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Ethics and Multicultural Contexts: Understandings and Applications

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This article focuses on the interaction of ethics with multicultural understandings of people and practice. We explore the place of biblical narratives, and their usefulness and application to understanding diversity and our work in multicultural contexts. Biblical stories suggest that diversity reflects an enduring aspect of God's kingdom, the continued presence of sin, and an arena for divine intervention and restoration. We also examine some of the ethical dilemmas that arise when applying ethical codes to clinical work with people from multicultural backgrounds. These include multiple relationships, informed consent, self-disclosure, and worldview perspectives. We use case examples to illustrate some of the dilemmas and propose changes that need to be made to bring resolution to the dilemmas. We hope that readers will better understand how ethics can be applied to our work both multiculturally and cross-culturally.

The United States is becoming a very diverse nation. In fact, the U.S. Census Bureau (2012) predicted that by the year 2043, racial/ethnic minorities will make up the majority of the U.S. population, 7 years earlier than previously projected. The American Psychological Association Center for Psychology Workforce Analysis and Research (APA, 2008) provides data showing that 86% of APA members and 92% of early career professionals who practice reported doing so with racial/ethnic minorities (cited in Vasquez, 2010). Therefore, if we are to provide quality of care to clients from multicultural backgrounds, therapists need to be culturally competent and ethically responsible (Barnett & Bivings, 2002; Pedersen, 1997; Vasquez, 2010).

In recent years, there has been considerable literature that addresses the area of cultural competence, but little has been written on the application of the ethical codes, particularly in controversial areas (Hays, 2008; Knapp & VandeCreek, 2007; McAuliffe, 2013; Paniagua, 2014). As a result, ethical codes are often applied without reference to cultural contexts, resulting in substandard care for people of color. One of the authors (Seegobin) recalled that earlier in his career, he met with a Middle Eastern couple for marital therapy. In the intake session, he conducted the typical marital interview that he had learned in graduate school, which was more from a European American perspective. He asked intrusive and personal questions without much consideration for their Middle Eastern background, its influence and impact on their marriage, and its role in disclosure to someone they had just met. Not surprisingly, the couple did not return for therapy. One of the lessons learned from that experience was that cultural considerations are an important aspect of the therapeutic process and need to be included at the beginning, in the intake interview. Quality of care can be undermined when cultural considerations are not given a priority in therapy (Gallardo, Johnson, Parham, & Carter, 2009). Additionally, lack of cultural awareness has been shown to be a factor in early termination (Paniagua, 2014).

Both the American Psychological Association (APA) and the American Counseling Association (ACA) provide guidelines that are helpful in multicultural contexts. For instance, the APA Ethics Code (2010) states that:

> Psychologists respect the dignity and worth of all people...Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, and consider these factors when working with members of such groups. (Principle E: Respect for People's Rights and Dignity, p. 4)

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Similarly, the ACA Code of Ethics (2014) states that one of their core professional values is "honoring diversity and embracing a multicultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts" (p. 3). Echoing Boyd-Franklin, Hays noted that "demonstrations of respect are considered a core part of culturally responsive practice (Boyd-Franklin, 2003)" (Hays, 2009; p. 355). Deepening this emphasis, Hays proposed that respect is more highly valued than rapport in many cultures, but also cautions that what is deemed respectful behavior varies across cultures. For example, in African-American culture, looking an authority figure in the eye is considered defiant, while looking down and away is considered a mark of respect toward that individual. Another way in which respect may be communicated lies in the pacing of therapeutic engagement; immediately challenging client beliefs may connote disrespect or be perceived as enacting cultural imperialism. Fostering trust is a cardinal element of this process; trust may be absent or extremely fragile when a member of an oppressed minority cultural group encounters a therapist who represents a more dominant culture.

In spite of these guidelines, ethical dilemmas have arisen when ethics codes conflict with the patient/client's beliefs and values in multicultural contexts. In an effort to bring some resolution to these dilemmas and enlightenment to the discussion, the four ethnic minority psychological associations have been working on responses to the APA Ethics Code that will facilitate clinical work and research with their various groups. On August 3, 2013, at a workshop at the national convention of the American Psychological Association, the four ethnic minority psychological associations (the Association of Black Psychologists [ABPsi], the Society of Indian Psychologists [SIP], the Asian American Psychological Association [AAPA], and the National Latino/a Psychological Association [NLPA]) expressed their discontent with the current APA Ethics Code (2010), indicating that it prevented them from effective clinical work with people from their respective groups. They proposed some changes that will facilitate this work.

The ABPsi indicated that "their guidelines were rooted in Afrocentric values and reflected historical trauma and psychological consequences of slavery and discrimination experienced by African Americans" (Morse & Blume, 2013, p. 1). Their ethical model is focused on healing that occurs through the valuing of collective community responsibility. The SIP revealed that the APA Ethics Code does not value the significance of relationships, spirituality, and community that are core Native values. They have written their response to the APA Ethics Code (Garcia, 2014). The AAPA reaffirmed their need for the APA Ethics Code to consider the role of cultural values and traditions in response to the effects of colonialism. The NLPA wants the ethics guidelines to reflect their struggles and shared cultural values (Morse & Blume, 2013). Hays (2009) summarized, "major practice theories are and always have been embedded with many of the values supported by the dominant culture . . ." (p. 356).

As a result of the need to make the APA and the ACA Ethics Codes more relevant to multicultural populations and to clinical work and research within Christian settings (Sanders, 2013), we will first explore the place of biblical narratives and their application to understanding diversity and our work in multicultural contexts. We will then examine some of the ethical dilemmas that arise when applying ethical codes to clinical work with people from multicultural backgrounds. Thirdly, we will use case examples to illustrate some of the dilemmas and propose changes that need to be made to bring resolution to the dilemmas.

