3 Ethical Guidelines for Working with Culturally Diverse Clients

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Introduction

Population projections estimate that by 2060, the USA will be a minority-majority country (Colby & Ortman, 2015). As the population of the USA becomes increasingly racially/ethnically diverse (López, Bialik, & Radford, 2018; Vespa, Armstrong, & Medina, 2018) and more American adults identify as LGBTQ+ (Newport, 2018), it is imperative for helping professionals to engage in therapeutic work that is both ethically and culturally informed. However, the provision of ethical and culturally informed practice continues to lag behind these changing demographics (Gallardo, Johnson, Parham, & Carter, 2009; Rogers & O'Bryon, 2014). To illustrate, studies persistently report how mental health professionals continue to work with Spanish-speaking clients (Castaño, Biever, González, & Anderson, 2007; Delgado-Romero et al., 2018; Delgado-Romero, Unkefer, Capielo, & Crowell, 2017; Verdinelli & Biever, 2009), LGBTQ+ individuals (Murphy, Rawlings, & Howe, 2002; Xavier et al., 2012), and people with disabilities (Man, Kangas, Trollor, & Sweller, 2017; Rivas & Hill, 2018) without receiving appropriate training (Rogers & O'Bryon, 2014). This problem is compounded by the frequent separation of ethical and multicultural concerns when working with clients. As noted by Gallardo et al. (2009):

> When the ethical lens supersedes the cultural lens in a potentially "unclear" therapeutic encounter, thereby placing the clinician before the client, the clinician's desire to "self-protect" may overshadow the clinical needs of the client. (p. 427).

This separation of multicultural and ethical considerations may lead to practices that fail to consider the client's presenting concerns within their cultural contexts and instead impose Eurocentric, heteronormative, and patriarchal values (Sue & Sue, 2008; Wendt, Gone, & Nagata, 2015). Accordingly, it is critical to consider and rethink professional ethical codes and standards within a culturally informed framework (Fisher, 2014).

This chapter provides a brief overview of professional ethical codes in relation to multicultural ethics, ethical guidelines, and their juncture with multicultural competencies. This is followed by a discussion of criticisms of ethical codes in relation to multicultural counseling, an introduction into the concept of multicultural ethical competence, examples of culturally informed ethical decision-making frameworks, and examples of intersections between multicultural ethics and legal issues in working with diverse clients. Two ethical dilemma cases are presented along with various recommendations and considerations. It is important to clarify that the ethical decision-

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Table 3.1 Resources for helping professionals and trainees

Ethics codes	Ethics guidelines and commentaries	Practice guidelines
American Association for Marriage and Family Therapy (AAMFT) Code of Ethics (2015)	National Latinx Psychological Association (NLPA) Ethical Guidelines (2018)	Competencies for counseling with transgender clients (Burnes et al., 2010)
American Counseling Association (ACA) Code of Ethics (2014)	Society of Indian Psychologists: Commentary on the APA's Ethical Principles of Psychologists and Code of Conduct (García & Tehee, 2014)	APA guidelines for assessment of and intervention with persons with disabilities
Association of Black Psychologists: Ethical Standards of Black Psychologists		APA guidelines for psychological practice with girls and women
American Psychological Association (APA) Ethical Principles of Psychologists and Code of Conduct (2017)		APA guidelines for psychological practice with lesbian, gay, and bisexual clients
The National Association of Social Workers (NASW) Code of Ethics (2017)		APA guidelines for psychological practice with transgender and gender nonconforming people
		Association for lesbian, gay, bisexual, and transgender issues in counseling (ALGBTIC) competencies for Counseling with lesbian, gay, bisexual, queer, questioning, intersex and ally individuals
		Association for Spiritual, ethical, and religious values in Counseling (ASERVIC) competencies for addressing spiritual and religious issues in Counseling
		Practical guidelines for counseling students with disabilities (Beecher, Rabe, & Wilder, 2004)

making approaches provided here are not exhaustive, but instead a guide of considerations as proposed by current multicultural competency guidelines. Also in this chapter a table (Table 3.1) of published ethical codes, practice guidelines, and commentaries from various organizations is provided as a resource for clinicians and clinical trainees. However, practitioners must be aware that this is not an exhaustive list and it is also their responsibility to search for updates in ethical codes and standards of care.

