Ethics: Spiritual Issues in Clinical Practice

Part 1: Handling Ethical Issues
Interview with Terry Northcut, PhD

BARBARA ALEXANDER: Welcome. I'm Barbara Alexander. You are reading or listening to a series of interviews from On Good Authority's program on ethics and spiritual issues in clinical practice.

Many ethical issues arise out of the incorporation of spirituality into one's clinical practice. These range from the appropriateness of prayer in the therapy or counseling session to informed consent between client and therapist about whether and how spiritual and religious issues are discussed. Self-disclosure is also an ethical and, obviously, a clinical issue. And, what if you bump into your client at your church or synagogue?

Now, there are basically two types of ethical theories - rule or principle ethics and virtue ethics. The most obvious example of rule ethics for clinicians is the code of ethics of his/her particular profession. Every mental health profession has its own code. The areas covered include informed consent, level of competence, confidentiality, dual relationships, etc.

Virtue ethics emphasizes character and virtue. This theory defines certain traits of character which are universally understood to make one a morally good person.

According to Dr. Len Sperry in his outstanding book, Spirituality in Clinical Practice, the question in virtue ethics is not, "Is this action moral?" but rather, "What kind of person am I becoming?" He states, "according to virtue ethics, moral virtues are states of character concerned with controlling and directing not only one’s thoughts and rational processes, but also one’s emotions and feelings. The repeated performance of virtuous actions leads to the acquisition of virtue. The morally virtuous person aims at morally good ends rather than being clever and goal oriented."

In what one of our speakers, Dr. Ed Canda, refers to as, "spiritually sensitive practice," you can’t have one without the other.

In this interview, we will look at rule ethics combined with common sense. We heard from our speaker, Dr. Terry Northcut, in our previous clinical program about spirituality, and she returns now with a discussion of some of the ethical issues involved.

Dr. Northcut is the Director of Doctoral Programs at Loyola University School of Social Work in Chicago, Illinois, where she is also an associate professor. She received her MSSW at the University of Tennessee and her PhD at the Smith College School for Social Work. Dr. Northcut is the co-editor with Dr. Nina Heller of the book, Enhancing Psychodynamic Therapy with Cognitive Behavior Techniques. Her writing and research has lead her to publish and teach in the areas of integrating theory and practice, post modernism, the development of clinical social workers, and religion and spirituality in psychotherapy.
ALEXANDER: Dr. Northcut, I have a number of questions about the ethical aspects of therapists including spirituality in their clinical practices. When people talk about including spirituality in their practices, they often mean direct spiritual experiences together. So, what are some of ethical issues in that?

NORTHCUT: The biggest ethical issue from my perspective is on whose initiative is the practice occurring? Do clients coming into treatment know that this is the way the practitioner practices? If so, they are informed, and it is informed consent that they want to participate in this. I have major reservations, and I think it is an ethical problem when clinicians don’t inform clients that this is a part of their practice and then introduce it once a relationship is forming. In that event, clients don’t have full information about what they may feel coerced to participate in.

So, one of the standards or ways of resolving this dilemma is to have clinicians be very clear: Are they practicing and including spirituality implicitly or explicitly?

Sometimes it may come up at the client’s initiative. For example, "Will you pray for me?" or "Can we pray in this session?" Generally in those situations, I try to have the client take the lead about what he or she is thinking and what the request means. I have had clients do that, or where they have served in a ministerial function for themselves, and they might bring in something that they have done or performed in their church setting and share it with me. Then it is a matter of having them help me understand what it is that they want me to learn or experience from this.

I also had a client reach over and bless me as she went out the door. I was befuddled, but also aware that the client knew that if she did it on the way out, we wouldn’t talk about it at that point. This was right before vacation of mine, and she was, in a sense, trying to ensure that I would be safe and so forth. That’s how we eventually talked about that.

But, getting back to the issue of when and how to introduce this, I think the client’s lead is paramount. I think if you are going to introduce something, and if you have not prepared the client that this is the way you practice, then it should be done tentatively in terms of "Are there spiritual practices that you have found helpful?" There are ways that that could be included in terms of making sure the client is in the driver’s seat around these issues, because once there is a therapeutic relationship - or from the moment the person becomes your client, the client is coming at a point of vulnerability, and you can’t always say, "Well, she didn’t say she minded."

You can’t assume that the client won’t feel coerced in some way. So, I think that is the biggest danger - when it is done in such a way that the clients feel that they must do it or are coerced in some way.

ALEXANDER: Especially when the client is someone who has a big "need to please."

NORTHCUT: Yes, very much so. Or where there is trauma in the background - if the spiritual act in some way involves a physical touch, or hugging, or anything like that, I always say that the clinician is on a very slippery slope there. While you want the client to feel empowered and you don’t want to be "over" them, you can never lose sight of your ethical and legal responsibilities to monitor the treatment process. You have to protect the client at all cost - over your ideas about spirituality. That is my advice.

Now it's different, I think, if the clinician is advertising and hopefully has achieved some expertise in this area or received training and so forth - in terms of pastoral counselors or clinicians who have been affiliated in some way with some extra religious or spiritual training, and they advertise that
way. The client is coming to that person for that purpose, and the goal is spiritual enhancement or spiritual direction. Then that’s informed consent; they know what they are getting into. That’s how I draw the distinction, as well, between pastoral counseling or spiritual direction verses a generic psychotherapist. In other words, to what degree have they been monitored in some way and trained around this specialized area.

ALEXANDER: So, I wonder where the line is. Let’s say that therapists, for instance, call themselves Christian counselors. Does that mean something? Does it mean that they have taken course work and had actual training in Christian counseling? And, then, what is the difference between that and pastoral counseling?

NORTHCUT: Unfortunately, the way the different states and our country are set up, people can say anything about what they are. Saying that you are a Christian counselor doesn’t necessarily mean that you have extra training and credentials. I think clients should be informed and should ask what additional training the therapist has had. In some states pastoral counseling has a certifying body that certifies pastoral counselors. For a client’s benefit, I would hope they would pursue those who do have the additional training - to make that explicit. Because if therapists are advertising as Christian counselors, what is assumed is that it will be an explicit part of the treatment - that the therapist and client will look at what ways - in this particular case, the Bible - or in what ways the behavior is in direct opposition to it. It would be an explicit part of the treatment. But, it does not necessarily mean just in the label that the person has gotten additional training.

ALEXANDER: If you are a Christian counselor, and somebody comes to you not knowing that, are you obliged to disclose that?

NORTHCUT: I think so, if you are advertising as a Christian counselor. If you are not, then it becomes interesting, or more intriguing, I guess, or more of a dilemma in terms of how much to disclose to clients if they are not coming for the particular purpose of spiritual direction, but they want to know your belief system.

The easier way to get off the hook would be to say, "Well, it depends on the client." But I think it depends on the context in which the client is asking that. I think the question is a little different than, say, asking about your sexual orientation. I think there are certain things you have to understand. Sometimes I will discuss with clients that my concern about telling them my belief system is that it might affect what they feel comfortable talking about. You don’t want to make it so that some things are off limits.

Children will often ask, "Do you think there is God?" They will ask certain things. I think adult clients may ask this, as well, in terms of having just experienced a loss, or if they are struggling with life or existential issues.

I don’t think there is a general rule of thumb about whether you answer. You have to use your clinical expertise to determine what the effect might be in telling this, and then respond. Unfortunately, you usually have to make that decision in two seconds. But once you respond, then I think you, as a good practitioner, want to understand the impact of what you have said and see what the client then feels. If you chose not to respond, does the client feel shut out? Or, if you chose to respond, does that make the client feel like you won’t understand particular issues? So, if you are not advertising a particular belief system, I don’t think there is a rule, necessarily, if the client is inquiring about your beliefs.

I have had clients referred to me where somebody has told them that I know about that stuff -- religious and spiritual issues. The danger in that is that it sets me up, or it sets the clinician up, to have some expertise that they may not, in fact, have. I don’t have additional pastoral counseling or
religious training. I am the kind of general practitioner who practices it more implicitly, and it’s examined as part of a good history and then included in the treatment when it is at the client’s initiative, and when it seems appropriate. So, I think there is no good answer - or no single answer - on how much to disclose if you are not advertising it.

ALEXANDER: At what point would you say we are practicing outside of our level of training and competence?

NORTHCUT: I think if you are explicitly including it in treatment, meaning you are either advertising or including it at your initiative rather than the client’s, I would hope that there would be some additional training. This is my opinion, but knowing what schools around the country include, we are only training clinicians to include it as part of an understanding that this is part of every client - that it’s like taking a history and knowing the person’s religious and spiritual background, culture, as a way of understanding their difference and their world. We are not training students or clinicians to be skillful with different spiritual practices or religious beliefs. So I think when clinicians are explicitly including it at their own initiative, there should be additional training.

ALEXANDER: That is interesting.

NORTHCUT: Because I know that we are not preparing them to do that. There has been no monitoring [supervision] of what they are doing. And that’s the piece that concerns me - to what degree, then, are they accountable at all?

ALEXANDER: That is an excellent, excellent point. What about in supervision? If the therapist or student, let’s say, is a religious person and the supervisor is not, or vice versa, how do those issues get dealt with in supervision?

NORTHCUT: That’s a very good point. I had a similar situation come up where a supervisee’s client was anti-Semitic, and my supervisee was Jewish, and I am not. We talked about it in terms of my concerns that I couldn’t necessarily appreciate what it was like to sit with a client who was espousing very hateful ideas. So we talked about that piece of it first, in terms or our relationship, the supervisory relationship, and then we moved to looking at ways that this fit in with the client’s dynamics and so forth.

I think that to some degree you have to explore the differences of opinion or experience or beliefs between the supervisor and supervisee - whatever the belief system. I have also supervised students who are much more conservative than I am. I have talked about how we have different belief systems and that my job is to think about, to be mindful that usually, in this situation, the client does not know the belief system of the clinician. My responsibility is at all times the client’s mental health. So, I first talk about the issue between me and the supervisee and then secondly talk about the way it is or isn’t functioning in the client’s life, and then move to thinking about what that means in terms of the clinician’s role with the client.

I have found that you have to address it in some way in supervision so that, again, it doesn’t become something the supervisee -- there should be better language here -- but the people coming to you for supervision don’t start hiding what they say or what they are embarrassed about, or what they are secretly doing with clients and so forth. It has to be put on the table so it doesn’t go underground.

ALEXANDER: Boy, that is a good point in terms of hiding from the supervision what you are doing in your work.
NORTHCUT: Yes, and that's more of a danger, I think, in terms of a supervision relationship - the supervisee can't or is unable or is anxious about sharing with the supervisor what he/she is actually doing or feeling with the client. Then you are working at cross purposes.

ALEXANDER: Do you think a non-religious therapist can work in a religious agency?

