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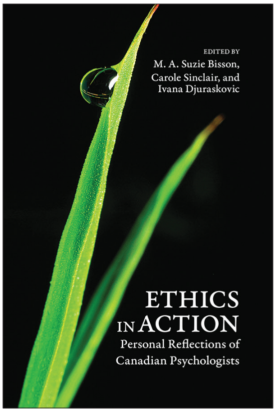

ETHICS IN ACTION: PERSONAL REFLECTIONS OF CANADIAN PSYCHOLOGISTS

Edited by M. A. Suzie Bisson, Carole Sinclair, and Ivana Djuraskovic

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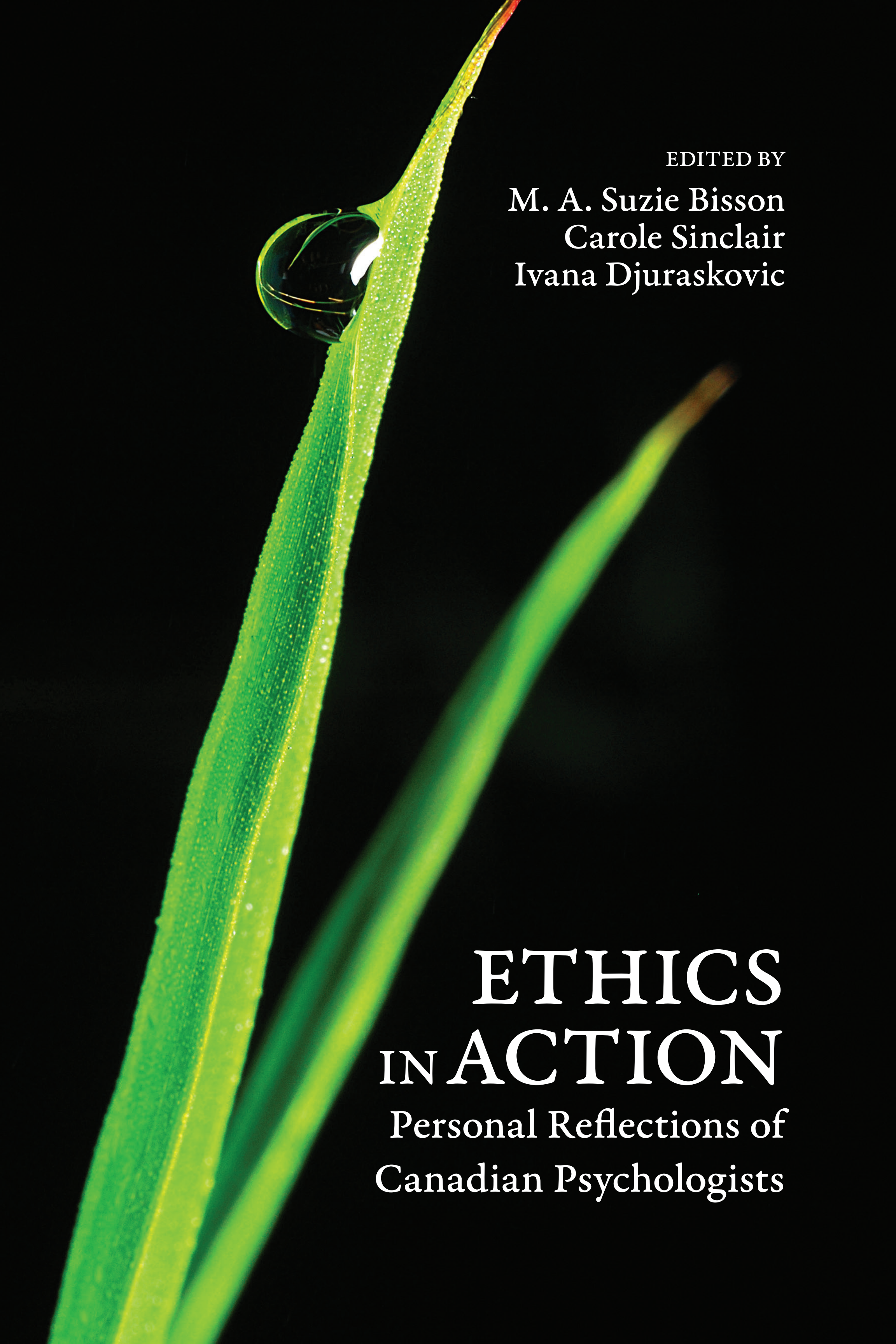