Applying Theological Principles to Ethical Decision-Making in Clinical Contexts

In a previous discussion of ethics and diversity, Canning, Arute, Librado, and Yu (2013) articulated how the biblical narrative provides a framework within which to form our understanding of cultural diversity. We claimed that a theological foundation, based on the narrative arc from Creation to Fall to Redemption and Resurrection, was necessary for grounding more applied efforts by helping professionals seeking to provide culturally sensitive care. In our approach, we examined the theme of diversity in culture across the unfolding Creation-Fall-Redemption-Resurrection story. Drawing upon Smith and Carvill's (2000) and McNeil's (2005) treatments, we made the following five observations about diversity within the biblical narrative:

- Diversity is a reflection of the goodness of creation and a partial expression of the image of God.

- Diversity is a medium for divine correction and restoration in the context of rebellion toward God.
- Diversity is one arena within which sin is still visibly expressed.
- Diversity is a context for redemption and restoration in our lives now.
- Diversity is a characteristic of God's reign both now and in the world to come. (Canning et al., 2013)

We proposed a multidimensional view of diversity reflecting these five theological observations. Our contention was that this kind of *multifaceted* understanding of diversity—one that is neither all good nor all bad—could provide foundational principles upon which clinicians could begin developing a biblically-informed approach to ethical decision-making. Here, we attempt to take the next step in that direction, moving intentionally from these general theological principles to their application in the particular world of clinical practice.

Principles About Diversity From the Biblical Narrative

PRINCIPLE 1: Diversity is a reflection of the goodness of creation and a partial expression of the image of God. It is on this first, foundational principle that we stake our primary claim, beyond the many arguments for considering culture that have been well articulated and supported within discussions of ethics in the mental health disciplines. The clinician who is operating from this foundational theological principle will routinely approach ethical decision-making with an eye toward identifying and engaging cultural dimensions of the situation. She will confidently expect that cultural material will provide *adaptive*, *meaningful* data that will guide and assist her in satisfactorily resolving the situation. Cultural dimensions of a dilemma may be plumbed for their resourceful elements because human beings, and the cultures they create, will, to some degree, reflect the image of God and the goodness of His diverse creation.

Early in my graduate student training, I (Canning) was doing therapy with adolescents in poor urban neighborhoods, some of whom were navigating the challenges and transitions involved in pregnancy and infant care. These clients introduced me to a common cultural practice of new mothers "staying in" or at home and inside, with their newborns for a full six weeks following delivery. My reaction to this practice was one of concern. I saw it as a recipe for isolation and increased risk for postpartum depression. My initial impression was that clinical competence required me to challenge this cultural practice. This required self-examination about the sources of my response.

In the cultural contexts familiar to me, there were no generally agreed upon traditions for when a new mother could venture out with her newborn. Many did so soon after birth. This seemed practical to me and appeared to promote social interaction. Furthermore, I was raised to place a high value on independence and self-determination as a woman. My gendered values bristled at the notion of a community-wide prescription like this. Mothers, I expected, would (and should!) make their own decisions about when to take their infants outside the home. Moreover, I had assumed that, given the choice, most would want to do so. Finally, my cultural framework, reinforced by psychology graduate training, privileged "scientifically generated" childcare knowledge. If I am truly honest, I saw the idea of "staying in" as medically uninformed, even naïve, and therefore unnecessary.

However, what I learned from further engagement with my clients—and from supervision, consultation, and broader experiences in their neighborhoods—was quite different than what I expected. Far from being isolating, "staying in" proved to be a nurturing, supportive resource during a time of transition and intense demands. The givenness of this widely accepted practice streamlined the expectations and conduct of both the community and the mothers during the prescribed six weeks. Friends and family members came to the new mothers and provided practical and emotional support. Mothers did not have to expend precious time or mental energy on garnering assistance, thus preserving these limited resources for the demanding tasks involved in newborn care.

In this case, my ethical obligation to be clinically competent led me away from an inclination to challenge a given cultural practice and toward embracing it as a resource. My dilemma was resolved through discovering the goodness, so to speak, in the cultural dimensions of my client's context. The assumption that there is goodness to be found in culture, however, applies not only to our clients' cultural realities, but to those of the clinician, to the relationship between them, and to the clinical context(s) in which ethical

dilemmas arise. To the extent that we overlook this, our resources will be needlessly constricted and our efforts toward wise, competent, ethical practice will be unnecessarily hampered.

PRINCIPLE 2: Diversity is one arena within which sin is still visibly expressed. This next theological observation about diversity sets up an important dialectic for the clinician in the midst of an ethical decision-making process. Operating from the first principle, the practitioner assumes and actively considers how cultural material relevant to the client, the clinician, and the situation may reflect the *goodness* of creation and the image of God being expressed. He will carry the expectation that cultural realities can function as a *resource* for successful resolution of the dilemma. Practitioners who believe that they, their clients, and their clinical contexts exist in a fallen world, however, will also need to critically examine cultural realities for the degree to which distortions and degradations may be evident, as a result. These too must to be taken into account in order to achieve ethical resolutions.

In the earlier example of "staying in," further reflection on culture as "good" resulted in the clinician embracing the culturally informed practice as resourceful. One can easily imagine a scenario, however, in which culturally-shaped admonitions for a woman to "stay in" would require further analysis. Let us suppose, for example, that expectations for a particular client's postpartum contacts and mobility were being further regulated by a partner as one means, among others, of control that included psychological and physical coercion and aggression. Intimate partner relationships are powerfully shaped by cultural beliefs, values, and practices, all of which inform gender and partner identity, relationship expectations and dynamics, and the allocation of power. Application of the second theological observation about diversity expands the analytic task for the clinician. It allows for the possibility that culturally-informed values, roles, practices, etc. may also be impacted by the Fall. As a result, a more complicated, dialectical stance is indicated. In the process of navigating with the client toward a shared understanding and focus for intervention, the clinician would need to hold in tension her respect for cultural influences with aims that are more consistent with disruption and change.