NORTHCUT: Ah. That comes up a lot, particularly around the issue of abortion. One of the things that I ask students to do as they are graduating is to think about what they are agreeing to when they are signing these contracts - so that there is not a surprise when they go to work for a religious agency, for instance, and say, "Gee, now I am not comfortable with it."

While students generally don't place an agency setting high -- when I have them do a values hierarchy, you know, the agency always come low -- they do have to think about what they are agreeing to abide by. And they have to be comfortable living with how they resolve the ethical dilemmas they are going to be confronted with because if the clinician is not religious, and they are working for that kind of agency, there will be a point of conflict. They have to feel comfortable with and know that they are going to have to live with their actions one way or another.

I have seen it work in different ways. A lot has to do with the personality of the clinician. I know for myself at some point, I felt that I had to leave an agency where I was working because it felt unethical to me not to be able to talk - in this case it was teenagers - about safe sex and birth control, etc. Some might be able to do it, but I think at some point, many do leave because the accumulation of those points where they feel like their values are not being honored gets in the way.

ALEXANDER: Excellent. Anything else you would like to add before we close?

NORTHCUT: No, this topic is certainly one that has received a lot interest and attention in the last few years. The volume of material that is out there is duplicating rapidly, and I am glad to see that it's an issue being discussed.

ALEXANDER: Dr. Northcut, thank you so very much. It has been a pleasure to talk with you.

NORTHCUT: You are very welcome.


This concludes our interview with Dr. Terry Northcut. I hope you have enjoyed this interview and that you learned from it. I must say here that the opinions expressed by our speakers are theirs alone and do not necessarily reflect the opinions of *On Good Authority*.

© On Good Authority, Inc.
Used with permission.
Interviews edited for readability by On Good Authority and athealth.com
Part 2: Ethics Codes and Violations
Interview with Frederic Reamer, PhD

BARBARA ALEXANDER: Welcome. I'm Barbara Alexander. You are reading or listening to a series of interviews from On Good Authority’s program on ethics and spiritual issues in clinical practice.

In this interview, we are making a return visit to Frederic Reamer, PhD, whom we interviewed in our ethics program on confidentiality. Dr. Reamer is a professor in the graduate program of the School of Social Work, Rhode Island College. Dr. Reamer has conducted extensive research on professional ethics and has been involved in several national research projects sponsored by the Carnegie Corporation, among others. His thirteen books and articles on ethical issues include: Social Work Values, and Ethical Standards in Social Work, a Review of the NASW Code of Ethics. He is also the author of chapters on professional ethics in the Encyclopedia of Social Work and the Encyclopedia of Bio-Ethics. He has been a commentator on national public radio's, "All Things Considered."

ALEXANDER: Dr. Reamer, I was quite surprised to learn that an evaluation of a person’s spirituality is included in the ethics code for social workers, and I imagine it is in the other professional codes, too. Why did that happen, I wonder?

REAMER: Well, I think the increased attention to spirituality - and religion, as well - and, of course, those are somewhat different, but clearly related phenomena - is an outgrowth of our enhanced appreciation of diversity issues in general. In the Social Work Code of Ethics, there is a particular standard that we added in the 1977 Code - parenthetically, I chaired the commission that wrote that. When we prepared that Code, we talked about how important it will be to acknowledge ethical issues related to what we call "cultural and social diversity in general," and that includes race, ethnicity, religion, disabilities, and so on. So, I think it is an indication of the evolution in our understanding of ethical issues in the helping professions generally – in psychiatry, psychology, counseling, social work, and so forth. We are now seeing that codified in a variety of professions.

ALEXANDER: Have you seen ethical issues related to spirituality come before various adjudication committees?

REAMER: I have, in several different contexts - one is in my role as chair of an ethics adjudication committee in my state and in conversation with colleagues in comparable positions around the country. In addition, I have seen this in my role as what the courts call an "expert witness" in court cases where there are malpractice suits that have ethical implications embedded in them and where religion and spirituality may come to light. So in these different contexts - in addition to just informal inquiries that I have received about the role of religion and spirituality in mental health and social work and psychology and so forth. In all those different contexts, I have encountered a number of ethical issues pertaining to spirituality and religion.

ALEXANDER: Can you give us some examples?

REAMER: Sure. I have encountered instances where practitioners have wondered about the appropriateness of praying with a client, for example. It is one thing, of course, to pray with clients in a program that is clearly sponsored by religious auspices -- whether it is a Catholic order or a Buddhist retreat - where spirituality and religion are explicitly part of the program and presumably the participants understand that - as opposed to a case I was involved in, in a public psychiatric hospital, a state hospital, where a psychiatrist was praying with a patient in the hospital, and
another staff member happened to come upon them and raised issues about the appropriateness of the psychiatrist pulling out the Bible and sharing it with a patient who was being treated for some pretty severe mental illness. So, that is one example.

A second example involves practitioners who themselves are very religiously observant, which, of course, is fine and appropriate, and who have to make some decisions about how much to disclose to their clients with regard to their own religious and spiritual orientations. Is it appropriate, for example, for a very religious psychotherapist to wear a crucifix around his or her neck? Does that seem objectionable to anybody? Perhaps not. Well, then, what about a religiously observant Jewish therapist, a male, who wears a yarmulke, or a kippah, as it’s called, which clearly conveys his religious orientation? What about a therapist who discloses to clients his or her own extensive involvement in church or synagogue activities? What about that therapist who discovers that a client is worshiping at the same church or synagogue, and it may just be a coincidence, but how does one handle that? What happens when a therapist finds out that his or her client has signed up to participate in a subcommittee sponsored by the church or synagogue? How does one manage those boundaries, particularly when meetings may occur in the therapist’s own living room? Is it appropriate to have a client in one’s own living room, even though the context is different, and it’s a church or synagogue subcommittee meeting?

What about instances where a client invites the social worker, the counselor, the therapist, to attend a religiously sponsored life cycle event? For example, is it appropriate to go to a client’s christening, or the christening of the client’s infant? Or to attend a bar mitzvah of a client’s child? If one goes, how does one handle the documentation? Does one get the client a gift? In this culture, gifts are often appropriate in those instances. But what about when one is the therapist? What is the meaning behind giving a gift, and how is that perceived?

Is it appropriate for a therapist to display religious artifacts in his or her office, crucifixes on the wall, or books that are displayed that clearly indicate strong religious beliefs and observance?

What about in culturally unique communities, ethnically unique communities? For example, in Native American communities, when a client and a therapist are both members of that community, and there are very traditional ceremonies that the client wants the therapist to participate in, and they’re not part of traditional psychotherapy?

Last year, I was invited to give a talk in western Canada, in Alberta, and I spoke to a number of clinicians who have been invited by their clients to participate in, what they call, "aboriginal practices" - "aboriginal traditions," or also called "First Nation" traditions. This has become such an issue in western Canada – that is, the boundary issues involved in a clinician’s participation in some traditional ethnic rituals - that their licensing statute now has a provision in it specifically addressing this issue and authorizing social workers - in this instance they are social workers - to participate in aboriginal practices as long as the social worker has received some training with regard to that aboriginal practice and is recognized by the aboriginal community as somebody who is knowledgeable and can participate. So, that’s just a handful of many examples I have encountered over the years of ethical issues that can arise related to spirituality and religion.

I would like to add at this point that I think the major challenge for us is to try to distinguish between the appropriate integration of religion and spirituality with clinical work, on the one hand, - and I firmly believe there are appropriate ways to integrate the two - and on the other hand, the inappropriate introduction of religion and spirituality in clinical practice.

I have also encountered a number of instances where, in my opinion, a clinician has introduced religion and spirituality inappropriately and unethically. I can give you several examples of what I consider to be ethical misconduct related to religion and spirituality - recognizing that there are
many instances when religion and spirituality are introduced into clinical work that, in my opinion, are not unethical. But here are some examples of inappropriate use of religion and spirituality.

I was involved in a court case, not in my own state, in another state, where I was asked to testify about negligence that was allegedly committed by a psychiatrist at a psychiatric hospital who, according to the evidence, introduced issues of religion in his counseling with an inpatient at the psychiatric facility. In this instance, the patient apparently had complained to several staff members about this psychiatrist, and the allegation was that the psychiatrist was introducing religion in an inappropriate way that the patient found offensive. The claims were so bizarre that the staff viewed this as additional evidence of the patient's psychiatric illness -- that he would make these observations about the psychiatrist on staff.

Well, weeks later, one of the professionals at this psychiatric hospital was leaving the hospital at the end of the day and encountered this particular psychiatrist kneeling on one knee outside the front door of the hospital and apparently babbling away using terminology that no one could understand. It was "word salad," if you will.

To make this long story short, it turns out that the psychiatrist himself had been treated for his own bipolar disorder, apparently had gone off of his own medication, and was manifesting some pretty severe symptoms, some psychotic symptoms as well, and that, in fact, the psychiatrist had been introducing some very inappropriate and rather bizarre religious content in his work with this particular patient. The patient’s complaints were not evidence of the patient’s psychosis, but were, in fact, evidence of the inappropriate use of religion by this psychiatrist - apparently a function of the psychiatrist's own mental illness.

Now, this example, as opposed to the second case where the clinician’s use of religion did not seem to reflect mental illness as much as the therapist’s firm belief that it would be helpful to this particular patient to discover Christ and to learn the Bible, even though the patient was never asked whether he wanted to learn those things and discover Christ and so forth. In the particular case that I am thinking about, the clinician would regularly introduce biblical references in conversation with the client, would occasionally bring in religious artifacts and literature, would introduce passages from the Bible and read them during sessions. This, too, was in a public mental health facility, not a facility operating under religious auspices.

ALEXANDER: In both cases, were you called on as an expert witness?

REAMER: Yes. In a number of cases what happens is the patient or the client will file a negligence lawsuit, a malpractice suit, alleging that he or she was harmed by the clinician’s inappropriate conduct, boundary violations, and so forth. What often happens in these cases is that the plaintiff, the party bringing the suit, will claim that he or she suffered emotional injury and harm as a result of the clinician’s inappropriate introduction of religious content.

Typically, the lawsuit will not focus entirely on that issue - often, that will be one of a number of allegations regarding negligence, malpractice, boundary violations, dual relationships, and so forth. What happens is that the plaintiff’s lawyer will locate so-called "experts," to use the court’s term, people who are familiar with ethical standards in the helping professions, who are familiar with boundary issues, dual relationships, that sort of thing, and will ask them to testify as expert witnesses either in a deposition or in actual courtroom settings, or both. That has been my role in the cases that I have mentioned and also in other cases.