Professional Codes of Ethics

Professional organizations within various helping professions have published ethical codes that incorporate ethical principles and standards that provide recommendations to ensure the quality of professional practice and to protect the public (Francis & Dugger, 2014; Herlihy & Corey, 2015). To distinguish these, principles tend to refer to general aspirations or moral values, that is, the moral values a profession aspires to achieve and embody (Kitchener, 1984; Pettifor, 2010). For example, the American Psychological Association (APA, 2017) code of ethics states that the principles it outlines should not necessarily be used to guide prescriptive behaviors, but instead provide an abstract goal of morality. APA's code prioritizes the principles of beneficence and nonmaleficence, fidelity and responsibility, integrity, justice, and respect for people's rights and dignity (APA, 2017). In another example, the American

Counseling Association (ACA) outlines their fundamental principles of ethical behavior as autonomy, nonmaleficence, beneficence, justice, fidelity, and veracity (ACA, 2014). Similarly, the National Association of Social Workers (NASW) states the principles of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence (NASW, 2017). The American Association of Marriage and Family Therapists (AAMFT) outlines six aspirational core values that similarly resemble ethical principles distinct from standards (AAMFT, 2015). While each of these helping professions has a distinguishable identity and focus, their ethical codes seem to be generally guided by principles of justice, integrity, and beneficence. Ethical standards, on the other hand, tend to be prescriptive behavioral rules and norms to guide clinical practice. Licensing boards throughout the USA, in turn, may use these standards to determine whether professional behaviors towards clients, colleagues, and organizations are ethical (Pettifor, 2010).

Code of Ethics Criticisms

The use of these ethical standards by licensing boards is predicated on the idea that ethical standards of the helping professions are morally and politically neutral (Comas-Díaz, 2014; Sue & Sue, 2008). This notion, however, fails to recognize that ethics are inherently informed by culturally defined moral values and norms, meaning that professional ethical codes are conceived within a specific cultural, social, and political context. The ethical codes discussed here were developed within an American context, with Eurocentric, individualistic, and patriarchal underpinnings. That is, a significant portion of the research and practice writings that inform ethical codes were primarily guided by White, male, affluent practitioners and researchers. Thus, while these ethical standards and principles are believed to be acultural, ethical codes generally reflect the cultural values and behaviors of the US White, middle, and upper class (e.g., individuality and privacy). These values are then imposed upon those from different social and cultural backgrounds. To illustrate, according to the principle of beneficence of the APA Code of Conduct (APA, 2017), psychologists are asked to safeguard the rights of the individual and their autonomy. However, this principle may not align with values of interdependence that may guide the relationships and behaviors of allocentric communities, and thus may be counterproductive when working with these communities (Comas-Díaz, 2014).

The assumed cultural neutrality of ethics codes is also reflected on who is identified as the cultural being when the codes speak of the need for professional and multicultural competence. Just as the communities served by practitioners, all helping professionals are shaped by cultural and social norms that are often grounded on ableism, cisgenderism, classism, heterosexism, nativism, and racism. As noted in the Society of Indian Psychologists' APA Ethics Code Commentary (García & Tehee, 2014), "Cultural competence begins with understanding your own values and biases" (p. 33). In other words, cultural competence requires the professional to be aware of how their culture and society influence them personally and, consequently, professionally. Yet, this step is not clearly identified within the ethical standards that speak of multicultural and/or professional competences. Instead, the helping professional may be assumed as an acultural agent that uses acultural interventions meant to help the cultural other. For example, in the APA Code of Conduct, Standard 2.01(b) Boundaries of Competence indicates:

> Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals (APA, 2017, p. 5).