Therefore, ethical, competent practice in culturally-informed situations such these requires that we avoid seeing culture in an all-or-nothing light. The application of theological principles 1 *and* 2 to our ethical dilemmas encourages analyses that are comprehensive and nuanced. Taken together, the principles will lead us to anticipate that clinically relevant cultural dimensions of a dilemma may yield evidence of the fallen aspects of culture, *as well as* the ways in which culture may reflect goodness in the situation. These expectations require that clinicians are skillful in critical analysis and can generate multiple perspectives on phenomena, in addition to the relational and intervention competencies needed to navigate such theologically and culturally complex waters.

PRINCIPLE 3: Diversity is a medium for divine correction and restoration in the context of rebellion toward God. An elaboration of this third principle requires us to tread carefully, as this theological assumption describes God's judgments, actions, and purposes in the world. Translating these divine functions (especially regarding the correction of human rebellion toward God) into a context of human judgment and action, especially those of professional helpers, is a tricky business indeed. Any attempt to apply this principle will need to be accompanied by healthy doses of humility and caution. That being said, we stand by this observation about cultural diversity, taken from an attentive review of the biblical narrative, and offer some thoughts on implications for the clinician committed to ethical, competent practice.

As practitioners and scholars who are also classroom instructors, clinical supervisors, and mentors, we have observed that instruction and training about cultural considerations in ethical decision-making are not infrequently met with trepidation on the part of our students and trainees. We have already acknowledged that cultural considerations introduce considerable complexity, and require sensitivity to the challenges of clinical work in general, and ethical dilemmas in particular. Insofar as they do so, it is understandable that increased complexity may be experienced as unwelcome, threatening, or burdensome. Clinical missteps in cultural competence can result in significant breaches of rapport and damage to the therapeutic relationship, the thought of which can understandably trigger significant anxiety. In addition to relationship harm, clinical harm may also occur in one of two forms: failure to provide needed care, and exacerbation of the problems for which treatment was sought. When trainees face unfamiliar cultural beliefs, values, practices, and contexts, they have

little in the way of direct experience upon which to draw, compounding the routine challenges faced in early clinical training placements.

No wonder, then, that feelings of anxiety, or of being overwhelmed, are a common response on the road to developing competence in this area of practice. Moreover, we should not be surprised to find inclinations in ourselves and our trainees, either subtle or not so subtle, to avoid embracing the demands of recognizing and engaging culture. Even with a high value and commitment to considering culture in clinical practice, students, trainees, and early and late career professionals alike are likely to be significantly stretched in this area of practice, at least from time to time. Furthermore, socialization to prejudices and structural racism exert heavy pressure on our thinking, emotions, and actions. And, as the second theological observation makes clear, we are responding to these challenges and anxieties as persons who are ourselves impacted by the Fall and capable of sin.

It is here that we have the opportunity to either escape or embrace the most disturbing aspects of encountering differences of gender, class, sexual orientation, ethnicity, and ability levels, to name a few. If we believe that we are not merely limited, but also sinful, we can expect to encounter not just inexperience, or lack of knowledge or skill in ourselves in clinically diverse contexts. We also can expect to encounter our own sin and others' sin. And if we understand the effect of the Fall to extend to social structures, processes, and settings, and beyond the impact on individuals, we will expect to encounter distortions and degradations in our systems and contexts of care. Doesn't this grave reality simply lead to more anxiety and burden as we practice across difference? Yes, and perhaps, no.

What this theological principle holds out for us, in fact, is a potential corrective to the psychological burden that we can experience. In fact, it enables us to view the complications and responsibilities of doing so as opportunities for God-given blessing. How so? The notion here is that God may, at some times, use the cultural differences, separations, alienations, ignorance, and misunderstandings we encounter in the course of our lives and work toward God's corrective and restorative ends. Not only can we grow *professionally* in these contexts, as has been the thrust of various arguments within our disciplines urging the development of cultural competence, but we may also anticipate the possibility of growth *spiritually*. But in so doing, we will be brought into contact with some of the most disturbing and destructive parts of our natures.

It is one thing to anticipate needing to grow in knowledge and skill development in order to effectively and efficiently handle ethical and clinical dilemmas. It is quite another to willingly face manifestations of our own sin. Yet practitioners who take seriously the notion that we are also subject to the effects of sin and the Fall will find it necessary to do so.

I (Canning) can attest to encounters with my own self-protectiveness, hyper-independence, prejudices, pride, and internalized racism in clinical contexts of difference. One particularly illuminating, painful, and humbling illustration comes out of my time as a graduate student researcher working with other graduate students, faculty-level researchers, and community members. Our project took place in one of the toughest, poorest neighborhoods in my city. Our community partners were gifted parents with whom we differed in religious orientation, age, life experience, race, and class, to name only a few. In the context of this work, I encountered two dilemmas that called for ethical decision-making on the part of myself and my faculty advisor.

One dilemma involved decisions over the order of authors on an important conference presentation; the other involved determining pay levels for student and community member assistantships. I have written elsewhere (Canning, 1999) about the feelings of resentment, jealousy, and entitlement that I became aware of in the process of these decisions. I realized that, despite my belief that I regarded my community partners as equals, my emotional and cognitive responses belied a view that the participation and contributions were comparatively less valuable than my own and my graduate student peers'.

I am grateful that my mentor (a Christian himself), did not spare me the pain of being confronted by attitudes within myself that I found repugnant. He helped me recognize prejudices that I had not identified myself with, nor realized were influencing my decision-making. Though painful, these realizations enabled me to repudiate those inclinations and embrace choices befitting the values to which I aspired.

These experiences were transformative for several important reasons. First, in my conversations with my mentor, I experienced not only his good counsel, but the correction and conviction of the Holy Spirit. Second, this mentor-mentee

encounter occurred in a larger context that facilitated my development along these lines. Our research team had a rich ethos of dealing with difference, and all members shared a commitment to working out difficulties that arose. This context provided access to tools, models, and opportunities to grow and apply the values I so earnestly desired to reflect in my character. The results, over time, shaped me as a person and a professional ever since.