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Dedicated to the memory of

Dr. Jean Pettifor,

with admiration and gratitude for her guidance,
mentorship, and extraordinary contributions to
the field of psychological ethics.

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This book would not have existed without the wisdom of Dr. Jean Pettifor who seeded the idea of a book on psychologists' experiences with ethics, using a more personal writing style. Jean was enormously helpful and supportive to us in the book's early stages. Even though she is no longer with us, we wish to express our deep gratitude for her help and for the legacy she left us after a 67-year career as a psychologist.

We also wish to express our deep appreciation for the 42 passionate and experienced authors, who responded to the call to bring this project to life. Their dedication to seeing this project through and their patience during the many stages of the process were outstanding.

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On a final note, we want to thank everyone who purchased a copy of this book and its contents, as all proceeds will go to the *Dr. Jean and Dick Pettifor Scholarship Fund*. The Scholarship helps fund graduate students' research projects in professional ethics in psychology.

It takes a dedicated community to help the world move in more ethical directions. Thank you for being part of that community.

Introduction

> *Ethics is not just an abstract intellectual discipline. It is about the conflicts that arise in trying to meet real human needs and values.*
>
> John Ziman, 1971

This book had its beginnings in the imagination and aspirations of Dr. Jean Pettifor. Integrally involved in the original development (1986) and subsequent revisions (1991, 2000, 2017) of the Canadian Psychological Association's *Canadian Code of Ethics for Psychologists* (variably called the *Code* or the *Canadian Code* in this book),[1] Jean was a champion of its ethical principles, values, and emphasis on decision making. However, she thought that the ethics literature tended to be overly "academic" and impersonal, and thereby less impactful than it could/should be. She believed there was much to be learned from psychologists' lived experiences of dealing with the ethical issues and dilemmas they faced. She also believed that adding their stories to the literature could enhance our understanding of ethics and the significance of the *Code's* principles and values. In her interactions with students and colleagues, she frequently engaged in conversations about their experiences, listening to their stories of success and struggle in trying to honour the *Code*'s principles and values, and with making ethical decisions in the context of internal, external, and cultural needs and pressures—all this set within the context of their own emotions and of living in an imperfect world.

Jean occasionally succeeded in convincing someone to present such an experience at a psychology conference. However, she found it difficult to find individuals to do so. Although willing to speak with her or in a small group in private "off the record," they often expressed fears of being misunderstood and criticized to the point of losing confidence in their ability to think through and respond to the ethical challenges they faced in their work. In addition, she thought that presentations at conferences were perhaps too sporadic and did not reach enough listeners to be of significant benefit. About five years before her death in 2015, she began to think seriously about putting together a book of lived experiences that could stimulate thinking about ethics in psychology on a more personal and engaging level. She thought that such a format would provide a bit more distance for those willing to share their experiences and points of view, and more opportunity to explain their thinking and choices—in other words, to feel less vulnerable. To this end, she invited two of the co-editors of this book, Suzie Bisson and Ivana Djuraskovic, to meet with her to discuss the feasibility of producing such a book. The group met several times to identify and speak with several potential authors. However, due to Jean's failing health, the meetings became more infrequent over time. Nevertheless, true to her nature and aware that she would not be able to complete the book in her lifetime, Jean encouraged members of the group to continue with the project after her passing, building on the ideas that had been generated thus far. This book is the outcome of that continued effort.