This is the only standard that specifically addresses multicultural competence in the entire APA ethical code. In the professional ethical

code for social workers (NASW, 2017), social justice is itself outlined as an ethical principle, including a call for social workers to "challenge social injustice…seek to promote sensitivity to and knowledge about oppression and cultural and ethnic diversity" (p. 2). This ethical code also includes specific standards for cultural competence separate from a general competence standard. Standard 1.05 Cultural Competency and Social Diversity includes four points providing guidance for cultural competence:

> Social workers should understand culture and its function in human behavior and society...Social workers should have knowledge based of their clients' cultures and...demonstrate competence in the provision of services that are sensitive to clients' cultures…Finally, the Social Worker ethical standards underscores the importance of seeking further cultural competence when needed...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, age, marital status, political belief, religion, and mental or physical disability.

The NASW (2017) also includes Standard 6.04 Social and Political Action which further outlines a professional orientation to "engage in social and political action that seeks to ensure that all people have equal access to the resources, employment, services, and opportunities they require to meet their basic human needs and to develop fully" (p. 8). The standard includes a call for social workers to act against the exploitation and discrimination against a group of individuals based on membership to a specific group. The AAMFT (2015) Code of Ethics emphasizes within their aspirational core values the importance of "Diversity, equity, and excellence in clinical practice, research, education, and administration" (p. 2). This code of ethics does not make further mention of cultural competence or guidance in working with culturally diverse populations.

Perhaps a better example of recognizing the helping professional as cultural being is given by the ACA Code of Ethics' Standard A.4.b. (2014), in which the counselor is asked to be "aware of—and avoid imposing—their own values, attitudes, beliefs, and behaviors" (p. 5). As stated in this standard, the counselor is required to have self-awareness and understand how their values, beliefs, and behaviors may influence their interventions. Furthermore, the ACA Code of Ethics consistently describes a call to cultural competence and cultural considerations within various standards throughout the entire, demonstrating an intentional integration of cultural focus through each standard of practice. Overall, the ethical codes of the helping professions present very open and ambiguous calls for multicultural competence. While ambiguity in the ethical codes is meant to facilitate a decision-making process that is inclusive of different perspectives (Strech & Schildmann, 2011), a clearer articulation of the helping professional as a cultural being is required for multiculturally competent ethical decision-making.

Multicultural Ethical Competence

Regulatory bodies that operate by imposing rules of conduct and strict behavioral code as a form of ethical guidelines without a thoughtful consideration to a multicultural philosophical foundation or multicultural moral framework may be failing to provide ethical guidelines that truly seek the beneficence of clients (Pettifor, 2010). To clarify, Pettifor (2010) states that a *prescriptive approach to ethics* is one that defines a standard of behavior focused on avoiding harm. Ethical codes utilizing this approach prioritize professionals doing the "minimum required" amount of work by the practitioner that ensures the reduction of risk of harm and to ensure there are no potential legal and ethical repercussions. This practice does not truly focus on the client's well-being and successful treatment, and while it can be detrimental to any client, it can become severely more dangerous for marginalized and/or minority communities that present with particular and unique presenting concerns. In contrast, an *aspirational focus* seeks optimal levels of care by promoting the respect, integrity, and genuine interest of upholding ethical principles in order to obtain the welfare of the client. Of course, a prescriptive

approach may be easier as it provides significantly easier framework to determine unethical or ethical behavior: either you performed an action, or you did not.

The danger of lacking a multicultural moral framework and the application of a prescriptive ethics approach runs the risk of practicing unintentionally racist and culturally insensitive counseling practices and ethical decision-making (Gallardo et al., 2009; Pedersen, 1997). For example, a moral framework that lacks engagement in a critical examination of its own cultural biases may result in an *ethnocentric thinking*, that is, judging others' behaviors, emotions, and thoughts based on one's own ethnic/racial perspective. This may then lead to the pathologizing of diverse cultural practices and ultimately fail to truly serve clients in need.

