use professional judgment when designing training experiences they conduct that require student self-growth or self-disclosure. Students are made aware of the ramifications their self-disclosure may have when rehabilitation counselors whose primary role as teachers, trainers, or supervisors require acting on ethical obligations to the profession. Evaluative components of experiential training experiences explicitly delineate predetermined academic standards that are separate and do not depend on the level of self disclosure of students. As a condition to remain in the program, rehabilitation counselor educators may require that students seek professional help to address any personal concerns that may be affecting their competency.

**H.8. CULTURAL DIVERSITY COMPETENCE IN REHABILITATION COUNSELOR EDUCATION**

**PROGRAMS AND TRAINING PROGRAMS**

**A. DIVERSITY.** Rehabilitation counselor educators actively attempt to recruit and retain a diverse faculty and student body. Rehabilitation counselor educators demonstrate commitment to cultural diversity competence by recognizing and valuing diverse cultures and types of abilities faculty and students bring to the training experience. Rehabilitation counselor educators provide appropriate accommodations as required to enhance and support the well-being and performance of students.

**B. CULTURAL DIVERSITY COMPETENCE.** Rehabilitation counselor educators actively infuse cultural diversity competency into their training and supervision practices. They actively educate trainees to develop and maintain beliefs, attitudes, knowledge, and skills necessary for competent practice with people across cultures.

**SECTION I: RESEARCH AND PUBLICATION**

**I.1. RESEARCH RESPONSIBILITIES**

**A. USE OF HUMAN PARTICIPANTS.** Rehabilitation counselors plan, design, conduct, and report research in a manner that reflects cultural sensitivity, is culturally appropriate, and is consistent with pertinent ethical principles, laws, host institutional regulations, and scientific standards governing research with human participants. They seek consultation when appropriate.

**B. DEVIATION FROM STANDARD PRACTICES.** Rehabilitation counselors seek consultation and observe stringent safeguards to protect the rights of research participants when a research problem suggests a deviation from standard acceptable practices.

**C. PRECAUTIONS TO AVOID INJURY.** Rehabilitation counselors who conduct research with human participants are responsible for the welfare of participants throughout the research process and take reasonable precautions to avoid causing injurious psychological, emotional, physical, or social effects to participants.

**D. PRINCIPAL RESEARCHER RESPONSIBILITY.** The ultimate responsibility for ethical research practice lies with principal researchers. All others involved in the research activities share ethical obligations and responsibilities for their own actions.

**E. MINIMAL INTERFERENCE.** Rehabilitation counselors take precautions to avoid causing disruption in the lives of research participants that may result from their involvement in research.

**I.2. INFORMED CONSENT AND DISCLOSURE**

**A. INFORMED CONSENT IN RESEARCH.** Individuals have the right to consent to become research participants. In seeking consent, rehabilitation counselors use language that: (1) accurately explains the purpose and procedures to be followed; (2) identifies any procedures that are experimental or relatively untried; (3) describes any attendant discomforts and risks; (4) describes any benefits or changes in individuals or organizations that might be reasonably expected; (5) discloses appropriate alternative procedures that would be advantageous for participants; (6) offers to answer any inquiries concerning the procedures; (7) describes any limitations on confidentiality; (8) describes formats and potential target audiences for the dissemination of research findings; and (9) instructs participants that they are free to withdraw their consent and to discontinue participation in the project at any time without penalty.

**B. DECEPTION.** Rehabilitation counselors do not conduct research involving deception unless alternative procedures are not feasible. If such deception has the potential to cause physical or emotional harm to research participants, the research is not conducted, regardless of prospective value. When the methodological requirements of a study necessitate concealment or deception, the investigator explains the reasons for this action as soon as possible during the debriefing.

**C. VOLUNTARY PARTICIPATION.** Participation in research is typically voluntary and without any penalty for refusal to participate. Involuntary participation is appropriate only when it can be demonstrated that participation has no harmful effects on participants and is essential to the research.

