

CHAPTER 4

Ethical Practice in an Increasingly Diverse World

A serious moral vacuum exists in the delivery of cross-cultural counseling and therapy services because the values of a dominant culture have been imposed on the culturally different consumer.
(Pedersen & Marsella, 1982, p. 498)

The Pedersen and Marsella (1982) quote with which we opened the chapter is certainly both a warning against and a condemnation of unethical professional practice. Granted, the observation was made over 30 years ago, and we can take some comfort in the fact that our professions' attention to multiculturalism has become so widespread and intense that it has been called a "fourth force" (Pedersen, 1999). In addition, professional organizations (e.g. AAMFT, ACA, AMHCA, APA, NASW) have realized and have continued to discuss the implications of multiculturalism on the ethics of practice, which in turn have resulted in the extensive revisions of the codes governing ethical practice (see Table 4.1).

Human service professions have made clarion calls for practitioners to become multiculturally competent, warning of the possibilities that our own cultural values and biases can override those of our clients (ACA, 2005). Even though most professionals recognize the ethical responsibility

Table 4.1 Calling for Cultural Competence

<i>Organization</i>	<i>Statement</i>
American Association for Marriage and Family Therapy (2015)	1.1. Marriage and family therapists provide professional assistance to persons without discrimination on the basis of race, age, ethnicity, socioeconomic status, disability, gender, health status, religion, national origin, sexual orientation, gender identity or relationship status.
American Counseling Association (2014)	Page 4. “Counselors actively attempt to understand the diverse cultural backgrounds of the clients they serve . . . ”
American Mental Health Counselors Association (2010)	C.1.g. Recognize the important need to be competent in regard to cultural diversity and are sensitive to the diversity of varying populations as well as to changes in cultural expectations and values over time.
National Association of Social Workers (2008)	1.05.c. Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability.
American Psychological Association (2010)	Principle E. 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.

to practice in a multiculturally sensitive manner (Lee, 2003), the reality is that in practice the avoidance of the negative effect of internalized bias and narrow worldviews is not an easy, nor is it a “one-time” task. Undoing our internalized prejudicial attitudes and bias requires an ongoing process of learning and unlearning in order to become and remain an ethical, multiculturally competent practitioner (Duan & Brown, 2016).

The current chapter is but one source and stimulant for that learning and unlearning. The chapter highlights the need for each practitioner to increase his or her awareness of both personal and professional biases; biases that can color his or her view of clients and even the approaches employed to assist them in their time of need. The chapter invites the reader to not only understand the codes of ethics that specifically address issues of diversity but, more importantly, to develop a perspective that allows him or her to engage in all practice decisions with multicultural sensitivity.

OBJECTIVES ●

As such the current chapter will help you to do the following:

- Increase your awareness of your own “worldview” and its potential impact on your practice decisions.
- Understand those ethical standards specifically addressing issues of diversity and the need to develop multicultural competence.
- Value the need to employ a lens of multicultural competence to review and reconsider (a) elements guiding the therapeutic relationship, (b) the processes of assessment and diagnosis and, (c) the formulation and implementation of a treatment plan.

PREJUDICE: PERVASIVE IN AND THROUGHOUT ● THE HELPING PROFESSION

Human behavior, human problems, and the process of helping occur within a social and cultural context. For a human service professional to view individual concerns or a person’s problems as separate from that person’s social, cultural context is to misunderstand them. There was a time when we in human services worked with clients of similar ethno-cultural backgrounds. However, the “flattening” of our world has increased the diversity of the populations we serve. No longer are we simply working with those who may differ from us in terms of social class or education, but we now engage with

clients who differ from us in terms their fundamental worldviews, beliefs, and values. Our professions are truly multicultural in the populations we serve, with both the helper and client bringing unique cultural values and social roles to the interaction.

It is generally agreed among human service providers that appropriate treatment necessitates awareness of critical differences between ourselves and our clients in our beliefs and sensitivities as related to mental health, including such things as the presentation or expression of symptoms and even possible treatment preferences (Snowden, 2003). In fact, it could be argued that human service providers who do not integrate cross-cultural factors (e.g., gender, sexual orientation, ethnicity, race, age, social class) into their practice infringe on the client's cultural autonomy and basic human rights and thus lessen the chances for the development of an effective therapeutic relationship and process. Clearly, these conditions would serve as fodder for unethical practice. Increasing one's competence in providing ethical and effective service to an increasingly diverse client base begins with an increased awareness of the potential of both personal and professional bias and restricted worldviews.

Increasing Awareness of Personal Worldview

As indicated above (see Table 4.1), our professional codes of practice are clear in their directives regarding the need for ethical practitioners to increase awareness, sensitivity, and competence in working with a diverse client population. Our own cultural conditioning and the values and beliefs, or if you will, "worldview" that have been created can be identified as an "invisible veil," which not only operates outside of our consciousness but colors our assumptions about the nature of reality, ideal health and pathology, and approaches to helping (Sue, 2004). Our educational programs have incorporated multicultural counseling training throughout their curricula, and it is most likely that you have been or most certainly will be challenged to review your own worldview in order to increase your awareness of how that worldview may taint your assumptions and your expectations regarding your client and the service you will provide.