Invitations to contribute a chapter to this book were sent to Canadian psychologists known to be involved in the teaching of ethics, contributions to the ethics literature, or in areas of psychology with much-discussed ethical challenges. They were asked to pass the invitation on to colleagues they thought might be interested. The nature and intent of the book were discussed at various convention presentations, and participants interested in contributing were invited to contact the editors. In addition to this introduction and the appendixes, which include a dedication to Jean, the book was structured to consist of six "Parts." For four of the Parts (A, B, C, and D), contributors were invited to focus their chapter on one of the four ethical principles of the *Code*, with the understanding that there often is overlap between the principles. For the other two Parts (E and F), contributors were asked to focus their chapters on either ethical decision making (Part E) or international ethics (Part F). Regardless of whether they focused on a particular ethical principle or were writing for one of the other two Parts of the book, contributors were asked to introduce themselves in their chapters and to explain why they chose to focus on their topic. They were encouraged to write in the first person as much as possible, and to provide questions for reflection at the end of their chapter that could be used in graduate or continuing education training or as personal reflections.

The resulting book has 21 chapters. To protect privacy, all use pseudonyms or otherwise disguise identity when describing the persons and circumstances involved, some are written by a single author, some by two or more authors. The authorship of a few chapters is interprofessional. Some of the chapters are highly personal; others are a little more academic or traditional in tone and writing style. However, all provide details and reflections on the lived experiences portrayed. A summary of the content of each Part of the book can be found below.

Part A: Principle I (Respect for the Dignity of Persons and Peoples)

Part A contains four chapters. The *first chapter* addresses the vulnerability of immigrant families and how a more intentional and conscientious approach to conveying respect for dignity is needed when working with them. The author demonstrates how she does this within the counselling framework, and the ways in which this conveys respect for their perspectives and worldviews, including the message that they have choices and that all human beings are connected and of value. The *second chapter* explores the importance of hospitality and faith in the worldview of many Muslim clients, and how considering each client as a "guest" and integrating faith-based concepts into practice can help to convey respect for dignity. These ideas are discussed in the contexts of cultural competence, the existence of Islamophobia, and taking care not to assume that hospitality and faith have the same meaning to all Muslims. The *third chapter* explores the dignity of work for persons living with developmental disabilities, and the culture of exclusion, discrimination, and lack of opportunity that exists in much of our society. It outlines ways in which psychologists can support such clients in their families, communities, and workplaces, and draws on Principle I to explain why and how attention to self-determination, self-expression, identity, and each person's social context is important. The *fourth chapter* in Part A is devoted to a discussion of psychological services for transgender youth and the push for better language and understanding of transgender issues. There is a focus on handling the issues of confidentiality, privacy, and informed consent with transgender youth; the need for gender nonconforming language that conveys general respect; and the need for promotion of trans-equality and non-discrimination.

Part B: Principle II (Responsible Caring)

Part B has four chapters. The *first chapter* focuses on the challenges in caring responsibly for persons in long-term care. The authors focus on the complexity of relationships (especially in rural and small communities), the scarcity of resources, the high vulnerability of the residents, and the need for advocacy. They reflect on how attention to many of the values of Principle II has helped them to keep residents' well-being in focus. The *second chapter* looks at the role of what the authors call "inner work" in caring responsibly, particularly with respect to self-care. The authors outline many of the ways inner work can be undertaken, whether as students or seasoned practitioners; how to maintain a safe environment for students when such work is integrated into the curriculum; and the impact of inner work on engaging with clients. The *third chapter* links responsible caring to several aspects of supervision, including the role of deliberative and reflective practice and the concept of professionalism. The authors propose that supervisors must be role models for responsible caring, and that it will be only through increased emphasis on supervision as a professional practice that responsible caring will be actualized for supervisors, supervisees, and clients. In the *fourth chapter* in Part B, the authors outline steps for honouring the principle of responsible caring in couple and family therapy, particularly with respect to achieving the competence needed to engage in such work. They reflect on the impact of the lack of opportunities for formal training and encourage practitioners and students to engage concerted searches for such opportunities, and also to advocate with universities and training sites for the provision of such training.