**D. CONFIDENTIALITY OF INFORMATION.** Information obtained about participants during the course of research is confidential. When the possibility exists that others may obtain access to such information, ethical research practice requires that the possibility, together with the plans for protecting confidentiality, be explained to participants as part of the procedures for obtaining informed consent.

**E. INDIVIDUALS NOT CAPABLE OF GIVING INFORMED CONSENT.** When individuals are not capable of giving informed consent, rehabilitation counselors provide an appropriate explanation to and obtain agreement for participation and appropriate consent from a legally authorized person.

**F. COMMITMENTS TO PARTICIPANTS.** Rehabilitation counselors take reasonable measures to honor all commitments to research participants.

**G. EXPLANATIONS AFTER DATA COLLECTION.** After data is collected, rehabilitation counselors provide participants with full clarification of the nature of the study to remove any misconceptions participants might have regarding the research. Where scientific or human values justify delaying or withholding information, rehabilitation counselors take reasonable measures to avoid causing harm.

**H. AGREEMENT OF CONTRIBUTORS.** Rehabilitation counselors who conduct joint research establish agreements in advance regarding allocation of tasks, publication credit, and types of acknowledgment received, and incur an obligation to cooperate as agreed.

**I. INFORMING SPONSORS.** Rehabilitation counselors inform sponsors, institutions, and publication channels regarding research procedures and outcomes. Rehabilitation counselors ensure that appropriate bodies and authorities are given pertinent information and acknowledgment.

**I.3. REPORTING RESULTS**

**A. ACCURATE RESULTS.** Rehabilitation counselors plan, conduct, and report research accurately. They provide thorough discussions of the limitations of their data and alternative hypotheses. Rehabilitation counselors do not engage in misleading or fraudulent research, distort data, misrepresent data, or deliberately bias their results. They explicitly mention all variables and conditions known to the investigator(s) that may have affected the outcome of studies or interpretations of data. They describe the extent to which results are applicable for diverse populations.

**B. OBLIGATION TO REPORT UNFAVORABLE RESULTS.** Rehabilitation counselors report the results of any research of professional value. Results that reflect unfavorably on institutions, programs, services, prevailing opinions, or vested interests are not withheld.

**C. IDENTITY OF PARTICIPANTS.** Rehabilitation counselors who supply data, aid in the research of another person, report research results, or make original data available, take due care to disguise the identity of respective participants in the absence of specific authorization from the participants to do otherwise. In situations where participants self-identify their involvement in research studies, researchers take active steps to ensure that data is adapted/changed to protect the identities and welfare of all parties and that discussion of results does not cause harm to participants.

**D. REPORTING ERRORS.** If rehabilitation counselors discover significant errors in their published research, they take reasonable steps to correct such errors in a correction erratum or through other appropriate publication means.

**E. REPLICATION STUDIES.** Rehabilitation counselors are obligated to make available sufficient original research data to qualified professionals who may wish to replicate the study.

**I.4. PUBLICATIONS AND PRESENTATIONS**

**A. RECOGNIZING CONTRIBUTIONS.** When conducting and reporting research, rehabilitation counselors are familiar with and give recognition to previous work on the topic, observe copyright laws, and give full credit to those to whom credit is due.

**B. CONTRIBUTORS.** Rehabilitation counselors give credit through joint authorship, acknowledgment, footnote statements, or other appropriate means to those who have contributed significantly to research or concept development in accordance with such contributions. Principal contributors are listed first and minor technical or professional contributions are acknowledged in notes or introductory statements.

**C. STUDENT RESEARCH.** For articles that are substantially based on students’ course papers, projects, dissertations or theses of students, and for which students have been the primary contributors, they are listed as principal authors.

**D. DUPLICATE SUBMISSION.** Rehabilitation counselors submit manuscripts for consideration to only one journal at a time. Manuscripts that are published in whole or in substantial part in another journal or published work are not submitted for publication without acknowledgment and permission from the previous publication.