To be effective, ethical helpers, we must be sensitive to (a) our own cultural framework and the way it biases our attitudes, values, behaviors, and approaches to helping, and (b) the client's cultural makeup and the role this plays in the creation and resolution of the problem presented. The requirement is NOT that one becomes expert and master of all cultural nuance. The goal is to be aware of one's own worldview as it serves to filter and color

client information and the dynamic of the helping relationship. Consider Case Illustration 4.1, which not only demonstrates one school counselor's desire to be helpful but also the negative effects that her somewhat limited and prejudicial worldview has on the helping relationship and dynamic.

Case Illustration 4.1

School Counselor: Filtering Client Information

Ms. Thompson is a senior high school counselor working with college placement. She has been recognized as extremely competent and quite successful at assisting her students to gain entrance to the colleges of their choice. Ms. Thompson also prides herself on being able to help her students gain entrance to the "best colleges."

Ms. Thompson is about to meet with Lida Alvarez, a transfer student who has shown an aptitude for mathematics. Lida's family recently moved to this district, having lived in a neighboring district for the past six years. Lida's family originally came from Argentina. Her family (Lida, an older brother, mother, father, and paternal grandparents) moved to the United States when Lida was 10 years old.

Ms. T: Hi, Lida. I'm Ms. Thompson, your college counselor. I see from your records that you are and have been a very good student. You appear to have a real knack for mathematics. I am interested in knowing what colleges you have begun to consider.

Lida: I am not thinking about going to college, at least not right after I graduate from high school.

Ms. T: Lida, if it is a financial issue there are a number of scholarships for which you would be a great candidate. I have a lot of success getting money for students.

Lida: No, it's not the money. I will be going to work with my siblings and dad in our family restaurant.

Ms. T: That is nice, Lida. However, don't you think that a person with your abilities should consider doing something beyond restaurant work?

Lida: It's not just restaurant work; it is our family's restaurant. It was originally my grandfather's and has been in our family for fifty

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years. They started it in Argentina, which my uncle's family continues to run, and we have had this one in the United States for 6 years now. This has been my grandfather's dream to bring his restaurant to the United States.

Ms. T: I didn't mean to suggest it is not a good restaurant. I just thought you may find it more stimulating and challenging to go on to college, maybe before you work in the restaurant.

Lida: Ms. Thompson, I am sure you mean well, but this really isn't about college, the restaurant, money, or any of that . . . it is about family, and for now my family needs me to work in the restaurant, and I want to be part of the tradition my grandfather started. There may be time later when I will want to consider something else, including college, but for now I am looking forward to graduating and helping out with my family. But, thanks for your help.

Potential Bias: Beyond the Personal to the Profession

While it is clear that this one counselor, Ms. Thompson, failed to grasp the value that family has for this one student and thus was pushing her "college agenda," it is not just our personal worldviews that can limit our understanding of our clients and the best means of providing them with ethical, effective service. The focus on elevating our awareness of personal bias and limited worldviews is essential. What may be missed in our training or our experience is the realization of the very subtle yet insidious effects of ingrained bias in our Western model of mental health and human service delivery. It is possible that the theories and paradigm employed to guide our processes of case conceptualization and treatment planning, having their roots in Western Psychology, are in fact prejudicial and limiting in our collective perspective. As such, it is essential that we not only increase our awareness of and sensitivity to our own personal bias but also those biases ingrained within our professional models of service delivery.

The European American worldview has been the basis for development of counseling as a profession, and the White middle class values have set the tone, the limit, the scope, and the process for counseling practices (Duan & Brown, 2016). Our theories have generally emerged from a philosophy that

(a) separates mind and body, (b) attempts to reduce experiences to a singular cause and, (c) sees the world in a deterministic (cause-effect) relationship (Kimura et al., 2005).

The effect of these assumptions and perspectives is that human service providers with a Western bias tend to focus on rational more than relational, logic more than emotion, competition more than cooperation, independence more than interdependence, and an individualistic rather than a collectivistic interest (Duan & Brown, 2016). It has been suggested that such an ethnocentric perspective of traditional mental health services has resulted in the underutilization of counseling services by ethnic and racial minorities (Ponterotto, Casas, Suzuki, & Alexander, 2001) and the overdiagnosis of various mental disorders of the culturally diverse (Schwartz & Feisthmel, 2009).

Our codes contain the ethical mandate to understand the cultural backgrounds of diverse clients; however, our practice is most often colored by a strong valuing of autonomy and individuality, elements that most clearly reflect the culture, norms, and values of Western society (Atkinson, 2004) and may demonstrate an insensitivity to our clients' diverse worldviews, where the valuing is on acceptance of rather than control over that which is uncontrollable or where the focus is on family and community rather than individual achievement and autonomy (Laurent & Dong, 2015).

Consider the following brief illustration of a young Chinese American woman, Changchang (Case Illustration 4.2).

Case Illustration 4.2

Changchang

Changchang is a 28-year-old MBA graduate student who has moved back in with her parents as a way of saving money during her years in graduate school. Changchang is single and like many in her program of study, deeply engaged in her graduate work. Changchang came to the counseling center with concerns about her stress level and the impact it is having on her physically (being unable to sleep, losing weight, frequent headaches) as well as her ability to concentrate on her studies. The initially identified source of the stress was the conflict she was experiencing with her parents. She described her parents as people who highly value academic achievement, to the exclusion of all other

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activities. It is this exclusive focus on her academics tasks and performance and her parental “prohibitions” about her engaging with other students in a social context that have resulted in her feeling “devalued,” “almost infantile,” and most certainly “trapped.” Changchang loves her parents and is truly grateful for their financial support during her attendance at graduate school. She shared her intense feelings of guilt about being “ungrateful” but noted that she was not sure that she could continue to endure their “old world values.”