In fact, I am sitting here looking at a newspaper article from a Virginia paper, several years ago, and I will simply quote several passages from this. This is yet another case where a client sued the therapist alleging a variety of boundary violations. One of the violations included the following, and I
will just quote from the newspaper article. According to the article, the therapist "used hypnosis, past life regression, and what he called 'spirituality guides and masters' as treatment techniques." The lawsuit, which I have seen, and this newspaper article, both indicate that the therapist had very strong spiritual beliefs, shared those with the client, allegedly gave the client a new spiritual name that would be used during counseling, shared literature with the client, invited the client to accompany him on retreats to spiritual events, and that sort of thing. This is a good example of a lawsuit that alleges a whole range of boundary violations and ethical misconduct, a portion of which includes issues pertaining to religion and spirituality.

ALEXANDER: In the cases where you have testified, what exactly did you say?

REAMER: Typically, my role in these cases is to comment on ethical standards in my profession, which is social work, as they pertain to a number of key concepts that would arise in discussions about the alleged inappropriate use of religion and spirituality. So, I will often testify about the ethics of informed consent, the ethics of conflicts of interests, ethical issues pertaining to what we call "undue influence," that is, pressuring clients to participate in activities or conduct themselves in ways they might not otherwise if they were left to their own devices.

I will often testify about issues concerning paternalism. That’s the ethics term that refers to the tendency that some clinicians may have to try to use techniques or introduce clients to therapeutic approaches which, in the clinician’s judgment, the client "needs." "This would be good for the client," hence paternalism, even though the client may not be convinced of that and may not have consented to these various approaches.

Just to summarize, I am often asked to testify about the ethical standards relating to boundaries, dual relationships, conflicts of interests, undue influence, the use of deception or misrepresentation, informed consent, coercion, those sorts of things.

ALEXANDER: Well, I would like to go through those practically one by one and ask you what is the ethical stance and position to take.

REAMER: I think it is fair to say that in all of the helping professions that are clinically oriented - psychiatry, psychology, social work, counseling, pastoral counseling, and so on - that we now fully embrace the ethics concept and principle of the "client’s right to self determination." That sounds rather hackneyed and trite, perhaps, but I think we take this very seriously. We believe that clients ought to be informed about the interventions that practitioners are using; they ought to understand the possible benefits and risks; they ought to have the opportunity to ask questions about these approaches and to refuse them if they so wish; they ought to be competent when they consent to these approaches and interventions. This is widely accepted, and we recognize that there may be some extreme circumstances when we have to override a client’s right to self determination - for example, when clients are suicidal, or they have harmed a child or plan to harm someone else - that sort of thing. But generally speaking, the presumption is that we should embrace the client’s right to self determination.

My concern is that there are some clinicians -- and I think this is a distinct minority - who, in some instances, feel so strongly about spirituality and religion -- it is such a part of the fabric of their lives -- that they believe that clients would benefit from sharing in their belief system, their observances, and so forth. As a result, they may violate the client’s right to self determination and the client’s right to give informed consent by introducing their beliefs and observances - sometimes in a manipulative way, sometimes in a sincere way, but ultimately in a way that is coercive and violates the client’s rights - in the name of religion and spirituality.
The major codes of ethics in the helping professions now have explicit standards regarding clients’ right to self determination, informed consent, that sort of thing. I think it is critically important for therapists and clinicians to take those standards seriously and to ensure that the ways in which they introduce spirituality and religion is consistent with prevailing ethical standards.

I do think there is a way to do that. Let me give a few examples. I think there are a number of residential programs, a number of out-patient programs, that have clear religious or spiritual affiliations. They are sponsored by churches; they are sponsored by synagogues; they are sponsored by some group that has an explicitly spiritual or religious mission. Their publicity makes that clear - that is, everything from their yellow page ads to their brochures, the signs on their offices, so that any client or prospective client walking through the door presumably would understand that in this particular setting, the staff, is going to introduce issues relating to religion and spirituality.

Personally, I don’t have a problem with that approach. As long as the staff and the programs are very clear about who they are and what they do, competent clients and prospective clients have the right to decide whether this is for them or not. I would be troubled if an agency uses any form of deception or misrepresentation -- of course, I don’t like bait and switch as we say -- where people are enticed to come through the front door under one set of assumptions and then discover that the program is really something quite different. There are some notorious examples of that kind of bait and switch. But I think, generally speaking, agencies that have clear religious and spiritual affiliations and auspices handle their approach quite ethically. I am not troubled by that.

I know of some programs that are organized, to some extent, around Twelve-Step approaches, that are sponsored by churches and religious groups. They may incorporate prayer and discussion of religion in their treatment, and that’s okay with me as long as it is consistent with prevailing ethical standards. But, then let’s move away from the programs that are explicitly affiliated with religious and spiritual communities and organizations and talk about settings where that is not an explicit part of the mission. Take, for example, a therapist who is in a community mental health center sponsored by the local county or a non-profit group, and that particular therapist happens to be very observant religiously, spirituality in his or her own work. The question arises: Is it appropriate for that clinician to introduce prayer or topics of religion or spirituality during the course of counseling? I would find that rather troubling if, in this public setting that is not clearly affiliated with religion and spirituality, someone were to introduce those issues without the client’s request. That seems to me to be introducing one’s own personal issues into that clinical relationship in a way that is not appropriate.

ALEXANDER: In my therapy practice, I have tended to use examples or metaphors or quotations -- I hope they haven’t been cliché-like -- but quotations from Shakespeare or great poets, or from the Bible. Now, sometimes I do not remember whether the quote is from the Bible or Shakespeare; it’s bound to be one of the two. So, is something like that unethical?

REAMER: It does not strike me as unethical. I can imagine, for example, working with a client where the client is talking about his or her anger in his or her relationship with a neighbor or someone at work or a family member, so the clinical work focuses on how to handle anger, and the client has fantasies of revenge, and the therapist makes some casual reference to, “Gosh, you know, this sounds an awful lot like, oh, what does it say in Deuteronomy about an eye for an eye.” That kind of casual reference - well, that doesn’t trouble me, and, in fact, it might even be helpful, it seems to me, for a client to think about his or her wish for revenge in that context.

I think it is quite another thing if the therapist then begins to talk about Christ’s teachings, or what the Torah has to say, or what the Code of Hammurabi has to say, or any such document, as a way to try to shape the client’s thinking. But, the casual reference to an image or a metaphor that is
biblically related or related to the Torah or Koran, or what have you, I don't find that particularly troubling. When it begins to move in the direction of what, in the ethics trade, we call, "undue influence," or "coercion," subtle or otherwise, that is what I find troubling.

ALEXANDER: Let me go through some other questions that listeners submitted to me when I was planning this program. I sent an email to all the people on my list asking if they had any questions for the ethics part of this program, and people did send in a lot of questions. Some of these questions are self-disclosure related. For instance, one person asks, "How do we respond when people call us and ask our religion or if we are Christian counselors?" How are we to answer that, or are we to answer that?

REAMER: Well, I think it depends upon where one works. For example, if one works in a program that clearly markets itself as a Christian counseling agency, it seems to me just fine to be very clear about one's religious affiliation. You know, if a client says, "What do you exactly mean by Christian?" I have no objection to someone spelling that out because it is clear that's the mission of that particular agency, and then the perspective client can decide whether that's a good fit or a bad fit.

On the other hand, if someone makes that call to a counselor or a psychologist or a social worker at a publicly sponsored community mental health agency and starts out by asking, among other things, "By the way, what is your religion? What is your religious affiliation?" I would not respond to that with self-disclosure at that point. At some later date, I might, if I think it is clinically appropriate and relevant, but at that point I would probably respond by asking the perspective client what he or she is concerned about, if anything -- "Why do you ask?" I would pursue the meta-question, if you will: "What is it that leads you to bring this up, and let's talk about that, and I will make a judgment as to whether information about my own personal life is or is not relevant or helpful here, and I will explain my thinking."

To me, it's very much like a client who asks at the front end of a relationship, "By the way, are you in recovery? Have you ever tried cocaine or alcohol?" I think there are some treatment settings where a candid response to that question is considered quite appropriate and not at all unusual. For example, in a residential treatment program for drug and alcohol problems staff are always asked, or often asked, whether they are in recovery. The norm in that context may be, "Well, it's okay to answer that question."

 Whereas, the exact same question across the street in a private psychotherapist's office might be viewed very differently because the norms are different where it's appropriate to talk about why the client is asking the question, and I know that there are some clinicians who do feel comfortable talking about the fact that they are in recovery. They will acknowledge that if they think it is clinically relevant, and I know others who will respond by saying, "Well, my approach is that I don't think it's very helpful for me to talk about my own issues, and we can talk about that -- whether you find that frustrating or not -- but let me explain why I am not comfortable answering your question." So I think the norms, the expectations, the responses differ dramatically depending upon context, setting, sponsorship, auspices - however you want to view it.

ALEXANDER: A reverse of that particular issue is this. Another listener asks, "In clinical situations where it is good practice to explore spirituality with the client, is it then bad practice not to do so?"

REAMER: Well, that's an interesting question. Is it bad practice not to explore it? I think if one takes a look at the evolution of standards in the helping professions regarding assessments, that is, conducting a comprehensive bio-psycho social assessment, one sees an interesting trend. That is, over the years, we have learned that in addition to getting the usual background information on individual mental health and family and work history and relationship history and so forth, it is
important to ask about spirituality, not necessarily because one is going to incorporate that explicitly and aggressively in one’s treatment, but I think we have come to the realization -- it’s taken some time but we are getting there -- that it’s important for us to be familiar with all important aspects of a client’s life.

For many people - not all - religion and spirituality are important relevant elements of their lives, and I think it would not be appropriate for a clinician to be unaware of that, or to put it differently, I think there is not only a clinical, but an ethical obligation to understand the relevance of religion and spirituality in a client’s life.

In fact, in the Social Work Code of Ethics, we have the following sentence, "Social workers should understand culture and its function in human behavior in society recognizing the strengths that exists in all cultures" and that is followed by, "Social workers should have a knowledge base of their clients’ cultures and be able to demonstrate competence in the provision of services that are sensitive to clients’ cultures and to differences among people in cultural groups."

We have an ethical duty to insure that we grasp the relevance not only of ethnicity but also of religion and spirituality in clients’ lives. But that’s not to say, in my opinion, that we necessarily convert that information into intensive, aggressive pursuit of issues related to religion and spirituality in treatment. It seems to me that the skillful and ethical practitioner is someone who gathers that information and then uses it judiciously and ethically when it is appropriate.

For a client who is deeply religious, it may be very helpful clinically to make periodic references to issues of spirituality and religion. That’s one way to connect with that client and to help that client work through issues in his or her life.

With a client who says, "You know, I was raised in a deeply religious, observant household, and I have rejected all of that for a variety of reasons, and I find organized religion offensive." Well then, it seems to me that a therapist who periodically introduces references to organized religion is not serving that client well and may very well be harming that client.