**E. PROFESSIONAL REVIEW.** Rehabilitation counselors who review material submitted for publication, research, or other scholarly purposes respect the confidentiality and proprietary rights of those who submitted it. Rehabilitation counselors’ use care to make publication decisions based on valid and defensible standards. Rehabilitation counselors review article submissions in a timely manner and based on their scope and competency in research methodologies. Rehabilitation counselors who serve as reviewers at the request of editors or publishers make every effort to review only materials that are within their scope of competency and use care to avoid personal biases.

**F. PLAGIARISM.** Rehabilitation counselors do not plagiarize, that is, they do not present another person’s work as their own work.

**G. REVIEW/REPUBLICATION OF DATA OR IDEAS.** Rehabilitation counselors fully acknowledge and make editorial reviewers aware of prior publication of ideas or data where such ideas or data are submitted for review or publication.

**H. NON PROFESSIONAL RELATIONSHIPS.** Rehabilitation counselors avoid nonprofessional relationships with research participants when research involves intensive or extensive interaction. When a nonprofessional interaction between researchers and research participants may be potentially beneficial, researchers must document, prior to the interaction (when feasible), the rationale for such interactions, the potential benefits, and anticipated consequences for research participants. Such interactions are initiated with appropriate consent of research participants. Where unintentional harm occurs to research participants due to nonprofessional interactions, researchers must show evidence of an attempt to remedy such harm.

**I. SEXUAL OR ROMANTIC RELATIONSHIPS WITH RESEARCH PARTICIPANTS.** Rehabilitation counselors do not engage in sexual or romantic rehabilitation counselor–research participant interactions or initiate relationships with current research participants.

**J. SEXUAL HARASSMENT AND RESEARCH PARTICIPANTS.** Rehabilitation counselors do not condone or subject research participants to sexual harassment.

**I.5. CONFIDENTIALITY**

**A. INSTITUTIONAL APPROVAL.** When institutional review board approval is required, rehabilitation counselors provide accurate information about their research proposals and obtain approval prior to conducting their research. They conduct research in accordance with the approved research protocol.

**B. ADHERENCE TO GUIDELINES.** Rehabilitation counselors are responsible for understanding and adhering to national, local, agency, or institutional policies or applicable guidelines regarding confidentiality in their research practices.

**C. CONFIDENTIALITY OF INFORMATION OBTAINED IN RESEARCH.** Violations of participants’ privacy and confidentiality are risks of participation in research involving human participants. Investigators maintain all research records in a secure manner. They explain to participants the risks of violations of privacy and confidentiality and disclose to participants any limits of confidentiality that reasonably can be expected.

**D. DISCLOSURE OF RESEARCH INFORMATION.** Rehabilitation counselors do not disclose confidential information that reasonably could lead to the identification of research participants unless they have obtained the prior consent of participants. Use of data derived from counseling relationships for purposes of training, research, or publication are confined to content that are disguised to ensure the anonymity of the individuals involved.

**E. AGREEMENT FOR IDENTIFICATION.** Rehabilitation counselors identify clients, students, or research participants in a presentation or publication only when it has been reviewed by those clients, students, or research participants and they have agreed to its presentation or publication.

**SECTION J: TECHNOLOGY AND DISTANCE COUNSELING**

**J.1. BEHAVIOR AND IDENTIFICATION**

**A. APPLICATION AND COMPETENCE.** Rehabilitation counselors are held to the same level of expected behavior and competence as defined by the Code regardless of the technology used (e.g., cellular phones, email, facsimile, video, audio, audio-visual) or its application (e.g. assessment, research, data storage).

**B. PROBLEMATIC USE OF THE INTERNET.** Rehabilitation counselors are aware of behavioral differences with the use of the Internet, and/or methods of electronic communication, and how these may impact the counseling process.