For many practitioners presented with a client such as Changchang (see Case Illustration 4.2), the focus of intervention may be on assisting her to challenge her guilt as being both irrational and dysfunctional in nature. The clinician may assist the client to reframe her perspective so as to allow for her acceptance of her own autonomy and right of self-determination. While such a focus would seem supported by our core values emphasizing client autonomy and be congruent with a cognitive approach to therapy, some (see Laurent & Dong, 2015) have suggested that these feelings of guilt may be of value within an Asian culture, in that they perpetuate an interdependent, harmonious, and peaceful family relationship and thus are neither irrational nor dysfunctional. Without one’s developed multicultural competence, this value and perspective may be missed.

An illustration such as this is not presented as a directive to abandon our valuing of autonomy or the cognitive perspective but rather to encourage all human service providers to be aware of the subtle bias that may be operating in our practices and to be open to alternative worldviews presented by our clients.

While individual practitioners and our professions, as a whole, have made vast improvement in challenging this ethnocentric perspective, more research with expansive and representative samples will need to continue in order to increase the validity of our assessment procedures, diagnoses, and treatment protocols. In the meantime, it is essential that each of us, as ethical and effective practitioners, be mindful of our own personal limited worldviews and the limitations and potential bias ingrained in the professions in which we are engaged. Such increased awareness and acceptance of the myriad of worldviews is not only good practice but reflective of our ethical standards (see Table 4.1). Exercise 4.1 now invites you to consider potential values, assumptions, and biases ingrained in our Western-Psychology approach to helping.

Exercise 4.1

Examining Values, Assumptions, and Biases

Directions: Below you will find a table listing common targets or issues encountered by those in human services. Your task is to consider how the characteristics and culture of the client invite the clinician to revisit the issue through an alternative cultural lens. The exercise may require some research and in a couple of cases, you have been provided “hints” as to what to consider.

<i>Issue</i>	<i>Mainstream Human Service Position</i>	<i>Client Description</i>	<i>Multicultural Consideration</i>
(example) Establishing as a goal of counseling to increase the client's assertiveness	Human services value autonomy and the right to self-determination, thus this would, could be a legitimate goal	Client is 43 years old, female, from South Asia	The culture emphasizes finding meaning in group solidarity and relationship, de-emphasizing individualism and individual uniqueness.
Use of “smacking” and spanking in child rearing		The client is a Dominican, single mother who values the development of <i>respeto</i> in her 8-year-old child.	
Physical contact (hugging) between a clinician and a client		The client is a 61-year-old, Arab male	

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<i>Issue</i>	<i>Mainstream Human Service Position</i>	<i>Client Description</i>	<i>Multicultural Consideration</i>
Eye contact between therapist and client		A 23-year-old female from China, currently enrolled in a clinical psychology graduate program and receiving supervision in her internship	
Hallucinogen Intoxication		The client is a 27-year-old member of Native American Church	
Dependent-attachment behaviors		A 31-year-old Japanese female expressing a need for intense interpersonal attachment (hint: check the concept of <i>amae</i>)	
Bibliotherapy		A school counselor working with a second-grade Puerto Rican male having difficulty with controlling aggressive impulses (hint: the value of <i>cuentos</i>)	
Concept of "time"		A 25-year-old Latino male with a weekly appointment with a clinical psychologist	

RESPONDING TO THE CHALLENGE •

Over the course of the past 30 years, the human service professions have become increasingly aware of the role of culture and the potential of cultural bias in our theory and practice. As a result, there have been significant changes in the operational assumptions that undergird our approaches to service delivery (Ivey, Ivey, & Simek-Morgan, 1997). Some of the assumptions that have been challenged include (a) our very concept of normality, (b) the professions' emphasis on the individual (versus family or community), (c) the valuing of a goal of client growth in independence, (d) the universality of linear thinking, and (e) the reliance on verbal communications (Sue & Sue, 1999).

As evident in our evolving and evolved professional codes of ethics human service providers value the need to integrate cultural awareness and sensitivity into all aspects of our work. And as noted by Duan & Brown (2016), to provide service to culturally diverse clients, in the absence of such awareness and competency, is unethical.

The Ethical Practitioner Is AWARE

While increasing one's awareness and knowledge of alternative worldviews is necessary, we are in agreement with Sue et al. (2006) that competency goes beyond knowledge and skill and needs to be reflected in the very values, orientation, and "person" of the therapist. The challenge for all ethical practitioners is to increase awareness of her own assumptions, values, and biases as they undergird practice decisions. Such awareness is foundational to ethical practice, as noted by both the American Counseling Association (ACA, 2015, C.2.a) and the American Mental Health Counselors Association. (AMHCA, 2010, C.1.1)

Whereas multicultural counseling competency is required across all counseling specialties, counselors gain knowledge, personal awareness, sensitivity, dispositions, and skills pertinent to being a culturally competent counselor in working with a diverse client population (ACA, 2015, C.2.a).

