Hot Topics in Ethics—Applying Positive Ethics and Multiculturalism to Therapeutic Practice, Consultation and Interventions

Pennsylvania Psychological Association
Annual Convention

Harrisburg, PA
Ethics and Multicultural Committee

Thursday, June 18, 2015
Vignette 1: Anna in the Middle

Anna is a bilingual intern of Chinese descent at an urban community college counseling center. She has been assigned to evaluate Edward, a 20-year old Chinese immigrant, who has lived in the U.S. for 5 years. His first language is Cantonese but he appears to be fluent in English. He is currently failing all of his classes.

Upon his arrival in the U.S. at age 15, Edward was placed in a class for English Language Learners but expressed that he did not like being with the kids who were “fresh off the boat.” His parents were members of the Falun Gong and persecuted by the Chinese Communist Party. Edward witnessed the torture of his parents. His family is seeking asylum in the U.S.

Anna administers each Wechsler subtest with instructions in both English and Cantonese as he appears to be somewhat slow in understanding initial instructions in English. He obtains a score in the low average range in Visual Motor/Performance abilities and a low average Verbal score. Examination of subtest scatter yields a high average score in numerical reasoning and a borderline score in short-term memory. Anna tests the limits allowing Edward more time on speeded items after noting his performance score at the normal time limit and lets him use words in a sentence on the Vocabulary subtest rather than generating a definition. He appears able to complete tasks correctly given more time. He is also able to use words correctly in sentences. From these procedures she notes indications of higher potential.

Anna writes a detailed description of the Edward’s background and concludes that the Full Scale intelligence score may be a lower estimate of his potential given the information that she has gathered. In addition, she notes that while he did not express a language preference he did better when he was given instructions in Chinese.

Anna presents her preliminary report to her supervisor, Dr. Brown. Despite indications of higher ability noted in her report, Dr. Brown disregards the non-standardized testing of limits and concludes that his poor achievement in classes is due to his low average

1 Except where noted, these vignettes were based on vignettes created by the APA Ethics Committee.
intelligence based on his knowledge of many Asian students who have been in the U.S. for the same amount of time and are doing well academically.

Questions for Vignette 1

1. What principles and standards in the Ethics Code may be relevant to this situation?

2. How does a psychologist balance the benefits, and the limitations, of administering a psychological test or instrument that may not have been normed on a particular population?

3. How does a psychologist convey this balance in the testing feedback and written report?

4. How does a supervising or training psychologist teach this balance?

5. How can Anna most accurately represent the complexity of Edward’s test results in her report?
Vignette 2: Dr. Johnson & Felipe

Dr. Johnson provides weekly supervision and consultation to the staff of a community mental health center in the Rio Grande Valley. Many local families have ties on both sides of the US/Mexico border, living in one country, working in another, and traveling back and forth daily. Most families have relatives or ancestors from the rural Mexican heartland and this cultural tradition is a major aspect of the community’s heritage.

Dr. Johnson is a consultant, while the full time staff is accountable for the services being provided. Nevertheless, Dr. Johnson has noted that both the clinical staff and the agency’s administrators defer to her.

Felipe, a recent hire who graduated from an APA accredited program and is accumulating hours for licensure, presented the case of a sixty-three year-old woman, Senora Marquez, who was brought to the clinic by her son and granddaughter with whom she has been living. She had lived most of her life in a rural Mexican village until her husband died from cancer three years ago. Her son attributes this illness to toxic chemicals in the maquiladoras (factories operating in Mexico’s free trade zone) where he worked. However Senora Marquez believes that her husband’s death was the work of the Mal de Ojo (Evil Eye).

Senora Marquez has not adjusted well in Texas. Recently, she was found wandering outside, expressing anxiety and dread and talking to ghosts. Eventually she explained that her late husband’s spirit visited her at night complaining he could not rest in peace while she lived outside of Mexico.