**C. POTENTIAL MISUNDERSTANDINGS.** Rehabilitation counselors educate clients on how to prevent and address potential misunderstandings arising from the lack of visual cues and voice intonations when communicating electronically.

**J.2. ACCESSIBILITY**

**A. DETERMINING CLIENT CAPABILITIES.** When providing technology-assisted services, rehabilitation counselors determine that clients are functionally and linguistically capable of using the application and that the technology is appropriate for the needs of clients. Rehabilitation counselors verify that clients understand the purpose and operation of technology applications and follow-up with clients to correct possible misconceptions, discover appropriate use, and assess subsequent steps.

**B. ACCESSING TECHNOLOGY.** Based on functional, linguistic, or cultural needs of clients, rehabilitation counselors guide clients in obtaining reasonable access to pertinent applications when providing technology-assisted services.

**J.3. CONFIDENTIALITY, INFORMED CONSENT, AND SECURITY**

**A. CONFIDENTIALITY AND INFORMED CONSENT.** Rehabilitation counselors ensure that clients are provided sufficient information to adequately address and explain the limits of: (1) technology used in the counseling process in general; (2) ensuring and maintaining complete confidentiality of client information transmitted through electronic means; (3) a colleague, supervisor, and an employee, such as an Information Technology (IT) administrator or paraprofessional staff, who might have authorized or unauthorized access to electronic transmissions; (4) an authorized or unauthorized user including a family member and fellow employee who has access to any technology the client may use in the counseling process; (5) pertinent legal rights and limitations governing the practice of a profession over jurisdictional boundaries; (6) record maintenance and retention policies*;* (7) technology failure, unavailability, or crisis contact procedures*;* and, (8) protecting client information during the counseling process and at the termination of services.

**B. TRANSMITTING CONFIDENTIAL INFORMATION.** Rehabilitation counselors take precautions to ensure the confidentiality of information transmitted through the use of computers, email, facsimile machines, telephones, voicemail, answering machines, and other technology.

**C. SECURITY.** Rehabilitation counselors: (1) use encrypted and/or password-protected Internet sites and/or email communications to help ensure confidentiality when possible and take other reasonable precautions to ensure the confidentiality of information transmitted through the use of computers, email, facsimiles, telephones, voicemail, answering machines, or other technology; (2) notify clients of the inability to use encryption or password protection, the hazards of not using these security measures; and, (3) limit transmissions to general communications that are not specific to clients, and/or use non-descript identifiers.

**D. IMPOSTERS.** In situations where it is difficult to verify the identity of rehabilitation counselors, clients, their guardians, and/or team members, rehabilitation counselors: (1) address imposter concerns, such as using code words, numbers, graphics, or other non-descript identifiers; and (2) establish methods for verifying identities.

**J.4. TECHNOLOGY-ASSISTED ASSESSMENT**

Rehabilitation counselors using technology-assisted test interpretations abide by the ethical standards for the use of such assessments regardless of administration, scoring, interpretation, or reporting method and ensure that persons under their supervision are aware of these standards.

**J.5. CONSULTATION GROUPS**

When participating in electronic professional consultation or consultation groups (e.g., social networks, list serves, blogs, online courses, supervision, and interdisciplinary teams), rehabilitation counselors: (1) establish and/or adhere to the group’s norms promoting behavior that is consistent with ethical standards, and (2) limit disclosure of confidential information.

**J.6. RECORDS, DATA STORAGE, AND DISPOSAL**

**A. RECORDS MANAGEMENT.** Rehabilitation counselors are aware that electronic messages are considered to be part of the records of clients. Since electronic records are preserved, rehabilitation counselors inform clients of the retention method and period, of who has access to the records, and how the records are destroyed.

**B. PERMISSION TO RECORD.** Rehabilitation counselors obtain permission from clients prior to recording sessions through electronic or other means.

**C. PERMISSION TO OBSERVE.** Rehabilitation counselors obtain permission from clients prior to observing counseling sessions, reviewing session transcripts, and/or listening to or viewing recordings of sessions with supervisors, faculty, peers, or others within the training environment.