Will actively attempt to understand the diverse cultural backgrounds of the clients with whom they work. This includes learning how the mental health counselor's own cultural/ethical/racial/religious identity impacts his or her own values and beliefs about the counseling process. (AMHCA, 2010 C.1.1)

The ethical counselor not only has an increased awareness of his personal worldview as it intersects with other/alternative worldviews but also values the dynamic influence that one's cultural, values, and beliefs have on practice decisions. See Exercise 4.2.

Exercise 4.2

Personal Worldview

Directions: Below you will find a number of “issues” and client “descriptors” that may elicit a strong personal reaction, reflecting a specific value, attitude, belief, or even bias. We invite you to reflect on each as they may influence your attitude and approach to a client with this characteristic or type of problem. It may help to discuss your reactions with a colleague, peer, or supervisor.

Client characteristic:

- An overly indulged and pampered teen
- A strong, somewhat rigid, ethnocentric individual
- An unmarried, pregnant woman
- A veteran living on the street
- A 90-year-old showing signs of failing cognition
- A victim of a fire with massive total body scarring
- An abused spouse

Presenting Complaints/Issues:

- Heroin addiction
- Pedophilia
- Personality disorder—borderline
- Oppositional defiant disorder
- Hoarder
- Conflict with sexual orientation
- Multiple suicide attempts

Culture, Worldview, and the Nature of Professional Relationship

We now understand that much of what we took as *standard practice* when establishing a therapeutic relationship needs to be revisited with an eye toward our client's alternative culture and worldview. For example, while we in the West have generally embraced the value of counseling and mental health services, such is not the case in much of South Asia. For many South Asians who are experiencing psychological and development challenges, the preferred method of intervention is to seek support and assistance from an authority figure or extended family member. In many ways, this reflects their perspective that significant decision-making is the prerogative of the head of the household and targets that which is best, not so much for the individual as for the family (Chandras, 1997). In the rare circumstances where a South Asian client presents to an outsider for help, it would not be unusual to encounter familial demands to be consulted and or included in the therapy sessions, since issues and concerns are viewed as family business and not just that of the individual (Das & Kemp, 1997).

The ethical practitioner working with such a client would approach the establishment of informed consent, the setting of limits to confidentiality and boundaries, and even the valuing of client autonomy with an awareness of and sensitivity to this worldview, a point that is highlighted by our ethical codes of conduct (see Table 4.2).

Table 4.2 Ethical Practice: Manifesting Cultural Awareness and Sensitivity

<i>Practice Focus</i>	<i>Organization</i>	<i>Code</i>
Informed Consent	American Counseling Association (2014)	Standard A.2.c. The informed consent process and awareness of the role that language differences can play in the counseling relationship
Confidentiality	American Counseling Association (2014)	Standard B.1.a. Confidentiality and privacy from a cultural perspective
Diagnosis/ Assessment	American Counseling Association (2014)	Standards E.5.b, E.5.c, & E.8. Cultural sensitivity in the process of diagnosis and assessment

Autonomy

One of the fundamental principles that serves as a foundation to our ethical codes is the valuing of self-determination (i.e., autonomy). This valuing of the client as an autonomous agent gives direction to clinical decisions ranging from gaining informed consent, through goal setting, to termination.

Most practitioners understand that this principle of autonomy requires that protection be given to potentially vulnerable populations, such as children, the elderly, the mentally ill, or prisoners for whom autonomy of decision-making may be restricted. However, a question may arise as to the balancing of the clinician's valuing of autonomy with a client's valuing of a collective cultural worldview.

The very nature of this valuing of autonomy dictates that the clinician provides clients with the opportunity to choose what shall or shall not happen to them. But as suggested above, under some conditions (e.g., working with a client from South Asia) an alternative worldview may shift this power of decision-making to a source outside that of the client.

Informed Consent

In support of the value of autonomy, human service providers understand the need to provide all clients with that information that positions them to be able to make an informed decision regarding engagement in treatment. Informed consent is essential to our professional practice. It is not only in support of our core ethical value of autonomy but also is an expression of our valuing of the moral principle of beneficence.

Our codes of ethics and professional practice emphasize the need for clinicians to provide information in a way that is understandable to the client. For example, the American Counseling Association notes, "Counselors communicate information in ways that are both developmentally and culturally appropriate . . ." (ACA, 2014, Standard A.2.c). A similar directive is found in the American Psychological Association's code, where psychologists are directed to "obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons" (APA, 2010, Principle 3.10), and the National Association of Social Workers code, which highlights the need to provide clients with essential information in clear and understandable language: "Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable alternatives, clients' right to refuse or withdraw consent, and the time frame covered by the consent" (NASW, 2008, Principle 1.03).

The ethical, multiculturally competent counselor is not only concerned with the specific language employed when seeking informed consent but is also sensitive to the very impact that the process of gaining informed consent can have on some clients from diverse cultural backgrounds. By establishing conditions where our clients can make an informed decision to engage or not to engage, human service providers facilitate a sense of empowerment. This practice of seeking informed consent, while appearing somewhat commonplace, can be a transformational experience for those clients whose culture may have limited their sense of personal power. Consider how the client feels in Case Illustration 4.3.

Case Illustration 4.3

I Can Choose?