The lens utilized to understand ethical principles and standards also influences how practitioners solve ethical dilemmas (Bernal & Domenech Rodríguez, 2012). Fisher (2014) describes three ethical decision-making approaches often utilized in the helping professions: ethical absolutism, ethical relativism, and ethical contextualism. An absolutist approach or *ethical absolutism* describes an approach where ethical standards and codes of ethics trump contextual factors and dynamics within the interpersonal relationship. That is, in this approach the practitioner would be indifferent towards contextual factors, including people, situations, and other social influences and instead attempt to apply a "one-size-fits-all" approach (Fisher, 2013). This approach is typically associated with the belief that psychological practice and ethical standards are "objective" and universal. On the other hand, *ethical relativism* denies such existence of universality and rejects the so-called common moral values among all members of the human race. Instead, this approach accepts that cultural groups have their own set of cultural and moral frameworks. In this instance, ethical decision-making would occur within the confines of the moral framework of that cultural group. This approach may also result in certain risky implications, specifically in cases where a cultural group may ascribe to behaviors, beliefs, and attitudes that systematically endanger the well-being of others.

Conversely, Fisher (2014) calls for the consideration of *ethical contextualism* or universalist approach, a framework that blends the two previously mentioned approaches. In this moral framework there is a recognition for certain universal moral values given a shared humanity, while also recognizing that individual cultural groups have unique values (Pedersen, 1997). Moral principles such as beneficence, integrity, respect for human dignity, and freedom may be considered universal and as guides in attempting to make an ethical decision, while also considering the values of a client's cultural groups and identities to further guide the decision-making process. This process requires an active and intentional exploration of the practitioner's and the client's sociocultural context and moral values to negotiate a clinical decision that aspires towards those universal moral values and that also remains congruent with the client's own set of beliefs (Gallardo et al., 2009).

Linked to the previous moral framework, the concept of *multicultural ethical competence* is considered, which refers to a "process that draws on psychologists' human responsiveness to those with whom they work and awareness of their own boundaries, competencies, and obligations" (Fisher, 2014, p. 36). Therefore, it is not sufficient to be solely aware of one's own cultural values and biases, but rather to also critically consider the ways in which one's values interplay within the context of a counseling situation. Specifically, practitioners carry the heavy burden of being able to accurately gather information from clients in a manner that can provide a diagnosis which can influence.

A potential moral framework to consider would be "virtue ethics," a moral framework that considers cultural contexts and focuses on the importance of genuinely seeking the well-being of the individual (Fowers & Davidov, 2006; Meara, Schmidt, & Day, 1996). In contrast to the prescriptive ethics approach discussed earlier in this chapter, virtue ethics provides an approach of considering the unique needs of an individual and making decisions towards the beneficence and

service of the individual, as opposed to simply following the "correct" rules and "minimum required" responsibilities. Instead, virtue ethics sees the helping professional as a virtuous agent motivated to do good. The virtuous helping professional is one who also considers the role of emotions in multicultural ethical decision-making and understands the role the community they serve in the decision-making process (Meara et al., 1996; Trimble & Fisher, 2006).

Multicultural Ethical Decision-Making Models

Ethical violations transpire when agreed-upon moral imperatives are violated (e.g., engaging on a sexual relationship with a client) (National Latinx Psychological Association, [NLPA] 2018). While ethical violations are often clear to identify, ethical dilemmas are more difficult to identify and solve because they often occur within a context of competing demands for action that could be similarly valid depending on the values, beliefs, and traditions of the professional and the community they serve (NLPA, 2018). The vague language used by the ethical codes aforementioned (e.g., referring their respective professionals to simply consider multicultural factors in the ethical decision-making process) makes the process of multicultural ethical decision-making increasingly difficult. Therefore, even clinicians who strive to provide multiculturally competent services could find this process to be daunting simply due to lack of specificity as it relates to multicultural and/or professional competence and minimal training focus on multicultural ethics decision-making (NLPA, 2018). To address this, various ethical decision-making models have been proposed to guide practitioners, more than could be fully covered in this chapter. The following sections discuss historical and contemporary models of multicultural ethical competence, multicultural decision-making, and provide resources practitioners can use in their work with clients of diverse cultural, ethnic, and socioeconomic backgrounds.