**J.7. LEGAL**

**A. ETHICAL/LEGAL REVIEW.** Rehabilitation counselors review pertinent legal and ethical codes for possible violations emanating from the practice of distance counseling and/or supervision.

**B. LAWS AND STATUTES.** Rehabilitation counselors ensure that the use of technology does not violate the laws of any local, regional, national, or international entity, observe all relevant statutes, and seek business, legal, and technical assistance when using technology in such a manner.

**J.8. ADVERTISING**

**A. ONLINE PRESENCE.** Rehabilitation counselors maintaining sites on the Internet do so based on the advertising, accessibility, and cultural provisions of the Code. The Internet site is regularly maintained and includes avenues for communication with rehabilitation counselors.

**B. VERACITY OF ELECTRONIC INFORMATION.** Rehabilitation counselors assist clients in determining the validity and reliability of information found on the Internet and/or other technology applications*.*

**J.9. RESEARCH AND PUBLICATION**

**A. INFORMED CONSENT.** Rehabilitation counselors are aware of the limits of technology-based research with regards to privacy, confidentiality, participant identities, venues used, accuracy, and/or dissemination. They inform participants of those limitations whenever possible, and make provisions to safeguard the collection, dissemination, and storage of data collected.

**B. INTELLECTUAL PROPERTY.** When rehabilitation counselors possess intellectual property of people or entities (e.g., audio, visual, or written historical or electronic media), they take reasonable precautions to protect the technological dissemination of that information through disclosure, informed consent, password protection, encryption, copyright, or other security/intellectual property protection means.

**J.10. REHABILITATION COUNSELOR UNAVAILABILITY**

**A. TECHNOLOGICAL FAILURE.** Rehabilitation counselors explain to clients the possibility of technology failure and provide an alternative means of communication.

**B. UNAVAILABILITY.** Rehabilitation counselors provide clients with instructions for contacting them when they are unavailable through technological means.

**C. CRISIS CONTACT.** Rehabilitation counselors provide referral information for at least one agency or rehabilitation counselor-on-call for purposes of crisis intervention for clients within their geographical region.

**J.11. DISTANCE COUNSELING CREDENTIAL DISCLOSURE**

Rehabilitation counselors practicing through Internet sites provide information to clients regarding applicable certification boards and/or licensure bodies to facilitate client rights and protection and to address ethical concerns.

**J.12. DISTANCE COUNSELING RELATIONSHIPS**

**A. BENEFITS AND LIMITATIONS.** Rehabilitation counselors inform clients of the benefits and limitations of using technology applications in the counseling process and in business procedures. Such technologies include, but are not limited to, computer hardware and/or software, telephones, the Internet and other audio and/or video communication, assessment, research, or data storage devices or media.

**B. INAPPROPRIATE APPLICATIONS.** When technology-assisted distance counseling services are deemed inappropriate by rehabilitation counselors or clients, rehabilitation counselors pursue services face-to-face or by other means.

**C. BOUNDARIES.** Rehabilitation counselors discuss and establish boundaries with clients, family members, service providers, and/or team members regarding the appropriate use and/or application of technology and the limits of its use within the counseling relationship.

**J.13. DISTANCE COUNSELING SECURITY AND BUSINESS PRACTICES**

**A. SELF-DESCRIPTION.** Rehabilitation counselors practicing through Internet sites provide information about themselves (e.g., ethnicity, gender) as would be available if the counseling were to take place face-to-face.

**B. INTERNET SITES.** Rehabilitation counselors practicing through Internet sites: (1) obtain the written consent of legal guardians or other authorized legal representatives prior to rendering services in the event clients are minor children, adults who are legally incompetent, or adults incapable of giving informed consent; and (2) strive to provide translation and interpretation capabilities for clients who have a different primary language while also addressing the imperfect nature of such translations or interpretations.