Ultimately it boils down not only to clinical judgment but also to ethical judgment, and a lot of that has to do with the issues I mentioned earlier concerning boundaries and dual relationships, and undue influence. And, then, another term which many listeners are familiar with I suspect is "use of self" - to be cognitive constantly of the reasons why one is introducing issues of religion and spirituality. For the therapist and clinician to always ask her or himself, "Why did I bring that up? Am I addressing some of my own issues, and am I introducing some of my needs and concerns? Am I imposing my framework onto the client?" This is a familiar concept, of course. This is not very complicated, but I think we are less used to thinking about this with regard to spirituality, and I think we are at a point in our development as helping professions where we are becoming more aware of these issues.

ALEXANDER: In the situations where you have a client who is very religious or very spiritual, and it’s something that you know nothing about, does the code/ethical standard suggest that you should refer that person to somebody else who is?

REAMER: This is an interesting question. I guess my position is, if a client is very observant, very religious, this is an extremely important part of the client’s life, and the therapist knows nothing about that particular religion and is maybe someone who is quite secular in his or her orientation - that ethnically, not only clinically, but ethnically, that practitioner should discuss the issue with the client and say in a very diplomatic and candid way, "Well, let me tell you a little about my approach, and let me tell you that if you are looking for someone who shares your religious beliefs, who lives the kind of religious life that you do, I may not be the right therapist for you, and I’d be happy to try
to find someone who is" and let the client decide whether this is a good fit or a bad fit. And, of course, the clinician should use her or his own judgment as well.

On the other hand, I can imagine situations where religion and spirituality are important to the client, where the client feels very comfortable with this particular clinician, where the clinician has explained very forthrightly to the client that he or she doesn’t know a great deal about what it is like to be Buddhist or an Orthodox Jew or a member of the Muslim faith or what have you, and that the clinician is actually quite willing to learn more about that if the client thinks that would be helpful to the treatment. I can imagine situations where a client might bring in a book or a chapter or something like that, and it’s actually done in the context of the treatment, where the clinician spends some time learning about the client’s background so that the clinician can be as helpful as possible in the treatment.

I think it gets a little tricky. One doesn’t want then to have a study sessions with the client, because I think the boundaries can become blurred and all of that, but I know of many instances where clients have shared some kind of substantive, relevant information about their lives with their clinician - not just religion and spirituality. It could be other things - some medical condition they have that the clinician may not be very familiar with, or ethnic heritage, or who knows what. I think the chronic challenge is maintaining proper boundaries and incorporating that information in a way that doesn’t blur the boundaries - that makes it very clear that this is for clinical purposes, as opposed to merging the personal and spiritual lives of the clinician and the client.

I think one could argue that there is an ethical obligation to learn about the client’s religion and spirituality. Again, within limits, but that’s the implication of the ethics standard in Social Work Code of Ethics having to do with "Social workers having a knowledge base of their clients’ cultures." I’m paraphrasing now - they have to demonstrate their ability to be competent in the provision of services to people with different backgrounds. They have an ethical duty to learn about the client’s religion and spirituality.

ALEXANDER: Here’s another question. What if a patient asks you to pray with him or her?

REAMER: Yes, I find this one very challenging. Let’s say this is not a program that operates under religious auspices where praying might be considered quite appropriate and acceptable.

Let’s say it is in a public social service setting of some sort. I would be very reluctant, I think -- and I am speaking for myself -- I would be very reluctant to pray with a client. I am not saying it is inherently unethical. I think reasonable people can disagree about that. Here is what I would be concerned about. I would be concerned about possible confusion on the client’s part with regard to the nature of his or her relationship with me. What does it mean that we just prayed together? Is our relationship changing? Is this not the traditional therapist/client relationship? Is it evolving into something else? It may not be from my point of view, but it may be from the client’s point of view. It is hard for me to know that in every instance.

A second problem. In the ethics trade we often make a distinction between acts of impropriety and acts that involve the appearance of impropriety. I can imagine a good-hearted, altruistic, benevolent clinician who decides - "You know what? I am not particularly religious, but if it helps my client, I will pray with my client." I can imagine that. I can imagine that colleagues would either witness that or would hear about that through the grapevine, and the perception would be that the therapist was involved in an inappropriate dual relationship with the client that had these religious or spiritual elements, and I believe that perception counts for an awful lot in the ethics business. You may have instances where there is no concrete evidence of impropriety but where there is an "appearance" of impropriety. I think we have to be very, very cautious about taking risks like that.
Now, is that to say that I would never accept a client's invitation to say a prayer with the client - a brief prayer? I can imagine that I might do that. It is hard for me to be completely categorical about these things, but I must say that my instinct is that it makes me nervous.

I will tell you one thing I would do from a risk management perspective. If, in fact, I decided, spur of the moment, that with this particular client, saying a brief prayer might be therapeutically helpful - maybe even critically important given this client's approach to life - if that was my clinical judgment, what I would be very clear to do is to document in my case notes that the client invited me to say a prayer with him or her, and I did so for the following reason, and I would spell it out.

Now that might strike some people as rather excessive, but I am basing this on my considerable experience in court cases around the country where there have been allegations of inappropriate dual relationships where, for example, a therapist says, "I wasn't introducing religion or any such thing in our relationship. The client asked me to pray with her, and it was my clinical judgment to do that," but the case notes don't say a word about that. It's not in the notes, which, of course, could be construed as evidence that it wasn't clinical judgment, because had it been clinical judgment, that would have been reflected in the record. Now, it could be that it was clinical judgment, and the clinician just didn't think to document it. But that omission can be used against the clinician. I have seen it done.

While reasonable people can disagree about whether it's ever appropriate to pray with a client and how much and under what circumstances - that's a reasonable discussion and a reasonable debate - I would argue that if one ever decides to cross that line and engage in any kind of religiously relevant or spiritually relevant activity with a client for clinical purposes, that ought to be reflected in the case notes - in the chart - in the record so that if questions are ever raised, it's clear that this was part of one's professional judgment.

ALEXANDER: Dr. Reamer, because Christian counseling is kind of hot right now, there are practitioners who are Christian of whatever denomination and who decide to promote themselves as being Christian counselors, and I wondered about the ethics of that.

REAMER: One can think about this in a broader context, and that is, is it appropriate for clinicians to market themselves as having expertise that they don't have? - whether it has to do with eating disorders or hypnosis or bio-feed back or treatment of depression, or addressing issues related to religion? I think it is fair to say that it's inherently unethical for any practitioner to convey the impression that she or he has expertise that she or he does not have.

Now then you get into the question, "Well, what constitutes expertise?" If I market myself as somebody who is competent to treat eating disorders, it seems to me I'd better be able to demonstrate that I have had training in the treatment of eating disorders; I have had supervision in the development of my skills; I have read literature; I have gone to continuing education workshops. If I haven't done those things, and I get sued because of something I allegedly did related to my treatment of a client's eating disorder, I think I would be in very hot water.

Similarly, if I claim to have expertise related to the relationship between religion and clinical issues - I am a Christian counselor, or a Buddhist counselor, or whatever kind of counselor -- I think, that by way of analogy, I need to be able to demonstrate that this is an area I specialize in by virtue of continuing education I have gotten, literature that I have read, workshops that I have gone to, supervision I have received - that it's far more than "I have picked up a couple of books and read them" or "I've picked up a couple of magazines articles," or "I am a Christian person, or an orthodox Jewish person, or what have you, and that qualifies me as someone who really understands the connection between religion and clinical work."
While that knowledge from one’s own personal life can be very valuable - I wouldn’t discount that - but as a professional we have an additional responsibility, and that is to learn about, think about, and get training about how one integrates religion and clinical work. I don’t think one just gets that by living the life of a religious person. I don’t mean to demean the relevance of a religious life if that’s what people chose to do, but I don’t think that automatically qualifies one as having specialized expertise in helping clients explore their relationship between religion and spiritually, on the one hand, and their clinical issues on the other. So, to answer your question, if people chose to market themselves as having that expertise, it seems to me that the burden is on them to demonstrate that they engaged in activities which qualify them as having that expertise - that this not just self-proclaimed.

ALEXANDER: You know twenty to thirty years ago, one did not need to demonstrate all the expertise in all these particulars. You sort of thought, "Well, I am trained in understanding the meaning of these things. It doesn’t matter what the symptom is, or what the cause is, or what the presenting issue is. My training is to understand the meaning of these things," and it seems now that it is much more particular rather universal, isn’t it?

REAMER: Well, I think it is. We don’t want to institutionalize every aspect of knowledge, and it is impossible for any clinician to know everything there is to know about all the phenomena that walk through the front door, but I think it is fair to say that the ethical standards have become much more sophisticated. The expectations have increased. We have set the bar much higher.

So, for example, in the Social Work Code of Ethics, we have a few standards which clearly convey the message that social workers who claim to have expertise with regard to a particular phenomenon - in this case religion, but it could be anything else - need to know that they will be held to some pretty strict standards, one of which is, "Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience."

The very fact that that standard is in the Social Work Code of Ethics creates an expectation that not only ethics committees would use if a complaint is filed against the practitioner, but courts of law tend to use this as evidence of standards in the profession.

If someone says, "Well, I know something about religion because I grew up in fairly observant family, and I want to market myself as somebody who has this expertise," I would respond by saying - if this was a social worker, for example - that it is important to learn about this phenomenon of the relationship between religion and clinical work. One ought to read the literature and get some training, that kind of thing, because we have an ethical standard that says, "Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them" - and let me add parenthetically, this might be a new venture for this particular practitioner - "only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques." That is, if one’s moving into a new intervention or approach, marketing one’s self as having expertise in an area in which he or she hasn’t practiced before is carving out new territory. I think it’s very wise and prudent to be aware of the pertinent ethical standards, whether it is in the Social Work Code of Ethics or psychology or nursing or whatever it happens to be.

ALEXANDER: Dr. Reamer, thank you so much for all this information.

REAMER: Well, it is my pleasure. It is a complicated area. I think it is much more complicated than we appreciated years ago, but this is yet another indicator of the enhanced understanding we have of the complex ethical issues that clinicians encounter. The issues themselves are not necessarily
new, but I think our understanding is far deeper and wider than it once was, and I think that is what we are experiencing with regard to this topic of religion and spirituality.

ALEXANDER: Thank you very, very much.

Dr. Frederic Reamer's books are available through amazon.com and through the National Association of Social Workers Press.

This concludes our interview with Dr. Frederic Reamer. I hope you have enjoyed this interview and that you learned from it. I must say here that the opinions expressed by our speakers are theirs alone and do not necessarily reflect the opinions of On Good Authority.

© On Good Authority, Inc.
Used with permission.
Interviews edited for readability by On Good Authority and athealth.com

Part 3: Spiritually Sensitive Practice
Interview with Ed Canda, PhD

BARBARA ALEXANDER: Welcome. I'm Barbara Alexander. You are reading or listening to a series of interviews from On Good Authority's program on ethics and spiritual issues in clinical practice. As I indicated before, there are basically two types of ethical theories - rule or principle ethics and virtue ethics. The most obvious example of rule ethics for clinicians is the code of ethics of his/her particular profession. Every mental health profession has its own code. The areas covered include informed consent, level of competence, confidentiality, dual relationships, etc.