On the intake video, which Dr. Johnson reviewed in preparation for supervision, Senora Marquez appeared tired but physically healthy. Her mental status was otherwise good. In supervision Dr. Johnson suggested that Senora Marquez was suffering from complicated bereavement with the possibility of an underlying mood disorder. She recommended a cognitive/behavioral intervention and a referral for a medication consultation. Felipe responded that Senora Marquez would resist, fearing these approaches might unsettle her husband’s troubled spirit. Dr. Johnson did not press the point in supervision, wanting to ensure that Felipe was aware of her recommendation but also wanting to allow him some measure of professional judgment in how he
handled the treatment. This is consistent with Dr. Johnson’s general “style” of supervision.

The following week Felipe proudly announced that Senora Marquez’s problems were resolved. After consulting a curandera (traditional folk healer), he obtained a jar of holy water in which he placed an egg. He told his patient that her husband’s spirit would rest peacefully if she placed this jar under her bed. The family reported that she enjoyed restful nights thereafter.

Dr. Johnson is appalled: She feels that Felipe failed to follow supervision, that he was employing an intervention that lacked validation (and did not inform the client that this would be an experimental treatment), that he may have violated Senora Marquez’ confidentiality (when he consulted others without obtaining consent), and that he was doing his client a disservice by validating her delusional explanation for her symptoms. Dr. Johnson feels Felipe should be reprimanded, if not dismissed from the center.

Felipe argues that the intervention was legitimate because it honored his patient’s cultural beliefs and, more importantly, because it worked. The center’s staff mostly agree with Felipe and note that there is an ethical obligation to cooperate with allied professionals (referring to the curandera).

Questions for Vignette 2

1. What principles and standards in the APA Ethics Code may apply to this situation?

2. Should a curandera be considered an “other professional” under Ethical Standard 3.09, “Cooperation with Other Professionals”?

3. If the answer to question 2 is “yes,” what are implications for the mental health center’s policies regarding services to indigenous Americans, and for how Dr. Johnson might have supervised Felipe in this case?

4. How would Dr. Johnson assess her own cultural competence to supervise Felipe on this case? Would you agree?

5. How should Dr. Johnson conceptualize the role of traditional healers in the psychological services provided at the community mental health center?

6. What conclusions can we draw about the supervisory relationship between Dr. Johnson and Felipe in this situation?
7. How do we balance scientifically validated procedures with cultural beliefs that lie outside the realm of scientific verification? Is this balance an ethical challenge, a clinical challenge, or both? Is this question regarding balance a false dichotomy in this case?

8. How hard should Dr. Johnson press her opinions, both about the treatment and about what Felipe has done?
Vignette 3: Deaf Culture

Laura is a woman who is deaf and whose primary language is American Sign Language (ASL). She resides in a large metropolitan city. Over the past year, Laura has experienced increased depression and anxiety. She found out through the Deaf-community grapevine that there is a well-trained psychologist, Dr. Collin, at a local mental health center who speaks English, Spanish, and ASL. After consulting with a number of friends and the local deaf agency, Laura cannot identify any other signing mental health professionals in the city. Laura checks with her insurance company to see if Dr. Collin is on their provider list or whether there is a linguistically-competent mental health provider on the panel of providers. There is no other such provider, but the insurance company is willing to reimburse Dr. Collin.

During their first meeting Dr. Collin explains that she is skilled in working with culturally diverse people (i.e., Latinos) experiencing depression and anxiety. She also informs Laura that she has experience with Deaf culture because she had a deaf friend in college. Dr. Collin and her college friend communicated through spoken English, spoken Spanish, and some fingerspelling. Her friend did not know ASL. As the initial session progresses, Dr. Collin tries to communicate with Laura using spoken English and fingerspelling. The way Laura answers the questions indicates limited understanding. Dr. Collin continues trying to rephrase the questions using spoken and written English, to obtain more information from Laura about her depression. Laura becomes increasingly frustrated and finally writes that she needs a sign language interpreter.