PRINCIPLE 4: Diversity is a context for redemption and restoration in our lives now. The previous principle and example emphasize the gravity of conviction and correction in the context of difference. This one points us toward the constructive role God is able to play in such contexts. In the biblical view, correction in the hands of God is ultimately for His redemptive purposes in Creation. Holding a view of diversity as a context for these purposes enables us to hope for and expect God's good work in continuing to form us and those we serve in life-giving ways.

In the example I gave above, my moments of conviction and correction took place in the context of a team with a whole host of challenging differences involving long and painful histories of mistrust and injustice. As clinicians, we will inevitably come upon situations such as this. We will not understand our clients' cultural values, practices, or styles. We will ignore, misinterpret, judge, feel repelled by, or otherwise fail or wound our clients as a result of differences and prejudices. How will we respond to this reality while remaining committed to our ethical obligation to be competent in what we do? Along with the many excellent professional strategies we have been advised within our fields to employ, acceptance and confidence in God's corrective and restorative role in these situations may assist us.

The assurance that God is constructively at work in and through our differences, separations, and limitations may provide us with some relief, confidence, and courage in these challenging situations. It may guide us away from temptations to anxiety and avoidance toward a more curious, collaborative, confident response to the puzzling, disconcerting, anxiety-provoking, or otherwise arduous moments ahead of us in this kind of work. In turn, these qualities should help us remain present, despite uncertainties and differences, and facilitate the kind of critical thinking and complex, cognitive problem-solving required to effectively resolve ethical dilemmas. We may adopt a more interdependent, consultative stance that fosters further exploration with our clients, and input-seeking from supervisors and colleagues. Finally, we may develop comfort and commitment to the kind of life-long humility, self-examination, and skill-development that has been deemed necessary for the multi-culturally competent clinician, regardless of vocational stage (Smith & Trimble, 2016). These "fruits" that can grow from the application of this fourth theological principle are consistent with competencies necessary for ethical decision-making and conduct. So, rather than being overwhelmed by discouragement, anxiety, or avoidance of various kinds, we may learn to anticipate the benefits for ourselves and our clients when we encounter the fallen aspects of our own natures. We can reframe these clinical moments so they are less threatening. We may even begin to welcome them with the anticipation that they can be used by God to grow our characters and enhance our development as competent, ethical practitioners—and as Godly persons.

PRINCIPLE 5: Diversity is a characteristic of God's reign both now and in the world to come. This last principle provides a bookend to the first assertion that diversity reflects God's goodness in creation. Here the emphasis is on the goal or end of things. From this view, the idea that there is goodness in diversity is extended so that this form of goodness is to be expected within the Kingdom that is now and is *to come*. As such, diversity in human experience is not something that will go away or give way to homogeneity. In contrast, some conversations about diversity in the broader culture belie an assumption that outcomes of our challenges across difference are desirable when they land in places of agreement and similarity. If this sort of melting-pot view is applied to ethical decision-making, we may find ourselves expecting or searching for solutions that will fit all our clients, or at least all of our clients sharing certain cultural characteristics or contexts. Indeed, the higher the stakes in a particular clinical dilemma, the more pressure we may feel to search for prescriptions and answers that promise to reduce our risks and anxieties. This inclination could be exacerbated by the fact that ethical decision-making requires us to know and apply clearly prescribed standards, policies, and even laws to individual situations.

The theological principle in view here may assist us in the liminal place between clearly prescribed standards applicable to all providers, and

the cultural realities that push the boundaries of our specific application of these principles. It can serve as a reminder that we must consider whether and to what degree adaptations in our understanding and action may be necessary in a given context, given the particular cultural dimensions in play. Our goal in teaching and applying theologically- and culturally-informed ethical decision-making, then, is not, and indeed cannot be, to foster one-size-fits-all, melting-pot analyses or solutions. Nor is it to throw out the ethical standards with the bath water, so to speak. Instead, an important dialectic will be present between ethical standards and cultural knowledge and practice.

Furthermore, the direction and degree to which culture will exert influence on our application of standards will vary not only with client, practitioner, and contextual characteristics, but with the ethical situation itself. For example, there will be little disagreement (at the levels of making judgments and prescribing action about the responsibilities of clinicians) about clinicians' responsibility to avoid the sexual exploitation of clients. In these instances, introducing cultural considerations will yield important information about clinician-client relationship dynamics, sexual mores, communication about attraction, and other clinical dimensions of the situation, but it will not change our ethical obligation or alter the necessary outcome—avoidance of sexual involvement. Other kinds of ethical quandaries may have a higher likelihood that the actual goal or outcome in a resolution may differ depending upon cultural features of the situation. Evaluating the degree to which dual relationships in rural contexts and other underserved cultural settings are problematic or not is one such example. Clinicians have been advised that the perceptions, values, practices, and social realities of practicing within rural or other small, contained communities are essential considerations in our ethical decision-making (Backer, Goodnough, Levitt, & Moorehead, 2013; Schank & Skovholt, 2006). Further, for persons from oppressed cultures, trust may be so fragile that a non-exploitive multiple relationship is the prevailing bridge to sufficient trust to engage in treatment. In this and other areas of ethical standards, cultural realities are likely to strongly inform our thinking and the resolutions we propose.

In sum, cultural differences/diversity reflect both the divine plan for variety in all of its richness, and aspects of the Fall and human sinfulness. Diversity provides an opportunity for increasing our awareness of sin and a context for conviction, correction, and redemptive work. Engaging diversity prepares us for the coming kingdom in which diversity remains, but without the current conflict and pains.

Where these theological observations leave us is therefore far from providing highly specific prescriptions for clinical behaviors. However, we believe they go another step in the direction of theologically shaping our attitudes and expectations, and providing some additional resources for the clinician to navigate ethical dilemmas. In the next section, we discuss a few of the ethical dilemmas that therapists may encounter in working with culturally diverse clients.