Louisa is a 38-year-old Latina woman who has come to see Dr. Lane, a psychologist, at the urging of her pastor. Louisa has been very sad since her mother's death a few months ago. Her children are all in school during the day, and she has never had a job outside the home, as she feels she must follow her husband's wishes to stay home and take care of the family. She expressed extreme loneliness to her pastor one day after church, and although she doesn't think her husband would approve, she took the pastor's advice and made an appointment with Dr. Lane. The following is the first encounter between Dr. Lane and Louisa.

Dr. Lane: Hello, Louisa, it is very nice to meet you.

Louisa: Hello, Dr. . . . I'm not sure what you can do, but my pastor told me to come, and I'll do whatever you suggest if it'll make me feel better.

Dr. Lane: Well, I'm very glad you decided to come. We can talk about what you would like to talk about, and we can certainly see if there are things that you would like to change.

Louisa: You mean, you aren't just going to tell me what to do?

Dr. Lane: No, we can talk about those things together. But first, I'd like to go over what these sessions will do and what they won't do. Then you can decide if you think you would like to continue having these sessions with me.

Louisa: You mean, I can choose what to talk about? I could go somewhere else? I can choose?!

As you can tell from Louisa's response in Case Illustration 4.3, she was surprised that she was given a choice to make decisions on her own. For some clients, the respect, autonomy, and empowerment experienced within a therapeutic relationship may be received with a real sense of joy, awakening, and personal growth. However, not all clients will have such a positive response. It is possible that a client could experience stress and anxiety as a result of being placed in a position of such empowerment and decision-making, as it conflicts with ingrained cultural values. As such, it is important for all practitioners to be sensitive to the potential of such value conflicts and, as directed by one code of ethics, to "consider cultural implications of informed consent procedures and, where possible, counselors adjust their practices accordingly" (ACA, 2015, Standard A.2.c).

Confidentiality

Our codes of ethics and practice are clear in their support of treating a client's disclosure, when possible, as confidential. While the directive is clear, what may be less obvious is that this respect for client privacy as embodied in our codes of confidentiality may fail to consider the unique challenges to this principle when working with a client from another culture and/or worldview.

Consider a situation of a school counselor who finds herself in between school policy and cultural values (see Case Illustration 4.4).

Being ethical demands not only an understanding of our codes but also the application of those codes in conjunction with a respecting of a client's values and worldview. This point has been clearly articulated in the *ACA Code of Ethics*, which states, "Counselors maintain awareness and sensitivity regarding cultural meanings of confidentiality and privacy. Counselors respect differing views toward disclosure of information. Counselors hold ongoing discussions with clients as to how, when, and with whom information is shared" (ACA, 2014, Standard B.1.a).

As such, the counselor in our case illustration (Case Illustration 4.4) could neither simply follow the dictate of the organization in which she worked nor guarantee absolute confidentiality. Resolution of this ethical dilemma is not simple or clear cut. To resolve what is a culturally complex situation in a way that reflects the codes of professional practice and organizational policy while at the same time honors the client's worldview will require the counselor's reflection, sensitivity, consultation (with supervisors) and collaboration with the client.

Case Illustration 4.4

Please Don't Tell My Parents

Dr. Alonzo, the school counselor at S. J. H. High School, found herself in a bit of a quandary when approached by a 16-year-old student seeking counseling. The student presented as angry, anxious, and mildly depressed over the fact that her parents refuse to allow her to date, and as such she had been denied the opportunity to go to the prom with a boy from her class.

Given the presenting concern and the fact that the student's grades have been dropping, the counselor agreed to work with the student and in line with school policy informed the client of the need to obtain parental permission for continued contact. To the counselor's surprise, the statement that parental permission would be needed elicited a strong and unexpected reaction from the student. The student pleaded with the counselor to maintain confidence.

Dr. Alonzo was aware that the student's parents were immigrants from India and that the student's engagement in personal counseling may be creating a values conflict. While supporting the student's healthy development and unfolding sense of autonomy and empowerment, Dr. Alonzo was aware of the family and cultural values that empower parents and even extended family members to decide when and with whom dating, courting, and even marriage will take place. In addition, while accepting the school policy requiring parental consent for all "personal" counseling, she understood the very fact this student had disclosed such personal and familial information to a family "outsider" would be seen by her parents as a violation of family values and a source of shame for the family. It was this concern that served as the source of the student's strong emotional response regarding the need to seek parental permission.

Not only was the student now in crisis, but also the counselor found that she was stuck between two cultures, that of the student's family and the school in which she worked.

Boundaries

While all codes of ethics caution against engaging in multiple relationships with clients, professional and personal, the strict adherence to such boundary controls may not be relevant or even realistic for those working in

multicultural settings. Further, it is possible that sometimes it is more harmful to adhere to strict boundaries than it is to interact in a genuine, culturally congruent manner.

In some settings, it is by participating in community activities, such as graduation parties, community celebrations, or even sporting events, that one can gain the trust of clients. When these events are extensions of family celebrations, the human service provider, while being aware of the need to be cautious and considerate in what she does or says, must also be sensitive to cultural rules of hospitality so as not to be insulting or rude while attempting to maintain a semblance of appropriate boundaries. Such cultural sensitivity and awareness would extend to issues such as nonsexual physical contact, the sharing of personal information, and even the reception of gifts.