Part C: Principle III (Integrity in Relationships)

Part C has four chapters. The *first chapter* explores ethical challenges in maintaining integrity with third parties, particularly those seeking therapy information about clients. The authors encourage being proactive and straightforward with both third parties and clients about sharing information, and to respectfully challenge the power of third parties when needed. They make several recommendations, some of which they acknowledge are likely to challenge the business practices of third parties. The *second chapter* recounts the professional journey of the author after being hired by a university to provide clinical services in a student counselling centre as well as to be a member of faculty. The author focuses on challenges related to maintaining integrity, particularly with respect to managing multiple relationships and avoiding bias with supervisees and colleagues. He also touches on challenges in identifying priorities when ethical principles conflict. The *third chapter* describes the experience of an Indigenous psychologist learning to work with Indigenous clients, and the importance of professional boundaries being appropriate to the cultural context of clients. The author focuses on what it means to be a healer in an Indigenous community, and how she believes her relationships with clients relates to the physical, emotional, and spiritual dimensions of Indigenous life. The *fourth chapter* in Part C focuses on integrity issues in interprofessional collaborative practice, particularly in a rural environment. The authors share some of the ethical challenges they face, including how their daily interactions are linked, both personally and professionally, and how they manage these overlaps. They also discuss the importance of integrity in establishing collaborative relationships with local schools, hospitals, communities, and skilled individuals of all disciplines.

Part D: Principle IV (Responsibility to Society)

Part D has three chapters. The *first chapter* explores the impact an inherently adversarial legal system has on children and parents of separation and divorce who are embedded in such a system, as well as the impact this has on the psychological services provided in high-conflict divorce situations. The authors reflect on some of the barriers to the delivery of services in the family justice system and explore important societal-level ethical responsibilities for psychologists, including renewal of the court system. The *second chapter* outlines the psychological injuries frequently experienced by first responders and the need for safe work environments to prevent and deal with such injuries. The authors address the influence of organizational culture and the stigma attached to mental health problems, particularly on the ability and willingness to speak out, as well as the role that psychologists could be and have been playing in making the situation better. The *third chapter* addresses the importance of establishing and maintaining professionalism in new areas of practice. Using the example of equine-facilitated therapy, the authors explore the potential benefits of innovation, but also the importance of balancing such benefits with the potential for public harm while the new practice is being established. They propose concrete activities that psychologists can engage in to help establish professionalism in a new practice area.

Part E: Ethical Decision-Making

Part E is comprised of three chapters. The *first chapter* provides the back story to why and how an emphasis on ethical decision-making and the inclusion of an ethical decision making model in the *Canadian Code of Ethics for Psychologists* came about, and how it changed over the three revisions of the *Code*. The author focuses on the role of serendipity and how the contributions and wisdom of many Canadian psychologists played a major role. The *second chapter* outlines the thinking through process of a real-life ethical dilemma related to psychological assessment of school children in a First Nation community, using the steps of the ethical decision-making model in the *Code*. The authors explore the impact of English-language proficiency, historical trauma, and different understandings of the education system and psychology on such assessments, and the importance of establishing relationships and trust with communities over time. The *third chapter* also addresses a real-life ethical dilemma in which a provisional psychologist under supervision is asked by a client to be his primary support person when he undergoes Medical Assistance in Dying (MAiD). The provisional psychologist and the supervisor outline the ethical struggles they experienced in trying to decide whether to agree to this request; in particular, the difficulty in balancing competing values, the importance of support and consultation, and what they learned from the experience.