Virtue ethics emphasizes character and virtue. This theory defines certain traits of character which are universally understood to make one a morally good person.

According to Dr. Len Sperry in his outstanding book, Spirituality in Clinical Practice, the question in virtue ethics is not, "Is this action moral?" but rather, "What kind of person am I becoming?" He states, "According to virtue ethics, moral virtues are states of character concerned with controlling and directing not only one's thoughts and rational processes, but also one's emotions and feelings. The repeated performance of virtuous actions leads to the acquisition of virtue. The morally virtuous person aims at morally good ends rather than being clever and goal oriented."

What is a virtuous therapist? According to Dr. Sperry, a virtuous therapist is a professional of good moral character whose actions reflect both the practice of virtue and an ability to incorporate professional standards in daily practice. For example, a morally virtuous therapist would seek to be honest with his or her clients, not because this honesty would attract clients, but because honesty itself is valued by the therapist.

In the following interview, Dr. Edward Canda will discuss "virtue ethics." Dr. Canda is Professor and Chair of the PhD program at the University of Kansas, School of Social Welfare. Founder of the Society for Spirituality in Social Work, he has written widely on this topic and is co-author of Spiritual Diversity in Social Work Practice: The Heart of Helping. This book integrates existentialist, transpersonal and holistic systems theories with Buddhist, Christian, Hindu, Islamic, Judaic, and shamanistic traditions of helping, plus ethical guidelines and practical skills and techniques. While Dr. Canda's work is directed toward social workers, the principles are universal for all mental health professionals.
ALEXANDER: Dr. Canda, it’s your belief that spirituality is woven into all aspects of life, including, of course, the helping professions.

CANDA: Well, actually that is a good observation because I think that the work on professional ethics that clarifies principles and gives guidance for ranking and decision-making is very important. However, I often find that the principles are not explicit about the genesis of the principle. Where does it come from? Why should we even have those ethical principles aside from the fact that a professional organization like NASW says we should?

ALEXANDER: I think your main point really is that ethics begin with us personally. How did you come to that?

CANDA: One way that I have come to it is through my own personal journey. The other is through my professional study and work, and the two intersect, of course.

For myself, I became interested in spirituality very early because of my up-bringing in a very devout and sincere Catholic family. In that context my family’s spiritual culture, you might say, emphasized that spirituality is woven into all aspects of life and includes a tradition of self-reflection - like examination of conscience in the Catholic tradition, that even children learn. So, since childhood, my perspective has connected with many different spiritual traditions. Those included even early childhood experiences and training about the importance of looking at such questions as: Who am I? What is my purpose in life? How should I relate with the world? What is my vocation? Those very deep questions led me to an awareness of how we need to start with our personal and family and communal experience and spiritual growth, and then apply that to what we are doing in our social roles and in our professional lives. So, my professional work on spiritual diversity in social work has always come back to that primary starting point: Why do I feel called to do this? How could it be of service to others? What does that mean in the larger context of my sense of life purpose?

Actually, I think that is true for many people in some way - whatever their spiritual background. We often see this in applications to our social work masters program, when people describe why they want to go into the field, or why they want to continue at the masters level, that there was some kind of important pivotal life experience that heightened their senses as to what their lives should be about and why they should take on a path of service. For many people, it’s a sense of vocation, a calling. It’s not simply a role to take on to get a paycheck, but a desire to contribute to service and justice for others that relates back to something in their own experience. To me, it is important to have a clear cycling between your own personal journey and growth and what you are doing in your professional work.

ALEXANDER: What about the divisions between church and state -- the idea that there is a boundary in our work between the secular and the sacred that shouldn't be crossed? Is there anything much about this in the literature?

CANDA: Within this literature there are very few negative counter-positions about it, which is kind of interesting. I think I have encountered skepticism and concerns about it more widely as I talk with people and present at conferences. But, in terms of the literature, the main thing has been, until the last fifteen years or so, a lack of discussion, at all, about it. So, when it comes to really talking about - Is it appropriate? - most of the literature has been on the positive side - but expressing how it can be appropriate.

The concerns raised around, let’s say, distinct roles between religiously based helpers or theological approaches and professional social work -- those have tended to form a kind of dichotomy as though religion and religious practice is distinct from social work - and that they are
competing and even conflicting values and interests. Sometimes that can be the case, but it is not necessarily the case, and more often than not, social workers in their personal lives affiliate with some kind of religious tradition, and they are finding ways to connect and make complimentary their own personal religious commitments in their professional work.

In the larger society, of course, many social work and mental health and other human services are provided under religious agency auspices. In most cases, that's done without any violation of issues like separation of church and state, and that kind of partnership has been going on for at least one hundred years. The other problem with that assumption is viewing spirituality as only a matter of religious or sectarian belief and practice. The way that I define spirituality - it's a broader and more universal concept - so that spirituality has to do with the human search for a sense of meaning and purpose and morally fulfilling relationships with themselves, other people, the world, and the ground of being, however they understand that. So, even if someone is not involved in a religious affiliation, everybody has some kind of spiritual perspective, spiritual orientation to life.

And, social work as a profession, itself, has been strongly influenced in its formation by religious traditions, especially of Christianity and Judaism, and over time, even though it's secularized, it has continued in its values and ethics to incorporate implicitly many of the deeper moral commitments coming from those religious roots. So, many social workers come from a religious perspective, and whether they do or they don't, they're all trying to work out some way of connecting their spiritual orientation to what they do as social workers.

So, for me, it's not even a sensible question - Can we separate or should we separate spirituality and social work, or mental health practice, or clinical practice? It's an impossibility. We can pretend to separate it. People can try to bifurcate themselves, split themselves into their personal lives and their professional work, but, to me, there is a danger in doing that. They dehumanize themselves. In other words, if they split themselves up, they cannot relate to the helping process as a complete human being. They may relate to it in terms of a role function. But, the fullness of their humanity has been reduced.

So, for me, the question is - How can people work out complementarity, integration, and appropriate connection between the personal and the professional dimensions? And, that's one way that ethics is particularly important because ethics gives guidelines for how to connect one's personal commitments with the commitments of the profession.

ALEXANDER: You speak in your book about "spiritually sensitive practice," could you define that and talk about that for us?

CANDA: Spiritually sensitive practice means that the helping professional relates with the client as whole person to whole person. By the way, when I say client, I don't necessarily mean individual. It could be a family, a community, etc., but for the sake of simplicity, I will just refer to the singular.

It is similar to Martin Buber's idea of the "I-thou relationship." Buber was a Jewish existential theologian. He talked about the importance of relating as subject to subject, I to thou, a full person to full person, and this reflects a sense of what we more commonly in social work refer to as "unconditional positive regard" – a genuine caring and concern and respect for both oneself and the client without limitation to conditions. For Buber and for many people, that kind of relationship is a reflection of a relationship between the human being and the divine. That is, a relationship of unconditional acceptance and love. But, even for people who don't have that kind of belief system, the commitment to uphold the dignity and worth of the person and the relationship has to be primary.
In a sense, a spiritually sensitive practice is an expression and a fulfillment of basic social work principles and ethics about starting where the client is, respecting the person, unconditional positive regard, recognizing the inherent dignity and worth of people. So, that’s the moral foundation of it.

But then, more practically, spiritually sensitive practice means that we need to have a commitment to develop the appropriate knowledge and skills and comfort to relate with people of diverse religious and nonreligious backgrounds in a way that is respectful and competent.

**ALEXANDER**: In your book you say, "Realistically, people do not accord a professional standardized code of ethics authority over their moral and ethical decisions unless it is incorporated into the personal code."

**CANDA**: Right. I think the starting point for an ethical approach to spirituality in social work is being clearly grounded in the deepest truth of who we are, and out of that arises a natural morality of compassion and justice. But then, that has to be translated into more practical terms for action, for behavior as a professional, and so the code of ethics helps to make that translation. So, at that point where we are trying to connect our personal commitments around morality and values and ethics with the professional context, students, particularly in the educational process, are often struggling with that because they come into this professional socialization, being exposed to a code of ethics and a professional world view and standards that may or may not fit well and closely with the kind of personal framework they came into the educational process with.

So there needs to be a kind of interaction, a dialectic and dialogue between those two, even within the educational process -- between the personal and the professional there. Also, within the practice setting, as the students are in practicum or field placements and ongoing professional work, supervision and peer interaction around value and ethical concerns, I think it is really important to continue that dialogue and growth.

Actually, for me, the code of ethics that social workers adhere to is itself a very profound spiritual framework, starting with the basic principles of promoting respect and dignity and well being and justice for everyone - down to very more practical issues about our commitments to support the interests of clients and society and the agency and the profession, etc.

What the code of ethics does, I think, for many people is stretch and challenge the personal ethical framework they may have developed up to the point of coming into the profession, especially because the profession is so committed to providing respectful competent service to all people.

When it comes down to the actual experience of working with people and helping people across differences - that will stretch anybody. Even if somebody already espouses those values, it’s always stretching to be engaged in that because it’s a lifelong process to reflect on our personal, cultural, spiritual limitations and grow and expand in order to connect with and accommodate people in situations that are different from that.

So, I find that kind of interaction between the personal and the professional values to be very stimulative of the spiritual growth of the helping professional, and in some ways, reflection on professional ethics can serve as a catalyst to deeper moral reflection in the personal life of the helping professional, as well.

**ALEXANDER**: You also speak about people doing a spiritual autobiography as a way of, I suppose, getting started on this.

**CANDA**: Yes. Right.
ALEXANDER: What would be included in that?

CANDA: In a spiritual autobiography it’s helpful to reflect on, you might say, the storyline of one’s personal spiritual journey from earliest memories to the present and then to reflect on future hopes and ideals. It might be helpful to think of it like writing a novel with yourself as the main character and reflecting over your life story as a kind of narrative or novel, and think about who the main characters are. In other words, particularly, who are important teachers, exemplars, mentors, spiritual helpers, wise figures, in one’s life at different points that helped through different phases of the life cycle or at different important turning points in life where there was some challenged faced and how that was dealt with. To think about who these key figures are who played a role in helping to cultivate one’s sense of compassion and wisdom and problem solving in creative growth.

It’s also helpful to think about what are important spiritually based practices, if any, that have been important at different times in life, such as prayer or reading scriptures or important religious text or meditation or communal rituals and ceremonies or retreats or walking in the woods or music or whatever it might be for a person.

So it’s kind of like looking at the storyline, looking at important turning points, decisions made, helpers, resources that were there to support the process, and over the course of doing that, you will see certain themes in your life that may have changed and some that came to the fore and dwindled or some that continued throughout. By writing a kind of a story of your life that way and then by reflecting about what key values and ethical issues that may have come up at those different phases and turning points, it will give a clearer picture about who you are and where you have come from and how that relates to the value and ethical frame that you have now. Then, that will make it maybe easier to have some insight into why you react to the professional ethical code the way you do.