Researchers and practicing professionals have begun pushing for guidelines that demonstrate cultural awareness and service guidelines. To begin, a critical piece authored by Sue, Arredondo, and McDavis (1992) sought to initiate the conversation surrounding multicultural guidelines that aimed to redirect the previously misguided ethical standards that demonstrated ethnocentrism, a preference towards individualistic cultures, valued Western practices and beliefs over Eastern approaches, and the role of mental health service providers play in the realm of advocacy for their clients. This article also called for changes in the counseling program accreditation process (e.g., incorporation of multicultural courses and competencies as a core component of their training models). Specifically, the authors of this article served as pioneers in the field of the development of several counseling competencies and areas of research, including, but not limited to, guidance on the development of school and guidance counseling programs (Gysbers & Henderson, 2012), basis for research on microaggressions in counseling (Shelton & Delgado-Romero, 2013; Sue et al., 2007), and other critical expansions to multicultural competence and clinical practice (Arredondo et al., 1996; Constantine, Hage, Kindaichi, & Bryant, 2007; Goodman et al., 2004; Vera & Speight, 2003).

Another pivotal article that sought to directly challenge the ethnocentric approaches of the mental health professions, particularly those of mental health counseling and counseling psychology, was written later by Arredondo and Toporek (2004), wherein the authors highlighted the ways in which the mental health profession was neglecting the needs of entire populations. As a result, they reported the alarming concern of higher attrition rates in counseling among ethnically diverse groups of clients. Within the context of highlighting the deficits of the field, this article also provided suggestions and resources to the readers. Specific case examples also provided readers with the knowledge base of case studies that outline the complexity of the nature of the counseling relationship with special regard and attention given to context, multicultural awareness, and the history of marginalization being

perpetuated within the field of the "helping" professions. Perhaps most fundamental about this seminal article is its direct attempt to outline multicultural competencies as alive and malleable, designed to be ever-changing as to best meet the needs of clients. In addition to providing specific guidelines of how to begin working in a culturally sensitive manner with culturally diverse clients, the authors also remind practitioners to continually be aware and to evaluate their own multicultural values and biases.

Even prior to some of the previously mentioned seminal articles that aimed at creating ethical guidelines for practice with culturally diverse populations was consequential article authored by Casas, Ponterotto, and Gutierrez (1986). This article emphasized how mental health professionals who are not multiculturally competent should be considered unethical. It could even be argued that this bold statement was one of the pivotal moments in multicultural psychology, as it served as one of the catalysts towards calling out counselors who did not harbor the ability to work both effectively and ethically with clients of diverse backgrounds. After this article, the articles previously cited in the preceding paragraphs continued the momentum of several years of conversations on the topic of working with clients not of the Anglo-European heritage. These conversations continue today, resulting in continued efforts from concerned experts in the field to strive to develop new ethical guidelines specific to diverse clients.

Being multiculturally competent is an ever-changing process that does not end at a specific point in time (Arredondo & Toporek, 2004). As such, a practicing mental health professional does not arrive at a point of multicultural competence, but instead is continually striving to remain an active learner of issues in counseling. Per Casas et al. (1986) and Toporek and Reza (2001), a competent clinician must consider context, sociopolitical factors, language, religious, and the socioeconomic status of a client, couple, or family when considering assessment, diagnosis, and treatment. The same care should be taken when solving ethical dilemmas. Because sociopolitical factors are continuously changing and influencing both the professional and the client, the professional and regulatory bodies who interpret ethical guidelines and standards must also be willing to adapt, learn, and grow. As will be explored later in this chapter, taking a client out of the context of their situation is not only insufficient in meeting the counseling goals for a client, but also can result in harm to the client and their community.