The next day, Dr. Collin requests that the mental health clinic provide an interpreter for Laura as there is no interpreter on site. The clinic contacts a local interpreter agency and they send a nationally-certified ASL interpreter who has no background in mental health or mental health interpreting. The interpreter is one year out of the local community college interpreter training program. During the next session, Laura focuses intently on the interpreter and signs rapidly. Dr. Collin notices that Laura wildly gesticulates and exhibits constant facial expressions, which she interprets as anger and frustration. Laura explains that she is sad because of ongoing marital difficulties and fears her husband, who is also deaf, may be having an affair with a woman in another city. The interpreter summarizes what Laura is signing and frequently asks Laura to repeat her comments. At the end of the session, Dr. Collin asks if Laura would like to continue working together with the assistance of an ASL interpreter.

The same
interpreter would not always be assigned to the therapy sessions, however, due to interpreter availability issues. Laura becomes upset because she wants the same interpreter each time, although there is no other option.

A short while later Michelle, a friend of Laura’s, contacted Dr. Collin for an appointment. Michelle communicates with Dr. Collin using spoken English. Early in the course of her treatment, Michelle reported that she was having an affair with a deaf man. Recently, she shared with Dr. Collin that the man is married, which is exacerbating her anxiety about the relationship.

One day Dr. Collin runs into Michelle at a local deaf festival. Michelle introduces her “boyfriend” to Dr. Collin and they go about their separate ways. Later in the day, Dr. Collin runs into Laura who states that she is looking for her husband who drove to the festival with her good friend Michelle.

Questions for Vignette 3

1. What principles and standards in the APA Ethics Code may apply to this situation?
2. What is Deaf culture?
3. What steps would Dr. Collin need to take in order to become competent to provide services to Laura?
4. How do psychologists self-assess their own level of competence to work with Deaf individuals?
5. Is there a competence for interpreters? Is additional competence required for an interpreter working with a mental health professional?
6. What special challenges are there working for interpreters in the Deaf community?
Vignette 4: The Disappointing Sex Life of Alex and Sam

Alex and Sam have been seeing Dr. Carlton for one month. They agreed counseling would be helpful in making the decision to marry now that their state recognizes marriage equality. Friends recommended they consult Dr. Carlton as a psychologist who treats persons of the LGBTQI community affirmatively. Alex and Sam are very committed to each other, have been cohabiting for eight years, and both express a desire to move forward with marriage.

In exploring what caused them to seek counseling to finalize this decision, Dr. Carlton encouraged them to talk about their relationship. It became apparent there were some sexual intimacy issues; they revealed that they had not had sex in over a year. They are perplexed because during the first years of their relationship, their sexual life was intimate and mutually satisfying. They reported that their lovemaking was varied and versatile. Gradually, however, Sam had become somewhat shy or reluctant in response to some of Alex’s urges and eventually, to avoid conflict or discomfort, they had begun to avoid sex altogether. Alex wonders if Sam’s background as a former student for the ministry is part of the problem. Alex wonders if Sam’s history of sexual abuse as a child is also a factor.

They continue to find each other attractive and engaging, and they enjoy an active social life together. In all other ways Alex and Sam say they are very compatible. They handle conflict well enough and believe some conflict is normal, even healthy. Both confirm that they have been out as gay men for some time and are comfortable with their sexual orientation and identity. Neither wants to accept that they are embarking on a marriage that will be deprived of sexual intimacy. However, given that this is the only significant problem they have, they wonder if they should move forward with plans to marry and at the same time focus, in treatment, on their sexual problems. Dr. Carlton agrees that this may be a reasonable way forward. He suggests that one way to approach the problem might be to open the relationship up to the possibility of sex with other men, even though Alex and Sam report having been monogamous. Alex immediately affirms that he has thought about that possibility and wonders if it could strengthen their relationship; Sam, however, is stunned and offended. He cannot imagine what would possess Dr. Carlton to propose such a violation of their
commitment to one another and believes it would erode trust. In fact, Alex’s receptivity causes Sam to question Alex’s love.