**C. BUSINESS PRACTICES.** As part of the process of establishing informed consent, rehabilitation counselors: (1) discuss time zone differences, local customs, and cultural or language differences that might impact service delivery; and (2) educate clients when technology-assisted distance counseling services are not covered by insurance.

**J.14. DISTANCE GROUP COUNSELING**

When participating in distance group counseling, rehabilitation counselors: (1) establish and/or adhere to the group’s norms promoting behavior that is consistent with ethical standards; and (2) limit disclosure of confidential information.

**J.15. TEACHING, SUPERVISION, AND TRAINING AT A DISTANCE**

Rehabilitation counselors, educators, supervisors, or trainers working with trainees or supervisees at a distance, disclose to trainees or supervisees the limits of technology in conducting distance teaching, supervision, and training.

**SECTION K: BUSINESS PRACTICES**

**K.1. ADVERTISING AND SOLICITING CLIENTS**

**A. ACCURATE ADVERTISING.** When advertising or otherwise representing their services to the public, rehabilitation counselors identify their credentials in an accurate manner that is not false, misleading, deceptive, or fraudulent.

**B. TESTIMONIALS.** Rehabilitation counselors who use testimonials do not solicit them from current clients or former clients or any other persons who may be vulnerable to undue influence.

**C. STATEMENTS BY OTHERS.** Rehabilitation counselors make reasonable efforts to ensure that statements made by others about them or the profession are accurate.

**D. RECRUITING THROUGH EMPLOYMENT.** Rehabilitation counselors do not use their places of employment or institutional affiliations to recruit or gain clients, supervisees, or counselees for their private practice.

**E. PRODUCTS AND TRAINING ADVERTISEMENTS.** Rehabilitation counselors who develop products related to their profession or conduct workshops or training events ensure that the advertisements concerning these products or events are accurate and disclose adequate information for clients to make informed choices.

**F. PROMOTING TO THOSE SERVED.** Rehabilitation counselors do not use counseling, teaching, training, or supervisory relationships to promote their products or training events in a manner that is deceptive or would exert undue influence on individuals who may be vulnerable. Rehabilitation counselor educators may adopt textbooks they have authored for appropriate instructional purposes.

**K.2. CLIENT RECORDS**

**A. APPROPRIATE DOCUMENTATION.** Rehabilitation counselors establish and maintain documentation consistent with agency policy that accurately, sufficiently, and in a timely manner reflects the services provided and that identifies who provided the services. If case notes need to be altered, it is done in a manner that preserves the original notes and is accompanied by the date of change, information that identifies who made the change, and the rationale for the change.

**B. PRIVACY.** Documentation generated by rehabilitation counselors protects the privacy of clients to the extent that it is possible and includes only relevant or appropriate counseling information.

**C. RECORDS MAINTENANCE.** Rehabilitation counselors maintain records necessary for rendering professional services to clients and as required by applicable laws, regulations, or agency/institution procedures. Subsequent to file closure, records are maintained for the number of years consistent with jurisdictional requirements or for longer periods during which maintenance of such records is necessary or helpful to provide reasonably anticipated future services to clients. After that time, records are destroyed in a manner assuring preservation of confidentiality.

**K.3. FEES, BARTERING, AND BILLING**

**A. ESTABLISHING FEES.** In establishing fees for professional counseling services, rehabilitation counselors consider the financial status and locality of clients. In the event that the established fee structure is inappropriate for clients, rehabilitation counselors assist clients in attempting to find comparable services of acceptable cost.

**B. ADVANCE UNDERSTANDING OF FEES.** Prior to entering the counseling relationship, rehabilitation counselors clearly explain to clients all financial arrangements related to professional services. If rehabilitation counselors intend to use collection agencies or take legal measures to collect fees from clients who do not pay for services as agreed upon, they first inform clients of intended actions and offer clients the opportunity to make payment.