Ethical Dilemmas Encountered in Clinical Work with Culturally Diverse Clients

In this section of the article, we focus on some of the ethical dilemmas that frequently arise when we do clinical work with culturally diverse clients. Although these dilemmas may arise with any client, our discussion and application are related to work in multicultural settings. One of the foundational concerns is that the APA Ethics Code (2010) was written from a European American perspective and consequently does not work well with some people of color (Morse & Blume, 2013). As a result, we encounter ethical dilemmas that influence our work with culturally diverse clients. What are some of these ethical dilemmas and how do we go about resolving them? In this section, we will discuss four of the more prominent dilemmas, namely multiple relationships, informed consent, self-disclosure, and worldview (Collectivism vs. Individualism).

Multiple Relationships

Initially, the ethics code forbade multiple relationships because of its risk to harm clients. However, the most recent version of the APA ethics code (2010) allows for multiple relationships that are not harmful or exploitative. It says: "Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical" (Standard 3.05). There is much discussion in the literature on multiple or dual relationships in psychotherapy (Barnett, Lazarus, Vasquez, Moorehead-Slaughter & Johnson, 2007). Emphasis is placed on maintaining the boundaries between therapist and client. Lazarus and Zur (2002) discussed boundary crossings and boundary violations. Depending on one's theoretical orientation,

boundaries may be firm or permeable. From both clinical experience and the literature, it appears that boundary crossings with diverse clients enrich clinical relationships—perhaps even form their foundation—and seem to be more helpful to these clients (Vasquez, 2010). An example of appropriate boundary crossing occurs with some American Indian clients. In fact, psychotherapy may be hindered without dual relationships. Garcia (2014) noted that:

> Multiple relationships are common and in some instances expected in Native communities as relationships are both broad and deep. People in tribal environments are in multiple relationships. Native providers in urban areas are also in multiple relationships because there are so few of us. In certain instances, refusing to provide services because of the potential for multiple relationships would be construed as offensive and perhaps contribute to harm if no care was provided at all. Whether in a rural or an urban area, accessibility to culturally competent services is an issue, which needs to be factored in. We still need to have boundaries around these relationships, and confidentiality is key. We are operating in a context that was not considered when the code was originally written (p. 48).

Within this cultural context, clients are hesitant to develop counseling relationships with therapists whom they do not know. Lazarus and Zur (2002) indicated that often dual relationships enrich and further the therapeutic relationship. They noted that the therapeutic relationship may be compromised when boundary crossings do not occur. Additionally, Sanders (in press) discussed some of the reasons for multiple relationships occurring in faith communities and issues to consider when engaging in such relationships.

Informed Consent

Informed consent is a very important aspect of the therapy process. It not only helps the client to understand the therapist and the process of therapy, but also provides the opportunity for the client to become an integral part of the therapeutic process. One of the essentials of therapy, discussed very early in the training of therapists, is the necessity of having informed consent from the client. For some therapists and in some settings, therapy cannot proceed without the client providing written informed consent. As such, much emphasis has been placed over the years on written informed consent. Yet, much of what we do in psychotherapy is verbal. Most if not all of our counseling sessions are conducted verbally, yet we require clients to sign a written informed consent. Such a practice is common among European Americans but may not work as well with other ethnic or racial groups. An example of this occurrence is work with American Indians. Most American Indians make contracts that are verbal, and consequently are very suspicious of written contracts. The therapist's insistence on written informed consent can influence the course of therapy. The Society of Indian Psychologists' response to the APA Ethics Code (Garcia, 2014) indicated, "In some indigenous environments, it is culturally inappropriate to ask for signed informed consent. A verbal consent is appropriate. This permission can be documented in the form, in the research notes or recorded if the interview is recorded" (p. 49). SIP psychologists noted that Native elders often have difficulties with signing consent forms because of the history of abuse from the government.

Other clients who do not have English as their first language may be suspicious of signing informed consent in a language they do not understand. In such a case, it may be appropriate for the client to give verbal informed consent, and later on when he/she more fully understands the informed consent, can then sign the written informed consent in their first language. Insistence on clients signing a document that they do not understand is not a helpful or therapeutic practice. It can be perceived as manipulative or coercive, and thus may undermine trust.

Self-disclosure

Inappropriate self-disclosure by a therapist can be detrimental to the therapeutic relationship in that it serves the needs of the therapist without regard for its effect on the client. However, are there times when self-disclosure can be helpful? For some diverse clients, the therapist's disclosure is necessary for the therapeutic alliance and removes barriers between the client and therapist. Appropriate self-disclosure by the therapist seems to facilitate the building of the therapeutic relationship. Vasquez (2012) noted:

> Self-disclosure can be a powerful way to increase mutuality and connection with a client, student, or consultee. Increased professional visibility allows clients more power in the relationship than they would have with a less forthcoming psychotherapist; it is an expression of genuineness. Self-disclosure also serves the function of allowing the client to reciprocate empathy, which can promote mutuality and empowerment of the client (p. 31)

For example, among some Asian American clients, therapists' disclosure of their educational background and family constellation facilitates building the therapeutic alliance and fosters an atmosphere where client disclosure occurs more easily. Somewhat similarly, in a videotaped demonstration of an African American psychologist working with an African American female client that I (Seegobin) use in my Multicultural Psychotherapy class, Thomas Parham (2005) began his session by inviting the client to ask him questions that she had about him and his background. He shared personal information about himself, his religious background, and his reasons for choosing clinical psychology as a profession. He also responded to questions about a cross he wore. It appeared that his self-disclosure at the beginning of the intake session facilitated the self-disclosure of the client, trust in the therapist, and the building of the therapeutic relationship.