Actually, one of the things about spiritually sensitive practice that’s important is self-reflectivity. I like to use this analogy that - let’s say that it is relating to the code of ethics, or certain value positions of the profession, that a person might have difficulty with - maybe it conflicts with something in their religious upbringing. Sometimes people just look at whatever is bringing up this challenge as something outside of themselves - as an external thing that’s challenging them or causing some tension, and they might try to distance themselves from it or hide from it. That’s not really going to be a good way to grow around it. But if you look at your reaction to it - as you not only look at whatever the challenge, say the ethical challenge is, but you also look at where your own response comes from internally, it’s a kind of self reflection – like looking into your reaction as though looking into a mirror. You realize that your reaction is telling as much about you as it is about whatever that external challenge is.

ALEXANDER: This brings me to the point in your book about ethical considerations for using spiritually based activities.

CANDA: Yes.

ALEXANDER: How do we determine when activities are appropriate or not? Not so much clinical, but ethical.

CANDA: Yes. Let me start with a little bit of background. As you know from the book, we report findings from a national survey of NASW clinical practitioner members. Lee Furman was the lead on that study, and we found several points that relate to this issue that were pretty interesting to us, and I think important. One was that most social workers reported that they did encounter religious
and non-religious spiritually oriented issues with clients. And secondly, that most social workers employ some types of spiritually focused helping activities in their work; but third, most reported that they had very little or no training or preparation for how to do that. And, along those lines, that meant that they also didn’t have any specific preparation around ethical decision-making around doing that.

[A summary of the NASW survey results is attached.]

Further, most indicated concern that social workers may not have sufficient competency to be doing that, which itself is another major ethical issue. The NASW Code of Ethics stipulates competency as a prerequisite for engaging in any particular activity. So, that raises some concerns. Most social workers, at least as indicated by our survey, encounter spiritual issues with clients, incorporate some kind spiritually oriented practices, but don’t have sufficient training for how to do that.

But, in addition to that, [the survey] had some open ended questions that allowed people to write in additional comments. A lot of that had to do with ethical decision-making about how to, or when to, address spirituality in practice. We found that the vast majority of those comments suggested that respondents were taking into account broad ethical principles, such as client self-determination, so they were looking at things like the client’s readiness, expression of interest. They were concerned about not imposing or proselytizing religious values, and they wanted to respect client diversity. So all of those were positive indications about some kind of ethical reflection, but none of the respondents indicated that they had any preparation to help them with systematic ethical reflection on this.

The guidelines that we present in the book, as far as I know up to this point, are the only ones that lay out in a systematic, concise manner, some ethical decision-making guidelines focused specifically on spirituality. And, what I try to do in those -- maybe I should mention, by the way, that I adapted those from a much earlier article that focused on the issue of using prayer in social work practice, and I chose that at the time because the topic of praying for or with clients I often found was especially a hot button issue for many people - that it was very controversial. So, I thought it would be a good starting point to think about when, or how, or if, it might be appropriate. The guidelines that we presented in the book describe ethical guidelines more broadly for spiritual focused helping activities.

First of all, we say that a spiritually sensitive relationship is a prerequisite for dealing with spirituality and for applying spiritually based practices with clients in anything more than just a very cursory information gathering way. In other words, the relationship needs to reflect that sense of respect and skill and knowledge relating to the client’s own spiritual perspective before one should proceed very far with it. In order to do that, a starting point, I think, needs to be some type of basic identification of interest on the part of the client. So a very simple initial assessment, I think, is important in most situations that would involve some kind of in-depth interaction with the client.

Let say, though, that it is something more extensive and direct that the client wants. For example, the client says, "In the course of meditation, sometimes I have these experiences of really strong energy rushes going through my body that are very startling, and even though that’s not the purpose of my meditation, it’s happening spontaneously, and I am finding it becoming disruptive, and I am a little scared by it, and I am wondering what is going on." That’s a much more detailed and direct issue that even involves some tension and worry for the client. The social worker might be able to engage in some further discussion about that, still without special knowledge, to see if that would be sufficient with the client to sort out what is going on and maybe the client simply decides, "What I need to do is talk with my meditation teacher about it."
But, if the social worker were to be presumptuous and to give advice about that, like, "Well, why don't you try to doing the meditation this way," or "Don't worry about that." Or, on the other hand, what some mental health professionals do, unfortunately, with insufficient knowledge, is mis-assess or mis-diagnose symptoms described like that as signs of psychopathology and give inappropriate DSM labels that can become very damaging. So, in those cases the social worker especially has to be more careful to recognize the limitations of their knowledge and skill and through referral and collaboration be able to work with that more appropriately.

I think that is the other side of the concern. One side of concern is whether the client may engage in something that could be harmful if the social worker is not careful. But the other side is that the social worker may harm the client if the social worker is not careful. Sometimes clients report spiritual crises or emergencies that superficially have similar characteristics to some types of psychopathology, and then, if those are treated as psychopathology with, let's say, psychopharmacology and forms of counseling that attempt to restrict or limit some spiritual activities of the client - that can be very dangerous.

My meaning isn’t that practitioners need to know everything about everything; that’s impossible on any subject, but rather, that they need to be realistic about their own comfort, knowledge, skills, and use those to the full advantage of the client based on the client’s goals, and also use other resources that are available in the client’s extended family and community and spiritual support systems, as well as the larger environment that might need to be supplementing the client’s existing supports.

ALEXANDER: Is there anything else that you would like to add before we close?

CANDA: I guess, just in summary, for me, it seems particularly important that we ground the practicality of ethical decision making in the larger context of our lives as persons and our deepest commitments in our spiritual journeys, so that ethical decision making isn’t just a matter of applying a formula, like, let's say, if you have five different principles, how do you rank order them in what situation. To me, real life isn’t like that. Life is complex, diverse, spontaneous. Often there are different principles that are equally important, and simply, dilemmas exist.

Also, it’s not simply the professional who is making the ethical determination. The ethical determination process is a dialogue engaged in with the client’s system, so that the client and worker can engage in a discussion, for example, about what mutually feels right to pursue and how to pursue it. So, I guess I am cautioning against a sort of a elitist, expert-driven approach to ethical decision making in which the professional is the one doing the ethical decision making and imposing that on the situation, but rather, it is a product of both inner reflection of the worker and connection with colleagues and mentors and the clients, and out so of that dialogue, there can be a deeper and richer conclusion about whatever ethical decision is made.

ALEXANDER: Dr. Canda, I thank you so much for sharing your very thoughtful reflections of years of research and study and practice.

CANDA: I appreciate the thoughtfulness you put into preparing. It is obvious you identified parts that are very relevant to this, and you have brought good questions out of that.

This concludes our interview with Dr. Ed Canda. I hope you have enjoyed this interview and that you learned from it. I must say here that the opinions expressed by our speakers are theirs alone and do not necessarily reflect the opinions of On Good Authority.

© On Good Authority, Inc.
Used with permission.
Interviews edited for readability by On Good Authority and athealth.com

Part 4: Ethics, Education, and Character
Interview with Dennis Haynes, PhD

BARBARA ALEXANDER: Welcome. I’m Barbara Alexander. You are reading or listening to a series of interviews from On Good Authority’s program on ethics and spiritual issues in clinical practice. Our final speaker, Dr. Dennis Haynes, addresses the importance of modeling genuineness and integrity. He passionately states that all of the decisions we make are in context of our value preferences and patterns. I believe that you will hear in his interview that he is a person who walks the walk and lives out his beliefs and values.

I would note that while Dr Haynes is discussing this topic in terms of social work, the principles are universal for all the helping professions.

Dr. Haynes is an associate professor and program director of the master’s level graduate in the School of Social Work at the University of Texas-Austin. He is a prolific writer and speaker, especially and most recently on the subject of ethical guidelines for incorporating religion and spirituality into social work practice. He received the Texas Excellence Teaching Award from the University of Texas-Austin, School of Social Work, for the years 2002 and 2003.

ALEXANDER: Dr. Haynes, let’s begin by talking about your views on ethics, in particular in clinical practice.

HAYNES: Okay. To answer that question, let me give you a little background of who I am and then respond, if I could, to that question.

If you had asked me over twenty years as a clinician who I was or what I did, I would have said to you, "I am a marriage and family counselor," or "I am an adoption worker; I'm a child welfare worker." Nowhere in that period would I have probably said to you, "I am a social worker who does child welfare."

When I got my PhD, I became intrigued with that - of why in all of my preparation was that not my identity in some way? And, so, I did my dissertation around how we teach professional social work values and ethics to graduate students. That’s where my interest in all this came. Then in coming to UT-Austin in 1993 - because I have such a breadth of practice experience - most of the classes that I taught initially were practice oriented classes. We have an institute here at UT-Austin that was, at that time, called the Child Protective Service Training Institute. So, I became a trainer for that institute to child welfare workers and supervisors and administrators throughout the state of Texas - for about five years. I had a lot contact with child welfare workers during that time, but I was not training specifically in ethics. We had other kind of areas we were training in.

Then, when Texas mandated that there had to be ethics training for licensure and continuing education, the institute asked me to help develop a workshop that could go out to all child welfare workers. So, I did that along with others. Then, that was not enough so I began training school social workers, principally those that were agency-based rather than those who were private
practitioners. Private practitioners would sometimes hear about the workshops and come, but it was usually an agency context. The agency would sponsor me to come and train.

I discovered several things in that training. I trained probably a thousand social workers in Texas over that period of time, especially in the first couple of years after that was mandated. As I said, many of the trainings were in institutional settings. And, many of those settings included interdisciplinary clinical practice. For example, they might be in the school setting - the only social worker in that context - or with Child Protective Services (CPS), they might not have a supervisor as a social worker.

As I explored issues with these workers, I discovered that most of them were making their decisions, not based on the code of ethics and not even based on the identity or values of our profession, but more on the policies and procedures of the agencies where they were functioning. They would not consult with other social workers in making their decisions. They would not consult even within the agency or go to the NASW chapter for any questions or requests for information. They would ground their decisions on what the policies and procedures of the agency were.

As I did my training, another thing that concerned me - other than the feeling of isolation I found in many of the clinical social workers in Texas - was that if I asked them to tell me the ethical implications of a vignette that I gave them, they would respond 90% of the time or more with the practice decision, but not the ethical implications. It was very hard for them to articulate the ethical issues. That became a concern.

The other issue that was a concern was when I asked about ethical issues, they would focus on the dilemmas of the client, the agency, multiple clients, confidentiality, etc. Only once, out of a thousand social workers that I trained, did anyone step forward and say, "Well, I struggle with my own value conflict with this." I wanted them to begin to examine their own role as a decision maker and how that impacted the ethical decisions being made. Those were the issues that arose about clinical practice and ethics that were of the most concern to me.