Consider the situation in which a therapist is attending the college graduation party of a client with whom he did both career and personal counseling. At the party, he is presented a gift as a token of appreciation for all that he (and the client) had achieved. Many human service providers, whose codes of ethics caution against the “potential danger” of accepting gifts from a client, might find the situation one that not only makes them feel uncomfortable but also signals a violation of professional boundaries. This is especially true if the worth of the gift is significant and where the possibility of exploitation may exist (AAMFT, 2015). However, while our standards of practice caution the potential danger of accepting gifts from clients, they also invite us to “attend to cultural norms when considering whether to accept gifts from or give gifts to clients (AAMFT, 2015, Standard 3.9) and “recognize that in some cultures, small gifts are a token of respect and gratitude” (ACA, 2015, Standard A.10.f) and that rejection could be an insult and potentially damaging.

Thus, human service providers need to be aware of the cultural meaning of gift giving and the possibility that rejection could signal disrespect. This might be especially true for those clients who come from a culture that stresses hospitality, reciprocity, or the importance of gift-giving rituals (Barnett & Bivings, 2002).

Defining and Assessing a Presenting Concern

In defining mental health and diagnosing pathology, human service providers often employ a set of behaviors that have collectively been accepted as evidence of normality and ideal mental health (Sue, Sue, & Sue, 2006). The problem with such a paradigm is that it is possible that certain specific

cultural behaviors could be viewed as pathological when assessed through a culturally narrow lens. One example offered by Duan and Brown (2016) is that of an Asian American woman who is perceived as weak in ego strength and low in self-esteem, given her tendency to be highly compromising and tolerant of spousal anger. A lack of cultural awareness on the part of mental health providers and the tendency to employ diagnostic categories and criteria in another culture without ensuring their validity can result in inappropriate diagnoses. Codes of ethics, such as that of the American Counseling Association, caution against such a monocultural perspective: “Counselors recognize that culture affects the manner in which clients’ problems are defined and experienced. Clients’ socioeconomic and cultural experiences are considered when diagnosing mental disorders” (ACA, 2014, Standard E.5.b).

When engaging in clinical assessment, all mental health providers are ethically directed to employ approaches and instruments with proven validity and reliability. For example, “mental health counselors are directed to choose assessment methods that are reliable, valid and appropriate based on the age, gender, race, ability and other client characteristics. If tests must be used in the absence of information regarding the aforementioned factors, the limitations of generalizability should be duly noted” (AMHCA, 2010, D.1.a).

While it is obvious that current standardized “Western” instruments demand a level of linguistic competence, the risk to validity and utility goes beyond the client’s language capabilities. It is essential that the multiculturally competent and ethical practitioner not only ensure that procedures account for language difference but also employ concepts that are familiar and similar across cultures and normative standards that reflect the culture and uniqueness of the client. Psychologists, for example, have been directed by their code of ethics to employ those instruments where the psychometric properties have been established for the population being assessed (APA, 2010, Sections 9.02b, 9.02c) and interpret results from the perspective and language of the client (APA, 2010, Section 9.06).

A similar stance is articulated in the *ACA Code of Ethics*, stating “counselors select and use with caution assessment techniques normed on populations other than those of the client. Counselors recognize the effects of age, color, culture, disability, ethnic group, gender, race, language preference, religion, spirituality, sexual orientation, and socioeconomic status on test administration and interpretation, and they place test results in proper perspective with other relevant factors” (ACA, 2014, Standard E.8).

Without these measures, one can commit errors not just in diagnosis and classification but treatment planning and implementation. Again, as

noted in one profession's code of ethics, "Mental health counselors consider multicultural factors (including but not limited to gender, race, religion, age, ability, culture, class, ethnicity, sexual orientation) in test interpretation, in diagnosis, and in the formulation of prognosis and treatment recommendations" (AMHCA, 2010 D.2.c).

As such, it is imperative that when engaging in assessment, practitioners consider the degree to which they (a) know the range of normal behavior for this client's group; (b) know the patterns of disorder for this client's group; (c) know what the client's group considers the cause of disorder to be; and (d) know what treatment preferences the client may have and whether alternatives are available (Marsella, 2011).

Establishing and Implementing a Treatment Plan

When we speak of cultural competence in the provision of our services, we target more than the practitioner's knowledge of another culture. In developing culture competence, service providers need to embrace and value the need to be able to adapt interventions to meet the culturally unique needs of their clients (Whaley & Davis, 2007). In responding to the ethno-cultural uniqueness of our clients, we must come to respect the potential pernicious effects of myopically viewing standards of normality and treatment approaches through Western assumptions and practices. A point which is reflected in our professional codes of practice is illustrated by the statement found in the code of the American Mental Health Counselors Association as was noted earlier.

[change colon to comma]

Being sensitive and responsive to a client's cultural values and background in developing intervention goals and processes is essential if one is to be an ethical practitioner. As noted by the American Mental Health Counselors Association (2010), the ethical multiculturally competent practitioner will work to devise "integrated, individual counseling plans that offer reasonable promise of success and are consistent with the abilities, ethnic, social, cultural, and values backgrounds, and circumstances of the clients" (AMHCA, 2010, B.1.a). Consider the case of Valentina V. (see Case Illustration 4.5).

For many service providers, working with a client such as Valentina (Case Illustration 4.5), the valuing of client "autonomy" may give shape to treatment goals (e.g., increasing personal empowerment and self-determination) and even treatment strategies (e.g., use of cognitive interventions). While a counselor's focus on self-determination and empowerment as goals for counseling might be viewed as developmentally appropriate, they may

Case Illustration 4.5

Valentina V.