Multicultural ethical competence and ethical decision-making must begin with the helping professional taking inventory of their values and beliefs and understand how these values and beliefs influence their interpretation of ethical principles and standards as well as how they solve ethical dilemmas. It is also necessary to understand that ethics exist within a cultural, social, political, and historical context. To facilitate this process, Toporek and Reza (2001) propose in their article the Multicultural Counseling Competency and Planning Model (MCCAP) as a model to assisting professionals in growing in their cultural competence. The authors present this model as a "cube" where the standards and competencies of Sue et al. (1992) are considered on the intersection of context and assessment and plan components. The context refers to the counselor, whether they are functioning within personal (e.g., identity, beliefs, attitudes), professional (professional identity), and institutional (e.g., agency, institution of employment, local, state) environments. The assessment and plan components refer to the specific actions and plans that practitioner sets out to develop in their competences, beginning with the assessment of what one already knows, what is information is needed, and how that awareness and knowledge will be raised. Finally, the authors posit that these changes towards cultural competence need to occur within three domains: emotional, cognitive, and behavioral.

The National Latinx Psychological Association also provides an ethical decision-making model within their ethical guidelines that calls for flexibility and contextualization (NLPA, 2018). Generally, they propose common steps:

(a) clarifying the nature of the dilemma, (b) analyzing legal and ethical responsibilities, (c) consulting with other professionals, sources, and community members that could be potentially affected by the decision, and (d) brainstorming for many possible actions and myriad consequences. Authors of the NLPA ethical guidelines emphasize that the ethical decision-making process is a life-long process of growth and learning. They also strongly recommend approaching ethical decisions and conclusions to be "held with an open hand" (p. 25) that is, recognizing that decisions can be valid and useful while also understanding that they may be fallible.

Another potential resource for helping professionals is the "Ethics and decision making in counseling and psychotherapy" chapter by Cottone and Tarvydas (2016). In this chapter, the authors present a review table of various commonly used models of ethical decision-making, providing a description on the various steps and considerations within each model. Furthermore, the authors provide an in-depth description on the Tarvydas Integrative Model, composed of 4 stages: (1) interpreting the situation through awareness and fact finding, (2) formulating an ethical decision, (3) selecting an action by weighing competing, nonmoral values, personal blind spots, or prejudices, and (4) planning and executing the selected course of action. These resources are considered to be useful for clinicians to engage with current ethical decision-making models. Nonetheless, it is strongly emphasized that helping professionals actively seek up-to-date models and ethical concepts as these continue to develop as practitioners gain a better understanding of human diversity and ethical issues.

Ethical and Legal Issues

Beyond the implications of ethical decision-making within clinical decisions, ethics also largely intersect with important legal implications. This is of particular importance in the work with marginalized communities, as many marginalized communities also exist within legal oppressive systems. Such systems may be past or current, and in either case, they may have active and current impacts on the lives of clients. Thus, it is an ethical duty to be aware and proactive in preparing for the challenges faced when multicultural ethics and the law may be at odds. In the following, a few examples of current important legal issues are discussed. Again, this list is not exhaustive and may also be continuously changing as awareness and knowledge increase. Some of the legal issues discussed in the following may include laws that directly impact the training and/or practice of helping professions while other examples refer to general implications of how legal systems impact and potentially oppress entire communities.

Conscience Clause

A current conflict within culturally informed ethics and law focuses on the conscience clause. Based on the legislation passed in Arizona Statute, this clause reads that "a university or community college shall not discipline or discriminate against a student in counseling, social work, or psychology program because the student refuses to counsel a client about goals that conflict with the student's sincerely held religious belief…" (H.B. 2565, 2017). In effect, this law allowed practicum students to refuse clients with presenting concerns that contradict sincerely held religious beliefs, including a sexual minority orientation, gender minority orientation, and even clients that may be ascribed to a different set of religious beliefs. Ethical codes within helping professions are quite clear of the importance of competence in working with diverse clients, specifically in the ethical requirement of practitioners seeking competency through training, supervision, and consultation when working with culturally diverse clients they may have little experience with. Conscience clauses then directly contradict ethical guidelines as set by professional organizations.