ALEXANDER: Were the agencies’ policies and procedures very different from the ethical codes?

HAYNES: Yes, I mean they would be based in the practice context - you know, this is how we serve children in CPS; this is how we serve children in the school system. It would, again, be practice-focused and not nearly as focused on ethical dilemmas that might arise. Most agencies were not focusing on that; they were focusing on the practice issues, and truly you cannot separate ethical decision making and practice. However, workers have not been trained to do that, so you need to help them examine in more detail what complications might arise as far as ethical dilemmas for them as well as for the client or the agency.

ALEXANDER: Well, I suppose with sectarian agencies such as Catholic Charities or Lutheran Family Service or various agencies that are under a religious auspices of some kind - if any kind of spiritual issues would arise, would those necessarily be in the policies and procedures of that agency?

HAYNES: Not necessarily. As I looked at mission statements, as I looked at policies and procedures, sometimes it was clearly articulated, and other times it was just assumed because "we are (for example) a Christian based agency" that's just understood. It was not always articulated as needed.

ALEXANDER: What are some of your thoughts about how it should be articulated by these sectarian agencies?
HAYNES: Clients coming to receive service - of course, when we talk about informed consent, that's just one issue - need to be aware of the theoretical framework that the clinician, for example, might use. For example, if they incorporate spirituality or even religious interventions into their practice, which some sectarian agencies, of course, do, but then the clients need to be aware that that's part of the practice that we provide. So in making their decision about whether to receive service from that individual or from that agency, clients are aware, through informed consent, of those issues.

To simply say, "We are a Christian based agency" - to stay with that example - I mean, Christianity is very diverse, and so what does that mean? Sometimes we focus more on - if my religious persuasion, for example, is different than yours, then I need to be sensitive not to impose mine on you, and sometimes we do a better job in focusing on those who are different from ourselves than on those who are similar to ourselves. If we are both of the same religious persuasion, as far as denomination for example, we might assume we are "the same" and even in those cases, that is not to be assumed. Sometimes those who are going to sectarian agencies for service are going through spiritual or religious crises themselves. Maybe they are struggling with their faith. So we can't just assume that they are at the same place I am, that their belief system is the same as mine, etc.

Even within similar contexts, I think that is creating some ethical issues that need to be articulated between the worker and the client and in the agency policies, as well.

ALEXANDER: That is really an excellent point. You are more likely to explore the meaning of things with somebody whom you perceive as different.

HAYNES: Yes. And this is one of the dilemmas that we encounter in education for the mental health professions, if I can look at it from that lens. I believe that our students are trained to be sensitive in not imposing their values, etc., on clients they work with. They are much less sensitive to one another in the classroom. The assumption is that all social workers are the same; we all have the value base, so why in the world do you believe abortion is okay? And even from faculty in schools of social work.

I have had, for example, conservative oriented students come to me and say, "I thought this was a school of social work that valued diversity. As a conservative, I feel oppressed within this environment." So how do we create an environment that, yes, teaches the values, but respects diversity? Sometimes we are better at doing that with those who are different out there than with those whom we assume should be like us.

ALEXANDER: Well, in the educational setting how does one create such an environment that would allow for the range of values?

HAYNES: Yes. (laughs)

ALEXANDER: Tough question.

HAYNES: Well, actually, this is what led to my interest in my dissertation, because what I saw was that, in effect, students arrive at schools of social work, and we pretty much say, "Here are the social work values. Take them or leave them." So, there is an imposition approach of, "These are the values."

That goes against adult education principles. Adult education principles say that you must start with where that person is - that they see through the lens of their own experience and that you have to validate their experience before they are able to open and broaden their understanding of other perspectives. So, what students have said to me multiple times over the years in different
institutions is that students find out on the first day of class what’s acceptable to say and what’s not acceptable, and so they play the game.

And, we graduate students who have not been in an environment where they have been able to explore the conflicts between their personal and professional values, but they just go along knowing that when they graduate, they will do what they want to do anyway. Some say to me, "Well, I am going to work in a religious institution. It's not going to be a conflict between my values and professional values, so I'll just get the degree. Then I'll go do that."

But that goes against everything that we know about ethical decision making, which is that you must really explicate what your own values are and how that will play into all the work that you do. It's not just about religious or spiritual values. All of us have value preferences. For example, in child welfare I might believe that children do better in their development in a two-parent household. Well, that's a value, and if I do my work with that, then I might be imposing that value if I have not explored and understood how that might play out for persons who are different than what that value holds to.

ALEXANDER: This sounds like discussions of racism in the 60s and 70s when I was in graduate school - that there were things that you could say, there were things you couldn’t say, and if you dared to say something different than the party line, so to speak, then you were labeled.

HAYNES: Exactly. And what that says is that we must all be the same, and that values cannot change. I don’t agree with that. I mean it is more difficult, of course, to change core values, and they usually change through major life crises and experiences, etc., but I believe through education that our views can be expanded and broaden, and that’s why I am an educator - what can I do to help us see and respect a person outside of our own lens and to add to that differential lens for the students? Not to impose that on them, but to have them critically question for themselves.

When they do that, they have several choices. They can say, "Okay. I have seen this other lens now, and I still hold to my original value system. I am not willing to change that." Or they might say, "Well, I hold to this part of my value system, but I want to add this new piece into it." Or they might reject their value system and say, "No, I never understood it this way."

The goal is not to force them to change; the goal is to force them to see and then allow themselves to change. But if we present it in this - "You have to be this way" context, then that creates resistance. It creates defensiveness, and it does not open up someone to see "difference."

ALEXANDER: Are you finding that your point of view is unique in education these days?

HAYNES: (laughs) Particularly in social work education. Yes, because I think what we do in social work education is we feel so passionate - there is so much emotion in what we are about - that we have created this system that believes we all have to be, you know, "social justice means just one thing," and I am saying that it is broader than that. It has to be more integrative than that. And the code of ethics is usually presented as a guideline rather than as a mandate as to - this is the way you have to operationalize this value.

ALEXANDER: Which is it? Are codes of ethics mandates or suggestions or guidelines?

HAYNES: Both. Unfortunately, it is not clear. The code has both prescriptive statements, and it has idealistic statements - all within the same code of ethics. And it has not been articulated.

It tries to be in the way it is organized now, because it starts, of course, with a premise that these are our core values. These are the principles that follow from those values, and here are the
standards of practice as a result. The standards tend to be more prescriptive, but not all of them are. Some of them are still more like – this is how a social worker should perform, etc.

When I have done training with very experienced practitioners, and I provide a vignette, I will have many different interpretations, even from our most experienced practitioners. And so, I don’t believe a code can ever - or should ever - reach the point where it curtails critical thinking.

Ethical decision making is getting together with other professionals and analyzing these issues and reaching the point where based on that analysis, I can justify how I reached this decision - rather than memorizing a set of outcomes that we all have to apply. That would take away my thinking, my growth, my development that I need in order to better serve the clients that I am working with.

That is one of the dilemmas of the code. Some people take a code as they do a law and say okay, this is it, you call, you ask for service, this is what we do here at this agency. There is no critical thinking about that. There is no analysis of self and how I play into this picture. That creates real risks for the worker and for the client being served.

ALEXANDER: This is a very passionate point of view, and I appreciate this very much.

HAYNES: This is what is beginning to be said by a few persons, and I will give you a couple of references as I talk about it because I am not the only one thinking about this. There are many, many models of ethical decision making being developed, particularly in the last few years since the revised code of ethics came out. So you will have different writers presenting these models.

As you look at the models, most of them are problem solving models. Here are the conflicts, and if you take this route, here are the possible consequences; if you take the other route, here are the possible consequences; and how do you justify the decision that you have reached?

What that does is put the dilemma outside of the worker. It focuses on the practice dilemma. The worker is part of that, and so this is what is being challenged. Abramson, in 1996, said the same thing - that ethics in social work focused on decision making rather than the decision maker. The decision makers have to be very aware on an ongoing basis of the issues that arise for them - of their own value conflicts, etc., and they cannot just look outside of themselves.

The other person who has addressed this is Maryann Madison. She published an article, and this is what she added to the discussion - that usually we take an ethical dilemma, and we come to the decision for that particular practice situation, and then we move on until we encounter another dilemma, and we analyze that, come to a decision, and move on. She says that all of the ethical decisions we make are in context with our value preferences as workers. So if I were to take these continuing dilemmas that I encounter and analyze them and look at the decisions that I have made for that group of ethical decisions, then I would begin to see value preferences and patterns that I have. We cannot just examine those as if each ethical decision is independent from the previous or the one that we have yet to encounter. I think that is very important information. Again, Abramson speaking to the values of the worker, looking more at the worker's part of the ethical decision making and in looking at that as patterns of decisions rather than isolated one from another.

ALEXANDER: This really does fit into this topic of spirituality because I think the aim of spirituality for a lot of people is simply to become a better, more moral person.

HAYNES: Exactly. What Canda says about that particular issue is that to be spiritually sensitive, we have to be clear in our values. This is one of his principles, value clarity, and he says -- and it’s not just him - because the book that I pull from is from Canda and Furman, and Furman is the co-author, so the two of them would need credit for this - but what they say is that this is an ongoing
process. What we have intended to think about for client informed consent, for example, is that when clients walk in the door, I inform them of their rights and where I am coming from, and then I have met my ethical obligation, and we move on from there.

As we work together, different value issues will arise that I had not thought about as we began our work together. We talk to clients about journaling and about a lot of introspection for themselves, but workers must be doing that as well, and they must share with the clients about issues that might arise around these value commitments. That’s an ongoing process rather than just up at the front. I think that fits with what you are saying, Barbara, about this ongoing search for meaning and understanding.

We say we start where the client is, but that the starting point is never simply where the client is, but also where I as a therapist or social worker am. I think that is what I am talking about - that I bring myself, and wherever I am in my spiritual journey, if we are bringing religion and spirituality. That’s present, and if choose not to acknowledge that, then that’s where there can be, I think, more harm to clients because we are not tuning into our own process and how that connects with the client’s process.

ALEXANDER: How much of the worker’s own process gets disclosed or gets shared? That’s a big topic.

HAYNES: Right, right, and I don’t know that there is a simple answer for that. When persons in my workshop ask, my bottom line response is "We share only that which is beneficial to the client. We don’t use the client, of course, for our own development, etc. We use a supervisor, and we use consultation for those kinds of things.

But in that candor with clients, we’re trying to get them to be more open to their feelings, their thoughts. Can I not model that when it’s beneficial to the client to help them in their process? The decision of whether I disclose or not has to be in the best interest of the client. Those things that I discover in the process that do not serve the client but are for my own issues, I need to go for supervision for those issues." I know that is probably a trite answer, but that’s the only thing that I know in response to that question.