Part F: International Ethics

Part F is comprised of three chapters. The *first chapter* explores the experience of two psychologists, originally trained in their country of origin, and who subsequently received further training in Canada and then returned to their country of origin. They describe how what they learned in Canada was very transferable to a non-Canadian setting because it was attuned to interactional patterns and the preferences and goals of parents in the context of their culture. The *second chapter* focuses on the many ethical challenges faced by Canadian psychologists doing humanitarian work in international settings. The author reflects on how the *Code* was developed within and for a democratic society with basic equality, resources, and professional standards in place, and how it is not always applicable in the same way in societies torn by wars, fewer resources, and longstanding inequalities. The *third chapter* describes how the development of the *Universal Declaration of Ethical Principles for Psychologists* (2008) came about. It provides details about the backstory; the care with which the *Declaration* needed to be developed to reflect ethical principles and values that are held in common across the cultures of the world; how it has influenced global ethical thinking; and how it has contributed to the international advancement of psychological ethics, including in Canada.

NOTE

1 A reprint of the 2017 version of this document can be found in Appendix A.

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PART A

PRINCIPLE I

Respect for the Dignity of Persons and Peoples

1

The Faith and Courage of Immigrant Families: Some Lessons Learned Along the Way

M. A. Suzie Bisson

I love working with children; they are the next generation of our world. Children are enthusiastic, expressive, quirky, insightful, genuine, knowledgeable, energetic, curious, and creative. When offered a safe space to express their thoughts and emotions, I find that they consistently respond to the invitation by sharing their stories. They express what troubles them, what solutions they think would improve their lives, what gives them hope, and what they dream about. In sharing their stories, children demonstrate that despite their life circumstances they still have faith in life and faith in humanity—albeit to different degrees. It is both a humbling experience and an honour, as a psychologist, to be one of the recipients of these stories and a witness to their faith.

In my 20-plus years of working with children who have experienced trauma, they continue to amaze me. For over 12 years, my work focused more specifically on providing counselling services to children who are either foreign-born or born in Canada to immigrant parents. My goal in writing this chapter is not only to share my passion for the work I did with children but, more importantly, to share what these young people have taught me about being a more ethical counselling psychologist and, I believe, subsequently a better person. In this chapter, I use the term *children* to refer to persons younger than 18 years of age, and I use the term *immigrant* to refer to persons who were born outside of Canada. It is important to note that immigrant children are seldom the ones who decide to resettle in a new country. In fact, some children learn about the transition only a few days or weeks ahead of time; still others are informed of the permanency of their stay only once they are on the plane or after having landed in Canada.

Vulnerability and Resilience

Immigrant children are vulnerable persons. The *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association [CPA], 2017) defines the term *vulnerable* as:

> individuals or groups whose dignity, well-being and best interests are more easily violated due to such factors as: (a) characteristics of the individual or group (e.g., level of cognitive and emotional functioning; history of oppression); (b) level of voluntary consent/assent (e.g., serious consequences threatened if consent not given); (c) interests of individual or group compete with interests of more powerful individual(s) or group (e.g., claimant and insurance company); and (d) high risk of harm (e.g., life-changing decision based on inadequate assessment) (CPA, 2017, Preamble).

The children's vulnerability was made clear to me on many occasions during my conversations with them. I vividly recall listening to a youth asking me how far he and his family should live from a high-rise building located in downtown Calgary that had a myriad of glass windows, in case the building was to explode. I also paid close attention when: (i) an elementary student asked if teachers in Canada force students to stand naked in front of the classroom when they misbehave, and (ii) when a child asked about why he was asked to write a thank-you letter to soldiers in preparation for Remembrance Day when, in his country of origin, soldiers had killed his parents. With the establishment of a strong and positive therapeutic alliance, children's questions and comments speak loudly about their experiences and their worries. Their words and behaviours highlight the areas of their lives where they feel more vulnerable and where healing is needed. The examples I offer throughout this chapter are shared not to foster judgement or criticism upon any person, system, or country, but rather to help develop a greater understanding of the subtle intricacies that play a role within the context of counselling, and to foster a stronger perspective of respect, caring, and kindness for all persons.