Immigration and DACA

Approximately 10.7 million (Krogstad, Passel, & Cohn, 2017) immigrants are currently living in the USA without documentation and approximately 700,000 individuals are currently enrolled in the Deferred Action for Childhood Arrivals (DACA) program (U.S. Citizenship and Immigration Services, 2019). For these communities, the lack of a recognized "legal status" by the US federal government has significant psychological and social implications. Significant empirical research supports how documentation stress/marginalization is associated with higher risk of physical, emotional, and academic disparities (Gonzales, Suárez-Orozco, & Dedios-Sanguineti, 2013; Roth, 2017). Within the context of ethical multicultural practice, practitioners serving members of this community and/or clients who may be closely associated with this community should be informed about the legal issues that impact this community, as well as the social, cultural, and health implications that this may have. Furthermore, sensitivity regarding this identity must be practiced (e.g., setting additional safeguards for confidentiality and note taking; Delgado-Romero, Nevels, Capielo, Galván, & Torres, 2013). Confidentiality is more critically emphasized given the huge risks of deportation that could occur if a client's legal status was discovered. Within the context of virtue ethics and multicultural ethical practice, a practitioner needs to be prepared in advance to advocate on behalf of and protect their client's documentation status in the case of a medical emergency, legal situation, or in a situation where a client may need to contact the authorities. Participating in Know your Rights workshops and educating their clients about the client's rights is a necessity when working with this community (Chavez-Dueñas & Adames, 2017, 2018).

Case Examples and Ethical Decision-Making

In the following, two cases of ethical dilemmas are presented that include multicultural issues. Recommendations are provided after each case. It is important to emphasize that this chapter is only providing a few examples of how a practitioner may consider ethical dilemmas and that these approaches are not being presented as the only possible manner to making multiculturally competent ethical decisions. Ethical dilemmas are immensely complex and so it would be impossible to provide a comprehensive and absolute "solution." The following are provided as examples of how a clinician may go about considering the issues and factors that interplay in an ethical dilemma.

Case #1

Ceci is a 20-year-old, heterosexual, Latina women, currently unmarried and living with her parents. Ceci came to the USA with her family from El Salvador when she was 12 years old. She has attended two counseling sessions, reporting various anxiety symptoms. When Ceci arrives to her third session, she reports that during the past week she has been seeing large floating devices that have been following her around. Ceci stated she believes these devices are sending information about her to a secret government agency documenting her every behavior. Ceci also said that she has been hearing voices that have been helping her plan how to attack and destroy the devices. The clinician is strongly considering hospitalization, suspecting that Ceci is having a psychotic episode. However, the clinician remembered Ceci reported in an earlier session that she and her parents are undocumented and is concerned that hospitalization may put Ceci and/or her

family at risk for deportation. The clinician is uncertain if Ceci will pose a risk to herself and others but is concerned her symptoms may worsen if she is not placed in psychiatric care. The clinician is also aware the latter option may have worse implications for Ceci and her family if legal authorities became involved with the case. The clinician needs to decide soon as Ceci is getting ready to return home at the end of the session.

Considerations

In the previous example, there are multiple ethical code standards that may influence the decision that a clinician could take regarding Ceci's situation. This case makes it imperative for the clinician to be familiar with undocumented migrant rights prior to this sort of circumstance to occur. This calls for clinicians to be preemptively prepared and aware of potential ethical and legal issues that may arise when working with populations who may be particularly vulnerable to legal action.

In the decision-making process given this case, a clinician would strive to "avoid harm," that is, an attempt to minimize or to remedy unavoidable or anticipated harm. The clinician has assessed that Ceci may not be in a mental state to be left without clinical oversight and may be a danger to herself. While Ceci did not make statements of harming others, due to her psychotic symptoms, she may put others at risk if her symptoms worsen. The clinician must then consider the risk. Now, the next steps that the clinician takes to ensure that Ceci is safe are of critical importance. Ceci's legal status may be another level of potential risk and harm for the client: if hospitalizing leads to Ceci's immigration status being questioned by authorities, she may be at risk for deportation. In this case, the clinician must consider Ceci's sociopolitical reality and consider that the risk of deportation may be a higher risk of harm for her client. However, due to Ceci's symptoms, to not place her under professional clinical care would also be harming.