Worldview (Collectivism vs. Individualism)

Worldviews address five basic questions: what exists, how we know, how things work, what is good/bad or right/wrong, and who we are. Worldviews provide the lens by which we understand ourselves, our problems, decide which interventions are acceptable and which are not, and what goals we embrace or eschew.

The ethical guidelines for both the APA and the ACA seem to be written from an individualistic perspective, making its application difficult in collectivistic cultural settings. Many of the guidelines focus on the individual, such as "self-determination" (Principle E). Psychologists "obtain the informed consent of the individual" (3.10; Informed Consent). "Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law" (4.05). In contrast, in the section regarding couples and families, the focus shifts:

> When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset (1) which of the individuals are clients/patients and (2) the relationship the psychologist will have with each person. This clarification includes the psychologist's role and the probable uses of the services provided or the information obtained. (See also Standard 4.02, Discussing the Limits of Confidentiality). (10.02, Therapy Involving Couples or Families)

Even here though, the tendency is to view one individual as patient/client and the others as collateral participants who are thus accorded less protection in terms of privacy, confidentiality and so on. By contrast, in a collectivist culture one might treat the family or group as the patient/client and custodian of confidentiality and other concerns.

For some clients from collectivistic backgrounds, individual therapy that asks questions such as "What do you want?" and "What is best for you?" do not take into consideration that the client's decisions not only affect him or her, but also the individual's family and community. Sometimes, when these questions are answered from a more collectivistic perspective, the therapist may view the individual as too enmeshed with family or not sufficiently individuated. For persons of color, it is important to provide the "client" with the space to make decisions based on what is best for the family or community to facilitate progress in therapy.

In therapy, ethical decisions based on individualism can be counterproductive for some clients. For instance, rather than pathologize clients' behavior because of their worldviews, we need to examine the cultural context of the behavior and make culturally-informed ethical decisions based on the clients' worldviews. Otherwise, we risk imposing our worldview on the client, which violates Principle E, Respect for People's Rights and Dignity. Additionally, understanding and working from the client's worldview ensures quality of care and respect for the client's cultural background.

Ethically Engaging Cultural Differences

It should be clear from the foregoing material that the ways in which cultural factors may shape the therapy are multi-faceted. Cultural and worldview factors provide the context in which problems are conceptualized. They set the boundaries between interventions that are accepted or embraced and those that are rejected. They provide the underlying motivations for treatment—or for refusing it. Finally, several factors need to be present at once: 1) a deep enough cultural understanding or knowledge; 2) skillfulness in exploring how cultural factors shape patient/client perceptions of their problems, decisions about the kinds of help they will receive, and goals toward which they will work; 3) an attitude of respect and humility; and 4) the capacity to enter into a good-enough relationship to provide the context for effective multicultural work.

In summary, effective therapy requires understanding my clients well enough, in terms of his/her/their worldview so that I can negotiate informed consent that:

- includes an acceptable description of the problem
- articulates what is to be done about it
- identifies goals or outcomes
- promotes a collaborative working relationship of mutual respect and trust

In order to accomplish these goals it is essential that as the therapist, I must cross the bridge to meet my clients in the context of his/her/their worldview rather than expecting the client to meet me on my side of the gulf. Respect, understanding, and trust are essential to an effective working alliance. At the same time, I must remain sufficiently mindful of the community contexts in which we live so that I do not act in ways that trigger adverse consequences for myself or for my clients in those communities. For example, I may need to recognize that relatively harsh forms of discipline are acceptable within the client's culture but must also be mindful of the local community standards where we live and work. The next section provides case examples. These illustrate suggested ways of responding to ethical dilemmas.

Case Examples[1]

Summer. Summer was a married (for a second time) woman in her mid-thirties with two children aged 12 and 5. She presented with a mix of anxiety, depression, anger, and physical symptoms possibly linked to a motor vehicle accident five years earlier. Initially PTSD was a rule out, but there was not clear evidence to support the diagnosis. Due to the complexity of her symptoms, her ethnic background did not come up in the initial intake; it also was omitted on her background information form. Summer had an olive skin tone that provided no simple ethnic clues.

Silence and vagueness characterized much of the first three visits. At a subsequent session when I judged her trust was sufficient, I asked if I could inquire about her ethnicity; she said she was "1/4 white, 1/4 African-American, and 1/2 Native American." Then she informed me her first husband had abused her. During the next session she gave a general outline of what he had done. At this point it was clear that our initial treatment plan would need to be revised to address abuse, trauma, and PTSD. We began to talk about how I might help with the resulting depression and PTSD.

What do you make of the way Summer's treatment has unfolded so far? How might reflection on our differences shed light on how we can best proceed (see Hays, 2008; ADDRESSING model)? In what ways might cultural factors have shaped initial developments and guide ensuing steps? As I (Bufford) reflected on my work with Summer, I noted that although she was raised within the North American cultural milieu, she is linked to two minority cultures. It was clear that I was white, male, highly educated, and older. This helped me to understand more deeply that her initial engagement in treatment likely reflected a cautious exploration of my ability to be respectful and trustworthy.

Miriam. Miriam was a nursing student at a local college. She also worked as a nursing assistant in a residential mental health treatment facility that served patients who were chronically psychotic and dangerous to themselves or others. A Black woman, Miriam was born and raised in a central African country. A few weeks before she first saw me, a large woman patient at work had sneaked up behind her in the hallway, grabbed her by the hair, and repeatedly slugged Miriam on the side of the head. Miriam sustained a concussion; she had received medical treatment but was afraid to return to work.

Miriam gradually provided more details of her struggles. She was having difficulty in class and was not consistently attending. She had stopped running because she was afraid to go out and did not feel safe on the streets. Miriam said that she did not know what to do to be safe in this cultural setting. At home she would simply counter-attack in response to an assault—but in this country, especially at work—she knew she would be in trouble if she did so.