During the next session, Sam challenges Dr. Carlton’s ethics and wonders if he somehow takes their relationship less seriously because they are gay. Dr. Carlton initially bristles at this but agrees that he will examine his own feelings and beliefs as they work together.

Dr. Carlton calls you for a consult regarding Alex and Sam’s presenting question. He expresses his belief that gay men often find relationship boundaries challenging and notes that many of his gay clients have had open relationships. He readily acknowledges that he applies different standards to gay and straight couples and would never have proposed such an intervention had he been presented with the same issues by a straight couple.

Questions for Vignette 4

1. What principles and standards in the APA Ethics Code may apply?
2. Are there both clinical and ethical issues to explore in consultation? What ethical issues come to mind?
3. What kind of competencies do you think are needed to counsel Alex and Sam ethically?
4. Based on what Dr. Carlton has told you, do you believe he possesses those competencies?
5. Would it matter to you if Dr. Carlton was gay?
6. Do you think Dr. Carlton understands the effects of stigma on the couple's relationship? On their sexual relationship?
Vignette 5: Diversity in the Supervisory Relationship

Dr. Ruth Abrams, a Jewish post-doctoral therapist, presented an exploratory psychotherapy case of an adult African American female patient to her Jewish supervisor, Dr. David Stein.

Six months into the supervision, Dr. Abrams thought that the work was going very well. She found Dr. Stein to be keenly interested in her patient’s struggles, including her evolving anxious attachment to Dr. Abrams and its relationship to the traumas of her early life. These included abject poverty and separation from her mother from ages one to three. As the patient began to re-experience the painfulness of her early life, she became apprehensive that her therapist was not African American.

Dr. Abrams continued to feel helped by Dr. Stein’s supervision, but became increasingly anxious about how to work with the racial aspects surfacing in the work with her patient. Dr. Stein was very skillful in helping Dr. Abrams track multiple manifestations and meanings of the patient's racial reactions, and in helping the therapist to work with the patient on the patient’s real and transference experiences of race. The patient began to gain a fuller understanding of the various meanings of her racial experience and of the racial difference between her and her therapist.

However, in a series of sessions following the therapist’s unexpected week-long absence due to illness in her own family, the patient began to express rage over the fact that “millions of slaves had been killed in transit from Africa to America.” She began to express grave disappointment and rage that America had never come to terms with this atrocity. Though she did not explicitly mention her therapist’s Jewishness, she expressed doubt that her therapist could really understand how she felt.

When Dr. Abrams reported the above sequence to her supervisor, she was stunned when he erupted in a lengthy discourse on how there was no reasonable comparison to be made between the fate of the Jews in the Holocaust and the fate of African slaves. Dr. Abrams was unsettled by this departure from the supervisor’s usual calm and

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2This case was adapted from the Ethics Casebook of the American Psychoanalytic Association.
reflective approach, and by her own view that the supervisor was off track, so much so that she could not make use of that supervisory hour.

When Dr. Abrams consulted another supervisor about her feeling that Dr. Stein had perhaps demonstrated prejudice or insensitivity, Dr. Abrams was advised that Dr. Stein's narcissism would not allow him to meaningfully discuss what had happened. Dr. Abrams did not question this opinion or seek other advice. Thereafter, Dr. Abrams felt the supervision was stunted minimally useful; she discontinued it as soon as she reached the minimum number of required hours.