Valentina, an 18-year-old high school senior, entered the counseling center presenting as both anxious and depressed. Valentina is a Hispanic American whose grandfather left Mexico 30 years ago. The family—both grandparents, mom, dad and Valentina’s two older siblings—work in a small family owned farm and restaurant.

Valentina has demonstrated a gift for mathematics and has shared her interest in pursuing a degree in mathematics in hopes of becoming an actuary. Valentina, while excited about the possibilities that lay ahead, including the real possibility of receiving numerous scholarship offers, is also aware of the family tradition and expectation for all members of the family to engage in the family farming and restaurant business.

While there has been no direct prohibition presented by her family, the discussion within the family is about Valentina taking over all the bookkeeping responsibilities from her mom, living at home, and eventually marrying from within her community. The family expectations, when contrasted to the excitement and hope shared by her college-bound friends, has made Valentina feel torn between two worlds and has resulted in her increased stress, anxiety, and depression. The conflict is affecting Valentina’s ability to concentrate, and as a result, her grades have fallen dramatically. When asked about her school performance, Valentina’s comment is “why bother?”

also fail to reflect sensitivity and an awareness of the cultural context in which the client has been raised and the resultant values ingrained. It is essential to ethical and effective practice that we not only have clarity about our own values and biases but also respect alternative worldviews and the power of the ingrained cultural values. With such an awareness and sensitivity, the counselor in this case may be able to facilitate Valentina’s identification of all the issues involved and the depth to which she is experiencing a personal values conflict in which she is moved to accomplish both things—that is, to embody familial and cultural expectations as well as to experience new challenges and directions in her own life.

In addition to processing therapeutic goals through a multicultural lens, the ethical practitioner will also be sensitive to the need to modify

intervention approaches so that they are sensitive and responsive to a client's unique cultural orientation. While such modification may result in the inclusion of more "native" approaches and/or collaboration with elders of the community or identified healers, it also may direct the human service provider to actually ensuring that there is a community-based network of support. If these services are not present, the ethical professional should attempt to develop them by working with community leaders (Marsella, 2011).

● CONCLUDING CASE ILLUSTRATION

As you continue your engagement with Maria, it is important to attempt to view Ms. Wicks's interaction and interventions as they may or may not reflect her awareness of and sensitivity to multicultural issues. In Chapter 2, you were asked to reflect on your own competence in working with adolescents and Latina females. We now want to expand our view of this interaction through a multiculturally sensitive lens.

As previously suggested, it may be helpful to place yourself in the role of counselor, contrasting your reactions to those exhibited by Ms. Wicks. Finally, after reading and reflecting upon the interaction, consider the points raised in the section entitled Reflections.

Ms. Wicks: I can appreciate that you have in fact reached sexual maturity and feel like a woman rather than a child and that you feel that becoming pregnant at this point in your life would be a sign of God's blessing. Could you help me to understand how this fits with your Catholic beliefs in the importance of marriage prior to having a baby?

Maria: I go to church and my God is a God of love, and He wouldn't let anything happen unless it was right.

Ms. Wicks: Clearly you have strong beliefs and opinions, and I guess my question was seen as a challenge to those beliefs, but I was just trying to clarify my own understanding. Also, I wonder if you have any experience with young couples who had a baby where it was not really good for the parents, the couple, or the baby?

Maria: Yeah, there are plenty of sluts in our community that pop out babies. But this is different—they are not born out of love. Just sex!

Ms. Wicks: Have you and your boyfriend talked about how a baby in your life may change your life? You know, things like your ability to go out socially, or the financial impact, or . . .

Maria: Not yet . . . he doesn't want to discuss these things. . . . He just says, "We'll work it out."

Ms. Wicks: How do you feel about his response?

Maria: Honestly, it is frustrating. My cousin had a baby when she was 16 and had to drop out of school and is now living with my grandmother and is really having a tough time. I don't want that to happen to me.

Reflections

1. Most human service providers with a Western bias tend to focus on rational more than relational, logic more than emotion, competition more than cooperation, independence more than interdependence, and an individualistic rather than a collectivistic interest (Duan & Brown, 2016). Is there any evidence that Ms. Wicks may be operating from such a Western-biased perspective? If so, what impact, if any, does it have on the relationship and process of working with Maria?
2. At one point, Ms. Wicks appeared to be confronting Maria's position that a baby would be evident of God's approval of the relationship. How did you feel about that part of the interaction? Were there any ethical issues that may have been revealed?
3. From your perspective, does the revelation of Maria's participation in unprotected sex, along with her apparent valuing of the possibility of becoming pregnant, raise any concerns on your part regarding confidentiality?
4. As you see the unfolding of this interaction, what goal would you have for moving into the next session? How does this goal reflect your sensitivity to and valuing of the multicultural factors, including, gender, race, religion, age, ability, culture, class, ethnicity, and so forth?

COOPERATIVE LEARNING EXERCISE ●

Throughout this chapter, emphasis was placed on the subtle and pernicious effects that one's personal values and biases can have on professional practice. Further, it was noted that given the "Western-Psychology" bias found within our models and theories of practice, human service providers are potentially at risk of failing to "respect" and account for alternative worldviews while establishing goals and treatment plans. The final exercise (Exercise 4.3) is offered as an opportunity to increase both awareness and sensitivity to bias, both personal and professional, and their potential impact on service delivery.