With a safety plan, Miriam agreed to try some low-intensity running. Intense headaches ensued and I learned Miriam had not mentioned other headaches. She gradually revealed she continued attending school, but was unable to remain in her class, had fallen behind in her reading, and had trouble remembering things. We worked on a plan to begin some more consistent reading and study. During the visit, Miriam reported that studying also triggered headaches. We began to suspect these were residual effects of her concussion.

Miriam needed to pick up a check from work. She also wanted to resume work but was afraid to go back into the treatment unit. We planned *in vivo* desensitization; she was to sit in her car within sight of the building, stay for a time, and then return home. Instead, she attempted to go into the staff office. This produced nausea, vomiting, and another headache. She found another job but found she was unable to carry out work responsibilities there, much as study was beyond her.

The challenges of sorting out Miriam's intertwined physical and psychological symptoms could easily occur with a white American. So how might her cultural factors affect the treatment process?

As a cultural minority, the challenges of respect, trust, and worldview needed to be navigated. Other challenges, such as how much to share about her subjective distress, had to be navigated patiently, as her trust and desperation gradually led her to be more open with me. It doubtless helped that Miriam was familiar with anxiety and depression through work. Suddenly these were personal realities. Removed from her collectivist cultural setting, she hadn't developed a similar support system here. Interestingly, Miriam was able to articulate one of her cultural challenges: how to protect herself here in this setting.

We explored Miriam's options. She was increasingly convinced she had not healed physically and could neither continue her studies nor work successfully. Remaining in the US seemed less and less viable, but she feared that a return home would end her dreams of education and work in the US. Gradually, she came to accept that a return to home and family/community support was her best choice.

Adsila. Adsila [pseudonym] was in her mid-teens when she came for individual therapy. She presented with symptoms of generalized anxiety, experiencing panic attacks multiple times some days, and she was clearly working on identity, trying desperately to integrate two very different cultural heritages (American Indian and European American) into a strong sense of self. Adsila had been in multiple forms of therapy off and on for almost half her life.

Adsila knew many techniques to manage her anxiety symptoms. She could describe grounding exercises and relaxation methods, but still she struggled. She struggled to make meaning of her symptoms, and by the time she arrived at the community clinic, she was angry. She was angry at a society that seemed to ignore injustices, both past and present. She was angry at her inability to fully embrace the identified values of her tribe, and she was angry at those who could not seem to accept the heritage and identity that mattered so deeply to her.

Instead of focusing on the identity that Adsila struggled to shed (anxiety), Adsila and the therapist decided to focus therapy in a narrative way. Adsila worked each week to capture the exceptions: the moments she embodied her tribal and totem values. She used the medicine wheel to explore various relationships and aspects of her life. She brought in literature and information that helped her articulate her tribal history and worldview. And over the course of three months, Adsila's panic attacks became much shorter and less frequent. Her school attendance increased. Her social relationships shifted. She applied for a job.

After 10 weeks of therapy, Adsila began talking about an upcoming tribal ceremony, and she invited her therapist to attend. For Adsila, this was an extremely significant life event. It included a meal, a ceremony, the giving of symbolic gifts, and introductions to significant friends and family. For the therapist in training, this presented an ethical dilemma. It breached typical protocols and typical therapeutic boundaries, so the therapist consulted four licensed psychologists. All four psychologists were faculty members of an APA accredited graduate program and supervisors. Two of the psychologists identified as White and two identified as non-White, non-majority culture. Consultation results split down the middle.

Both members of the White majority culture expressed strong reservations about accepting the invitation. They outlined specific questions around expectations for the therapeutic relationship and concerns about the upcoming termination process. They made suggestions about considering a sort of limited participation in the event—perhaps attending the ceremony but not the meal, or attending briefly with as little direct involvement as possible. They expressed concerns about accepting any of the symbolic gifts offered to guests and made strong suggestions about what ought to be directly discussed with the client before and after the event, if it were, in fact, at all possible to attend.

On the other hand, both psychologists from non-White, non-majority cultures encouraged attendance. They raised some similar questions about what attendance might mean in the mind of the client. Would it alter power in the relationship or indicate an intention to maintain relationship past termination? How would the client and the family members or friends explain the attendance of the therapist and feel comfortable at the event? How could confidentiality be protected? They also asked about the therapeutic benefits that might come from attending the ceremony, since identity development and identity integration were so much a part of the clinical focus.

With the support of her supervisor, the therapist determined to accept the invitation and attend the event. She worked first, with the client, to consider termination and what termination would mean, both for their relationship and for the client's ongoing work toward her goals. Together, they came to understand the tribal ceremony as a sort of community extension of the client's work in therapy. For the client, it was her opportunity to publicly share and embrace the identity she wanted to claim. It was her way to ask for the support of her tribe—to be held to its values and to her part in that community—as an adult and a contributing member. She understood that the therapist in training would be leaving the clinic soon as part of the training rotation, and she wanted to use the naming ceremony as a bridge. The client wanted the therapist to attend the naming ceremony as a witness, to mark her ability to engage in life—or any future therapy—in a new way. With that purpose and meaning in mind, they quickly settled questions of confidentiality and logistics.

Summary and Conclusion

In this article, we explored the importance of making ethics codes relevant in multicultural settings. We discussed the application of theological principles to ethical decision-making in clinical contexts. We then focused on ethical dilemmas that can be encountered in working with clients from diverse backgrounds, specifically addressing the areas of multiple relationships, informed consent, self-disclosure, and worldview (collectivism vs. individualism). We also presented case examples to illustrate ways of responding to ethical dilemmas. We hope that this information will be helpful in our clinical work in multicultural settings. In conclusion, we agree with Barnett and Bivings (2002) who stated that:

> Ethical psychologists must possess the necessary training to provide competent care to clients from a wide range of diverse backgrounds. They should be aware of the guidelines and standards in the APA Ethics Code as well as their inherent limitations. They understand that a strict adherence to ethical standards may result in substandard care of clients from diverse backgrounds and that, at times, to be ethical will involve going beyond majority values and conceptions of appropriate treatment practices and relationships so that each client's treatment needs are met in a thoughtful, sensitive, and effective manner. These guidelines and standards must be interpreted and implemented with attention to and understanding of each client's background and beliefs (p. 25).