**C. REFERRAL FEES.** Rehabilitation counselors do not give or receive commissions, rebates, or any other form of remuneration when referring clients for professional services.

**D. WITHHOLDING RECORDS FOR NONPAYMENT.** Rehabilitation counselors may not withhold records under their control that are requested and needed for the emergency treatment of clients solely because payment has not been received.

**E. BARTERING DISCOURAGED.** Rehabilitation counselors ordinarily refrain from accepting goods or services from clients in return for rehabilitation counseling services because such arrangements create inherent potential for conflicts, exploitation, and distortion of the professional relationship. Rehabilitation counselors participate in bartering only if the relationship is not exploitative or harmful to clients, if clients request it, if a clear written contract is established, and if such arrangements are an accepted practice in the community or culture of clients.

**F. BILLING RECORDS**. Rehabilitation counselors establish and maintain billing records that are confidential and accurately reflect the services provided, the time engaged in the activity, and that clearly identify who provided the services.

**K.4. TERMINATION**

Rehabilitation counselors in fee-for-service relationships may terminate services with clients due to nonpayment of fees under the following conditions: (1) clients were informed of payment responsibilities and the effects of nonpayment or the termination of payment by third parties; and (2) clients do not pose an imminent danger to self or others. As appropriate, rehabilitation counselors refer clients to other qualified professionals to address issues unresolved at the time of termination.

**SECTION L: RESOLVING ETHICAL ISSUES**

**L.1. KNOWLEDGE OF CRCC STANDARDS**

Rehabilitation counselors are responsible for reading, understanding, and following the Code, and seeking clarification of any standard that is not understood. Lack of knowledge or misunderstanding of an ethical responsibility is not a defense against a charge of unethical conduct.

**L.2. APPLICATION OF STANDARDS**

**A. DECISION-MAKING MODELS AND SKILLS.** Rehabilitation counselors must be prepared to recognize underlying ethical principles and conflicts among competing interests, as well as to apply appropriate decision-making models and skills to resolve dilemmas and act ethically.

**B. ADDRESSING UNETHICAL BEHAVIOR.** Rehabilitation counselors expect colleagues to adhere to the Code. When rehabilitation counselors possess knowledge that raises doubt as to whether another rehabilitation counselor is acting in an ethical manner, they take appropriate action.

**C. CONFLICTS BETWEEN ETHICS AND LAWS.** Rehabilitation counselors obey the laws and statutes of the legal jurisdiction in which they practice unless there is a conflict with the Code. If ethical responsibilities conflict with laws, regulations, or other governing legal authorities, rehabilitation counselors make known their commitment to the Code and take steps to resolve conflicts. If conflicts cannot be resolved by such means, rehabilitation counselors may adhere to the requirements of law, regulations, or other governing legal authorities.

**D. KNOWLEDGE OF RELATED CODES OF ETHICS.** Rehabilitation counselors understand applicable ethics codes from other professional organizations or from certification and licensure bodies of which they are members. Rehabilitation counselors are aware that the Code forms the basis for CRCC disciplinary actions, and understand that if there is a discrepancy between codes they are held to the CRCC standards.

**E. CONSULTATION.** When uncertain as to whether particular situations or courses of action may be in violation of the Code, rehabilitation counselors consult with other professionals who are knowledgeable about ethics, with supervisors, colleagues, and/or with appropriate authorities, such as CRCC, licensure boards, or legal counsel.

**F. ORGANIZATION CONFLICTS.** If the demands of organizations with which rehabilitation counselors are affiliated pose a conflict with the Code, rehabilitation counselors specify the nature of such conflicts and express to their supervisors or other responsible officials their commitment to the Code. When possible, rehabilitation counselors work toward change within organizations to allow full adherence to the Code. In doing so, they address any confidentiality issues.