Exercise 4.3

Value Conflicts: Personal and/or Professional

Part 1: Part 1 invites you to review the brief description of each case and identify a specific goal and treatment approach or strategy that you would employ. After identifying your own goals and strategies, share these with a classmate, colleague, or supervisor. Is there any commonality? What do you feel is the source of the commonality, should such exist? If there are significant differences in the goals and strategies established, discuss the possible source of such diversity of opinion.

- The client is a 27-year-old single woman experiencing anxiety about the man whom she has been dating for 15 months and who she believes is about to ask her to marry him.
- The client, a 34-year-old male, was “mandated” to attend counseling after being stopped for a traffic violation and discovered to have an ounce of marijuana in the car.
- A 52-year-old female came to counseling because of anxiety and concerns about taking a job promotion, which would require relocation to another state.

Part 2: In Part 2, we have provided some additional information about the clients. As an ethical practitioner, would you, based on this information, modify your original goal and/or approach? If so, how and why?

- The client is a refugee from Somalia and a victim of the practice of genital mutilation as a child. Additionally, the gentleman, while Muslim, is from Saudi Arabia and not Somalia.
- The client is from Nepal and is one of eight graduate students attending the local university here in the United States. As he explained, the traffic violation (i.e., “rolling” through a stop sign) occurred when he was on his way to meet up with the members of his community to celebrate the festival of Holi. Further, he explained that the marijuana was *bhang*, the leaves and tops of the plant that would be consumed at the festival.
- The client is a very successful PhD biochemist who has rapidly advanced in a major pharmaceutical company. She is an only child of Chinese parents and recently had her mother (father

is deceased) move from China to live with her, because of her mother's failing health. Her mother is just beginning to feel comfortable with her team of health care providers, and with the client finally accepting the new position, the thought of relocating with her daughter has caused her mother extreme anxiety.

Part 3: Along with your classmate, colleague, or supervisor, discuss the potential influence of personal or professional bias that may have been revealed by this exercise.

SUMMARY •

- It is generally agreed among human service providers that appropriate treatment necessitates awareness of critical differences between minority individuals and others in beliefs and sensitivities related to mental health, including expression of symptoms, and in treatment preferences (Snowden, 2003).
- Our own cultural conditioning and the resultant values and beliefs color our assumptions about the nature of reality, ideal health and pathology, and approaches to helping (Sue, 2004).
- Some of the assumptions that have been challenged include (a) our very concept of normality, (b) the professions' emphasis on the individual (versus family or community), (c) the valuing of a goal of client growth in independence, (d) the universality of linear thinking, and (e) the reliance on verbal communications (Sue & Sue, 1999).
- The European American worldview has been the basis for development of counseling as a profession, and the White, middle class values have set the tone, the limit, the scope, and the process for counseling practices (Duan & Brown, 2016).
- Our theories have generally emerged from a philosophy that (a) separates mind and body, (b) attempts to reduce experiences to a singular cause and, (c) sees the world in a deterministic (cause-effect) relationship (Kimura, et al., 2005).
- When assessing clients, multiculturally competent and ethical practitioners not only ensure that procedures account for language difference but also employ concepts that are familiar and similar across cultures and normative standards that reflect the culture and uniqueness of the client.

- In working with clients of diverse backgrounds, it is imperative that one (a) knows the range of normal behavior for this client's group; (b) knows the patterns of disorder for this client's group; (c) knows what the client's group considers the cause of disorder to be; and (d) knows what treatment preferences the client may have and whether alternatives are available (Marsella, 2011).

● IMPORTANT TERMS

assessment	informed consent
autonomy	interventions
awareness	multiculturalism as “fourth force”
boundaries	multiculturally competent
confidentiality	personal worldview
deterministic view	Western Psychology
diagnosis	

● ADDITIONAL RESOURCES

Print

- Abdullah, T., & Brown, T. L. (2011). Mental illness stigma and ethnocultural beliefs, values and norms: An integrative review. *Clinical Psychology Review, 31*, 934–948.
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- McAuliffe, G. (2009). *Culturally alert counseling: An introduction*. Thousand Oaks, CA: Sage.
- Sue, D. W., & Sue, D. (2013). *Counseling the culturally diverse: Theory and practice* (6th ed.). Hoboken, NJ: John Wiley.

Web-Based

Association for Multicultural Counseling and Development. Providing global leadership, research, training and development for multicultural counseling professionals with a focus on racial and ethnic issues. <http://multiculturalcounseling.org/>

Multicultural Counseling and Social Justice Competencies. Websites linked to this site are (a) general websites regarding the study of social justice, culture, and race- or culture-specific information; and (b) psychology and counseling websites, especially those related to cultural competence and social justice or advocacy. <http://toporek.org/websites.html>

Nigatu, H. (2013, December 9). 21 racial microaggressions you hear on a daily basis. *Buzzfeed*, retrieved from <http://www.buzzfeed.com/hnigatu/racial-microaggressions-you-hear-on-a-daily-basis>

Video Clip of “Gua Sha/The Treatment” portrays the different cultural values between Western society (i.e., the legal and social welfare services in the United States) and a Chinese American family. http://www.youtube.com/watch?v=gMq9FDq_A0s Race: The Power of an Illusion: http://www.pbs.org/race/000_General/000_00-Home.htm

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