ALEXANDER: That's the only answer.

HAYNES: I do not believe that I am the expert coming in here. For example, if I am working with someone in an abuse situation, just because I have worked with persons in abuse situations before does not mean that I have the expertise - that assumes that everyone is the same. I am going to learn something in that encounter. It needs to be a mutual learning experience together. I hope that I am always growing and developing. I say to my students that there is a statement out of solution-focused therapy that I love, and it is, "Curiosity is competence."

Whenever I stop asking questions, whenever I stop seeking to learn, grow, develop, I become incompetent. When I think I know the answers - I stop seeking. So, that’s part of this whole process of spirituality, I believe, that ongoing seeking - that we never arrive; that we are always in process and open to that.

ALEXANDER: You are a very thoughtful person. I really appreciate these thoughts, and your point of view is very refreshing. Is there anything you would like to add before we close?

HAYNES: Those are the main points that I want to share, but I will just share something if I could to make it more personal. I am talking about how workers need to do that, so let me share "me" with you because I want to model that back. I think that is so important.
When I did my dissertation, the very first part that I focused on is what you and I have been discussing – the articulation of one’s own personal values and being open to that, etc. Well, then I came to UT-Austin to present a colloquium to see if they wanted to hire me, and my major professor said, "Don’t share any of that personal stuff." You know, "Don’t share even that you have been a practitioner because they are looking for someone who is a researcher. That’s what they want to hire, so don’t share that."

As I came to present, I thought, "My whole dissertation is grounded in that we start "here." How am I going to present this research without modeling that for the faculty there at the school? If that’s a good fit for the school then, yes, I want them to hire me, but I don’t want to hide what I am really about. That would not result in a good fit, even if I am hired."

That was one issue that arose - trying to model for our students, trying to model for our colleagues - what, I believe, is "genuineness." I believe one of our core values is integrity. To me, genuineness is integrity, and so how to model that with clients, how to model that with colleagues, and how to model that with the students is one thing that I wanted to share.

For the other, I go back to my religious roots, and it’s linked to social work. What attracted me to this profession, of course, and this is not unusual, is my faith base. All of that led me to want to serve, to be a resource to others, etc. I had an opportunity before I finished my college education to serve as a missionary for three years in Mexico. If you looked at my resume, you would see when I graduated, and, of course, that I graduated from Brigham Young University. I include that I served as a missionary, so you see very readily on the resume that I come from a Mormon faith background.

Well, the very first social worker who interviewed me in 1974 in California for my social worker position looked at my resume and said, "Dennis, how do you think that someone from your background could ever be a social worker?" That was the very first question that I was asked by a professional social worker! And my response was, "I feel very grounded in my own value system. I have no need to impose that on anyone else."

I was hired, and I believe that there was an assumption that if someone is "religious," that they are going to impose their values. Anyone can impose values whether they are conservative or liberal. It’s not the label. It’s this understanding of who we are individually and the respect for others to allow them to be who they are that creates this kind of climate that you and I have been discussing. So those two things - from a professional, and then the personal and the professional linked together.

ALEXANDER: Let me throw one more iron into the fire. In times when the economy is very tight, and there are more people looking for jobs than there are positions, it is, I think, harder to do that. I actually had a question submitted by one of the people on my email list when I sent out a request for questions to ask on this topic. This person said that she is in a religious agency, that they start their team meetings and staffings with a prayer, that everything is in a religious context which she doesn’t share, and she is very uncomfortable in it, and what can she do?

Well, what can she do? It seems to me -- you know I hate to say, "You made your bed, you lie in it," - but she knew or should have known what she was getting into.

HAYNES: Right, right. I believe that I can hold out who I am and at the same time, present an ability to respect, to integrate diversity, and that hopefully that will be the message that is heard, but someone might truly just tune in only on my own religiosity, if we look at it that way. So for her in the other direction, to come into an agency where that is the whole key, and she doesn’t share that, to
say, "I don’t come from this background, but I respect those for whom their religion is very much a part of their strength base," I think that is more what we are talking about instead of, "Well, if I tell them, then that’s going to rule me out for a job."

I think it’s the thinking. If I can demonstrate to you that I am aware of myself, and I have been critical in my analysis of that and how it impacts our relationships, then I think that’s valued. I hope that’s valued - to move us beyond labels to more of the integrity and genuineness of who we are.

ALEXANDER: Well I hope that’s true also. I thank you, Dr. Haynes, very much for carving out this bit of time for us.

HAYNES: Well, thank you very much.

ALEXANDER: This concludes our program. We hope that you have enjoyed these interviews and that you have learned from them. As always the opinions expressed by our speakers are theirs alone and do not necessarily reflect the opinion of On Good Authority. Until next time this is Barbara Alexander, thank you for listening.

© On Good Authority, Inc.
Used with permission.
Interviews edited for readability by On Good Authority and athealth.com

Part 5: Ethics Codes, Laws, and Regulations

Practitioners are governed by state laws and regulations and by codes of ethics. All major organizations in the mental health professions have adopted a code of ethics. Readers are encouraged to examine their state laws and regulations as well as provisions of the ethics codes related to the topics in this program. Below is information about some of the ethical issues and state laws and regulations in California and Florida related to topics discussed in this material.

ETHICS CODES

APA: Ethical Principles of Psychologists and Code of Conduct

Code of Ethics of the National Association of Social Workers
http://www.socialworkers.org/pubs/code/code.asp

California Association of Marriage and Family Therapists (CAMFT)
http://www.camft.org/CamftBenefits/whatiscamft_ethnic1.html

American Association for Marriage and Family Therapy Code of Ethics
http://www.aamft.org/imis15/content/legal_ethics/code_of_ethics.aspx

American Counseling Association Code of Ethics and Standards of Practice

Code of Ethics of the American Mental Health Counselors Association
http://www.amhca.org/assets/content/CodeofEthics1.pdf

National Board for Certified Counselors Code of Ethics
http://www.nbcc.org/assets/ethics/nbcc-codeofethics.pdf
CALIFORNIA PSYCHOLOGISTS

Accepted Ethical Standard for California Psychologists

Pursuant to Section 2936 of the California Business and Professions Code, the American Psychological Association's, *Ethical Principles of Psychologists and Code of Conduct*, is the accepted ethical standard applicable to the practice of psychology in California.

Laws and Regulations Relating to the Practice of Psychology can be found at http://www.psychboard.ca.gov/lawsregs/index.shtml

Cause for Disciplinary Action
Pursuant to California Business and Professions Code - Section 2960, 2960.1, 2960.5 and 2960.6, causes for disciplinary action include, but are not limited to, the following:

- Willful, unauthorized communication of information received in professional confidence.
- Being grossly negligent in the practice of his or her profession.
- The commission of any dishonest, corrupt, or fraudulent act.
- Functioning outside of his or her particular field or fields of competence as established by his or her education, training, and experience.

Professional Competence
A psychologist shall not practice outside his or her particular field or fields of competence as established by his or her education, training, continuing education, and experience. Sections 2930 and 2936, Business and Professions Code. Section 1396, California Code of Regulations.

FLORIDA:
Grounds for Disciplinary Action
Pursuant to Chapter 490, Florida Statutes: Psychology, s. 490.009, and Chapter 491, Florida Statutes: Clinical, Counseling, and Psychotherapy Services, s. 491.009, grounds for disciplinary action against a licensed psychologist, clinical social worker, marriage and family therapist, and/or mental health counselor include, but are not limited to, the following:

- Being convicted or found guilty, regardless of adjudication, of a crime in any jurisdiction which directly relates to the practice of his or her profession or the ability to practice his or her profession.
- ☐Failing to perform any statutory or legal obligation placed upon a person licensed under this chapter.
- Willfully making or filing a false report or record; failing to file a report or record required by state or federal law.
- Committing any act upon a patient or client which would constitute sexual battery or which would constitute sexual misconduct as defined in s. 490.0111.
- ☐Making misleading, deceptive, untrue, or fraudulent representations in the practice of any profession licensed under this chapter.
- ☐Being unable to practice the profession for which he or she is licensed under this chapter with reasonable skill or competence as a result of any mental or physical condition or by
• Reason of illness; drunkenness; or excessive use of drugs, narcotics, chemicals, or any other substance.

• Failing to meet the minimum standards of performance in professional activities when measured against generally prevailing peer performance, including the undertaking of activities for which the licensee is not qualified by training or experience.

• Failing to maintain in confidence a communication made by a patient or client in the context of such services, except as provided in s. 490.0147.

The following excerpts from the APA ethical guidelines are relevant to the issues discussed in this program:

APA ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT
GENERAL PRINCIPLES

Principle E: Respect for People's Rights and Dignity
Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making. 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. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices.

ETHICAL STANDARDS

2. Competence

2.01 Boundaries of Competence

(a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.

(b) 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, except as provided in Standard 2.02, Providing Services in Emergencies.

(c) Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, consultation, or study.

2.03 Maintaining Competence
Psychologists undertake ongoing efforts to develop and maintain their competence.

3. Human Relations
3.04 Avoiding Harm
Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.

3.05 Multiple Relationships
(a) A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person.

A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist’s objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.

Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical.

3.06 Conflict of Interest
Psychologists refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to (1) impair their objectivity, competence, or effectiveness in performing their functions as psychologists or (2) expose the person or organization with whom the professional relationship exists to harm or exploitation.

3.08 Exploitative Relationships
Psychologists do not exploit persons over whom they have supervisory, evaluative, or other authority such as clients/patients, students, supervisees, research participants, and employees. (See also Standards 3.05, Multiple Relationships; 6.04, Fees and Financial Arrangements; 6.05, Barter With Clients/Patients; 7.07, Sexual Relationships With Students and Supervisees; 10.05, Sexual Intimacies With Current Therapy Clients/Patients; 10.06, Sexual Intimacies With Relatives or Significant Others of Current Therapy Clients/Patients; 10.07, Therapy With Former Sexual Partners; and 10.08, Sexual Intimacies With Former Therapy Clients/Patients.)

3.10 Informed Consent
(a) When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.

(b) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual’s assent, (3) consider such persons’ preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally
authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual’s rights and welfare.

(c) When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding.

(d) Psychologists appropriately document written or oral consent, permission, and assent. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

3.11 Psychological Services Delivered To or Through Organizations

(a) Psychologists delivering services to or through organizations provide information beforehand to clients and when appropriate those directly affected by the services about (1) the nature and objectives of the services, (2) the intended recipients, (3) which of the individuals are clients, (4) the relationship the psychologist will have with each person and the organization, (5) the probable uses of services provided and information obtained, (6) who will have access to the information, and (7) limits of confidentiality. As soon as feasible, they provide information about the results and conclusions of such services to appropriate persons.

(b) If psychologists will be precluded by law or by organizational roles from providing such information to particular individuals or groups, they so inform those individuals or groups at the outset of the service.