Note

[1]All of the cases discussed in this article have been thoroughly disguised.

References

American Counseling Association (ACA; 2014). *Codes of ethics*. Retrieved from http://www.counseling.org/Resources/aca-code-of-ethics.pdf.

American Psychological Association (APA; 2010). *Ethical principles of psychologists and code of conduct*. Retrieved from http://www.apa.org/ethics/code/principles.pdf

Backer, A., Goodnough, G., Levitt, D.H., & Moorhead, H.J.H. (2013). Boundary issues. In D. H. Levitt & H. J. H. Moorhead (Eds.) *Values and ethics in counseling: Real-life ethical decision making*. (pp. 43-48). New York, NY: Routledge/Taylor & Francis.

Barnett, J. E., & Bivings, N. D. (2002). Culturally sensitive treatment and ethical practice. *The Maryland Psychologist, 48(2)*, 8, 25.

Barnett, J. E., Lazarus, A. A., Vasquez, M. J. T., Moorehead-Slaughter, O., & Johnson, W. B. (2007). Boundary issues and multiple relationships: Fantasy and reality. *Professional Psychology: Research and Practice, 38*, 401-410. doi: 10.1037/0735-7028.38.4.401.

Canning, S. S. (1999). Stretching Procrusteus: True confessions on the road to cultural competence in community research and action. [Special Issue: Cultural competence in community research and action]. *The Community Psychologist, 32*(1), 30-32.

Canning, S. S., Arute, I., Librado, A., & Yu, A. (2013). Ethics in culturally sensitive practice. In R. K. Sanders (Ed.) *Christian counseling ethics: A handbook for therapists, pastors and counselors* (2nd ed., pp. 310-342). Downers Grove, IL: Intervarsity Press.

Gallardo, M. E., Johnson, J., Parham, T. A., & Carter, J. A. (2009). Ethics and multiculturalism: Advancing cultural and clinical responsiveness. *Professional Psychology: Research and Practice, 40*, 425-435 doi: 10.1037/a0016871

Garcia, M. A. (2014). *Commentary on The American Psychological Association's (APA) ethical principles of psychologists and code of conduct.* The Society of Indian Psychologists. Albuquerque: NM.

Hays, P. A. (2008). *Addressing cultural complexities in practice: Assessment, diagnosis, and therapy*. (2nd ed.). Washington, DC: American Psychological Association.

Hays, P. A. (2009). Integrating evidence-based practice, cognitive-behavior therapy, and multicultural therapy: Ten steps for culturally competent practice. *Professional Psychology: Research and Practice, 40*, 354-360.

Knapp, S., & VandeCreek, L. (2007). When values of different cultures conflict: Ethical decision making in a multicultural context. *Professional Psychology: Research and Practice, 38*, 660-666 doi: 10.1037/0735-7028.38.6.660

Lazarus, A. A., & Zur, O. (Eds.), (2002). *Dual relationships and psychotherapy*. New York, NY: Springer.

McAuliffe, G. (2013). *Culturally alert counseling: A comprehensive introduction*. (2nd ed.) Thousand Oaks, CA: Sage.

McNeil, J. D. (2005). Unequally yoked? The role of culture in the relationship between theology and psychology. In A. Dueck & C. Lee (Eds.), *Why Psychology Needs Theology* (pp. 140-160). Grand Rapids, MI: Eerdmans Publishing Company.

Morse, G. K., & Blume, A. W. (2013). Does the American Psychological Association's code of ethics work for us? *Journal of Indigenous Research, 3*, 1-4. http://digitalcommons.use.edu/kicjoir/vol3/iss 1/2.

Paniagua, F. A. (2014). *Assessing and treating culturally diverse clients: A practical guide.* (4th ed.). Thousand Oaks, CA: Sage.

Parham, T. A. (2005). *Working with African American clients* (video). Washington, D.C.: American Psychological Association.

Pedersen, P. B. (1997). The cultural context of the American Counseling Association code of ethics. *Journal of Counseling & Development. 76*, 23-28.

Sanders, R. K. (2013). *Christian counseling ethics. A handbook for psychologists, therapists and pastors,* (2nd ed). Downers Grove, IL: InterVarsity Press.

Sanders, R. K. (in press) Multiple relationships in faith communities. In O. Zur (Ed.). *Multiple relationships in psychotherapy and counseling: Unavoidable, common and mandatory relations between clients and therapists.* New York, NY: Taylor & Francis/Routledge.

Schank, J. A., & Skovholt, T. M. (2006). *Ethical practice in small communities: Challenges and rewards for psychologists.* Washington, DC: American Psychological Association.

Smith, D. I., & Carvill, B. (2000). *The gift of the stranger: Faith, hospitality, and foreign language learning*. Grand Rapids, MI: Eerdmans.

Smith, T. B., & Trimble, J. E. (2016). Therapist multicultural competence: A meta-analysis of client experiences in treatment. In T. B. Smith & J. E. Trimble (Eds.) *Foundations of multicultural psychology: Research to inform effective practice* (pp. 49-64). Washington, DC: American Psychological Association.

U.S. Census Bureau. (2012). *U.S. Census Bureau projections show a slower growing, older, more diverse nation a half century from now*. Retrieved https://www.census.gov/newsroom/releases/archives/population/cb12-243.html

Vasquez, M. T. J. (2010). Ethics in multicultural counseling practice. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.) *Handbook of multicultural counseling*, (3rd ed., pp. 127-146). Los Angeles: Sage.

Vasquez, M. T. J. (2012). Ethics for a diverse world. In J. Frew and M.D. Spiegler (Eds.) *Contemporary psychotherapies for a diverse world*. (1st Rev. Ed., pp. 19-38). New York, NY: Routledge.

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