It is imperative at this point for the clinician to contact and inform Ceci's parents and obtain consultation from other colleagues. The clinician should consider the potential actions that could be taken to ensure that Ceci is not a danger to herself and towards others. This may include physically accompanying Ceci and her family to a hospital or psychiatric center. This may be beneficial in that it would allow the clinician to advocate in the hospital for their client. If the clinician is unable to accompany, they may consider asking for permission to contact a trusted family member, neighbor, religious leaders, immigration rights advocate that may be able to accompany. As mentioned previously, many of these possible actions require the clinician to be preemptively prepared for these sorts of emergencies and also necessitate an understanding of the client's social network to provide culturally informed recommendations.

Case #2

Chaske is a 9-year-old Sioux boy who was being seen on a bimonthly basis by an outpatient multidisciplinary nephrology transplant team. During a routine visit, a social work practicum student was staffed to the case when a nurse practitioner noticed some unexplained bruises on the patient's arms. When the practicum student's clinical supervisor asked the patient about the origin of the bruises, the father was the first to reply and began telling a long recount of different community events and celebrations that led up to the incident involving the bruises, as well as incorporating some humor into the situation. Given the nature of the father's testimony and how it included seemingly unrelated details and lightheartedness, the supervisor decided to meet individually with the patient to ask more questions. The patient responded to the supervisor's direct and aggressive questioning style in a similar pattern, including various details of other seemingly unrelated events before denying that the bruises were a result of any abuse or neglect.

Based on the style of communication from the patient and family, the supervisor determined

that there was likely manipulation and lying to hide the true reason behind the bruises, ultimately asking the student to make a report to the Department of Children and Families (DCF). When the practicum student raised concern that this report was being made prematurely, citing literature on narrative communication patterns and humor being more common among some Native American communities (Garrett et al., 2017; Thomason, 1991), the supervisor quickly dismissed the suggestion and herself cited the Social Work Ethical Guidelines (NASW, 2017). Ultimately, the DCF case was closed due to unfounded evidence of abuse or neglect. However, the family suffered severe consequences of having their community disrupted and questioned when case workers came out to interview the family on their reservation. After the event, the family transferred their care to a different hospital for fear of being judged or misunderstood again in the future.

Considerations

There are several ethical guidelines upon with to reflect when considering this case. To begin, the clinical supervisor, while considering the ethical guidelines of social workers having a duty to report suspected abuse or neglect of a child, neglected to consider the cultural components that may have led to the interpreted "deceitful" pattern of communication from the family. The code of ethics for social work clearly outlines the ethical necessity of having a multicultural knowledge prior to walking into a therapeutic relationship with a client of Native American heritage was key in this case. The supervisor in this example did not demonstrate cultural knowledge, ultimately resulting in the suggestion to file an unjustified case of neglect. Had the supervisor considered the suggestion of the supervisee, there could have been a chance that the supervisor would not have interpreted the communication style of the patient and his family as manipulative or as avoiding the question.

Conclusion

The field of multicultural competence is fast-growing and dynamic. Consequently, the moral frameworks and approaches that guide multicultural ethics must be also continuously challenged and changed to truly serve and help communities. This increases the challenge of maintaining multicultural ethical decision-making within clinical practice. Human diversity is infinitesimally complex, precluding the development of a standard ethical decision-making process that can be truly culturally competent. Instead, practitioners need to develop a critical consciousness regarding moral frameworks and ethical guidelines and continue engaging in self-reflection to further develop a multicultural ethical competence.

By engaging in a process of continuous self-reflection, addressing one's own privileges, power dynamics, and cultural biases in relation to "morality," practitioners can better practice remaining open to new cultural frameworks of morality. The conversation of ethics remains opened and many ethical dilemmas remained unanswered, but the importance is to remember that the critical and important role of the practitioner is to prioritize the welfare and well-being of the client and to utilize training, supervision, consultation, and empirical research to continue ethical practice with diverse clients.

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