Questions for Vignette 5

1. What Principles or Standards in the APA Ethics Code may apply to this situation?
2. How should the supervisor/supervisee determine when to discuss factors such as race, gender, age, sexual orientation, and religion in the supervisory relationship?
3. If Dr. Abrams had approached you following her discussion with Dr. Abrams’ colleague, would you have recommended exploring other avenues of addressing the situation with Dr. Stein, or would you have likewise recommended that Dr. Abrams move on?
4. Should the therapist bring up race and gender if the patient does not?
Vignette 6: Unsafe on the Job

Dr. Faure, the clinical supervisor, was concerned when Ms. Rand, a practicum student in her third year of psychology graduate training, called her about an hour and a half after the training clinic had closed. “I’m sorry to bother you,” Ms. Rand explained, “but I suspect that my last client may be stalking me.” Dr. Faure was aware that Ms. Rand had concerns about this particular client, who had a history of becoming abusive in relationships with women. Dr. Faure had supported Ms. Rand as she worked hard to maintain a therapeutic stance and set appropriate boundaries with a client who repeatedly asked why she could not date her clients, and would often wait until the session was over and the two were in the hallways, away from the cameras in the training clinic session rooms, to tell Ms. Rand how he felt about her. Tonight, in session, Ms. Rand planned to discuss transferring his care to a different therapist, as his strong romantic feelings for Ms. Rand were stifling any substantial progress in the treatment. Ms. Rand had been sufficiently concerned about the session that she had asked another student in her practicum group to observe the session over the video relay, in the event that her client began to escalate into aggressive behavior.

Ms. Rand explained to her supervisor that she had finished the session, met with the other student who had observed the session for debriefing, and completed her session note before leaving the clinic. However, when Ms. Rand got into her car, she saw that the client was still sitting in his vehicle, parked next to hers, in the clinic parking lot. He then tailed her in his car as she left. Ms. Rand first drove around the block to see if the client would follow a route that made no sense. He did. She then drove to the campus security building and parked right next to the door; the client finally drove on out of sight. Ms. Rand waited some time, not asking for help from security for fear that she would violate her client’s confidentiality, and drove home in the hopes that her client was not waiting out of sight. She then called her supervisor from the safety of her home. Once Dr. Faure was reasonably certain that Ms. Rand was not in immediate danger, she scheduled a supervisory appointment for the morning.

In processing Ms. Rand’s experience and considering next steps on this case Ms. Rand told Dr. Faure, “I’d rather not tell you this, but I believe that I ethically must. I think there are some elements of my background that may affect my objectivity with this

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3 This case was adapted from Park, Currier, Slattery, & Harris (in progress)
Dr. Faure was quite surprised to learn that Ms. Rand had been physically and sexually abused by her father as a child. She was a very successful therapist in the graduate training program, excelling in academics, sought out by her peers for consultation in practicum, and developing insightful lines of clinical research. Other clinical faculty had not observed any difficulties with stress, anxiety, or inappropriate reactivity in Ms. Rand. This was a challenge to Dr. Faure’s stereotypes about incest survivors. Dr. Faure accepted her job with the university partly to get away from working with survivors of incest and other types of traumas. Over several years she had seen so little progress among these clients that she had given up on expecting to be able to facilitate effective change in this population.

Dr. Faure observed that Ms. Rand’s hands were shaking as she went on to explain her concerns about how her client often justifies his domestic abuse by quoting Bible passages about how the man is the head of the household, particularly as her father had quoted those same passages to prevent her mother from interfering with his abuse. She observed that she has been trying to manage her countertransference to this client, but is frightened by his efforts to push her boundaries, and recoils from the faith perspective he espouses in sessions. She questions her ability to be objective and offer competent therapy, and believes she cannot ethically continue to work with him.

Questions for Vignette 6

1. What Principles or Standards in the APA Ethics Code may apply to this situation?
2. Do you think Ms. Rand handled the issue of her safety ethically?
3. How should a supervisor and supervisee determine when to discuss factors such as trauma and religion in the supervisory relationship?
4. What kinds of competencies are needed to supervise Ms. Rand’s work with this case effectively?
5. Based on what Ms. Rand has told you, do you believe that Dr. Faure possesses those competencies?