**L.3. SUSPECTED VIOLATIONS**

**A. INFORMAL RESOLUTION.** When rehabilitation counselors have reason to believe that another rehabilitation counselor is violating or has violated an ethical standard, they attempt first to resolve the issue informally with the other rehabilitation counselor if feasible, provided such action does not violate confidentiality rights that may be involved.

**B. REPORTING ETHICAL VIOLATIONS.** When an informal resolution is not appropriate or feasible, or if an apparent violation has substantially harmed or is likely to substantially harm persons or organizations and is not appropriate for informal resolution or is not resolved properly, rehabilitation counselors take further action appropriate to the situation. Such action might include referral to local or national committees on professional ethics, voluntary national certification bodies, licensure boards, or to the appropriate institutional authorities. This standard does not apply when an intervention would violate confidentiality rights (e.g., when clients refuse to allow information or statements to be shared) or when rehabilitation counselors have been retained to review the work of another rehabilitation counselor whose professional conduct is in question by a regulatory agency.

**C. UNWARRANTED COMPLAINTS.** Rehabilitation counselors do not initiate, participate in, or encourage the filing of ethics complaints that are made with reckless disregard or willful ignorance of facts that would disprove the allegation, or are intended to harm rehabilitation counselors rather than to protect clients or the public.

**L.4. COOPERATION WITH ETHICS COMMITTEES**

Rehabilitation counselors assist in the process of enforcing the Code. Rehabilitation counselors cooperate with requests, proceedings, and requirements of the CRCC Ethics Committee or ethics committees of other duly constituted associations or boards having jurisdiction over those charged with a violation. Rehabilitation counselors are familiar with the Guidelines and Procedures for Processing Complaints and use it as a reference for assisting in the enforcement of the Code.

**L.5. UNFAIR DISCRIMINATION AGAINST COMPLAINANTS AND RESPONDENTS**

Rehabilitation counselors do not deny individuals services, employment, advancement, admission to academic or other programs, tenure, or promotions based solely upon their having made or their being the subject of an ethics complaint. This does not preclude taking action based upon the outcome of such proceedings when rehabilitation counselors are found to be in violation of ethical standards.

**Chapter Summary**

Dear students in this chapter you have learned many things about the code of ethics for rehabilitation counselor. Just to remind and initiate your remembrance over what you have read in this chapter it was found worthwhile to mention those basic points. Generally speaking, a rehabilitation counselor is expected to act starting from accepting clients as human beings deserving respect, dignity and love and acting professionally with evidence and in the hemisphere of the science of rehabilitation, counseling and rehabilitation counseling.

Specifically speaking, a rehabilitation counselor is expected to play a great role in the following areas as required:

* Best possible level of ethical practice
* Seek out and personally adopt exemplary ethical practices of their own profession and other groups.
* Seeking to uphold the highest level of ethical practice by reflecting on the welfare of the clients served their needs, and the effects of the counselor's actions on the profession as a whole.
* rehabilitation counselors shall serve as advocates for individuals with disabilities with disabilities
* The following can be ethical violations, involving conflicts of business and professional interests, sexual misconduct with clients and/or students, fraudulent use of credentials, inappropriate personal financial gain, failure to act as a client advocate, disparaging remarks about a colleague, inappropriate billing practices, use of an illegal substance, and improper supervision techniques.

In this code of ethics for professional rehabilitation counselors developed by Common on Rehabilitation Counselor Certification, there are many sections ranging from Section A: the counseling relationship toSection B: Confidentiality, Privileged communication, and privacy**,** Ssection C: Advocacy and accessibility , Section D: Professional responsibility **,** Section E: relationship with other professionals **,** Section F: Forensic and indirect services, Section G: evaluation, Assessment, and interpretation **,** Section H: Teaching, Supervision, and Training **,** Section I: Research and Publication **,** Section J: Technology and Distance Counseling **,** Section K: Business Practices and Section L: Resolving Ethical Issues.

Therefore, we understand that the field of rehabilitation counseling is an area of a great concern both for the professionals and the clients which is governed by scientific procedures and laws.

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