Despite the many challenging experiences they encounter, children tend to be persistently resilient, even when their ways of doing so are not the healthiest. More often than not, they are willing to learn, to experience, and to give humanity a second, a third, and even a fourth chance to show them that peace, joy, and health are viable and feasible options in their lives. In their willingness to share their story and to look towards the future, children become excellent teachers. They teach us the importance of community, of respect and kindness, and of paying attention to what matters; also, they often help us understand that our words need to match our actions for trust to flourish. Moreover, they teach us that hope is one of the crucial elements in helping people move forward.

Principle I: Respect for the Dignity of Persons and Peoples

Throughout the chapter, I have chosen to highlight Principle I of the *Code* (Respect for the Dignity of Persons and Peoples), because of the central role it plays in an immigrant family's healing process. Due to having experienced limited control over their life circumstances, it is particularly important to take special care to integrate respect for immigrant families' self-knowledge, abilities and skills, as well as their goals and dreams, into the process and context of counselling. Although this could be said for all clients who seek counselling, immigrant families tend to have limited knowledge of the Canadian culture within which the practice of counselling psychology is embedded. As such, a more intentional and conscientious approach to Principle I is required to best meet the needs of immigrant families. The remainder of this chapter focuses on explaining and exemplifying what is meant by such a more intentional and conscientious approach.

Understanding a Family's Journey to Canada

Working with immigrant children entails also working with their parents or guardians. The parents' journey to Canada, at times, differs from that of their children. For instance, parents who come to Canada to work under the Temporary Foreign Worker program eventually are able, after having met numerous conditions, to become permanent residents and subsequently sponsor their spouses and/or children to join them in Canada. The process tends to take years and requires the parents residing in Canada to be separated from their spouses and children for an extended period of time. The long separation impacts not only the children and the parents as individuals, but also their relationship with one another. When trying to understand the journey of both parents and children, I have found that combining the model of refugee adaptation and development (Anderson et al., 2004) and narrative theory (White, 2000) is very helpful, as the combination provides structure and context to each immigrant family's journey. Through the process of learning about immigrant families' experiences, psychologists have the opportunity to demonstrate respect for the often-challenging life journey of each family member and to understand the influences that have fostered the decision to resettle in Canada.

Model of Refugee Adaptation and Development

The model of refugee adaptation and development proposed by Anderson and her colleagues is based on Bronfenbrenner's (1977; 1986) ecological systems theory. In this model, the pre-migration environment, the trans-migration environment, and the post-migration environment are each represented by an ecology (Anderson et al, 2004; Stewart, 2011). For instance, a parent who grew up in Eritrea (i.e., pre-migration environment), who then fled to Sudan (i.e., trans-migration environment) before resettling to Canada (i.e., post-migration environment) would have experienced three distinct ecologies. However, a parent who grew up in Eritrea (i.e., pre-migration environment), who then fled to Sudan (i.e., trans-migration environment), followed by a stay in the United Kingdom (i.e., second trans-migration environment) prior to resettling in Canada (i.e., post-migration environment) would have experienced four distinct ecologies.

Once in Canada, some families begin their journey in one province only to move to a different province months or years later. The level of similarity and differences between the two provinces is also important to consider. For instance, the provinces of Québec and Alberta are different in regard to their official language, culture, and some of their social systems (e.g., the structure of the education system). However, these provinces are similar in regard to other aspects (e.g., access to health care). As such, depending on the amount of time spent in various provinces and the level of integration experienced, a further ecological system could be added to represent the family's journey within Canada.

Taking the time to draw an ecological map, as originally illustrated by Bronfenbrenner, for each migration environment of a person's journey to Canada, including how much time the person spent in each environment, can be helpful to deepening psychologists' understanding of their clients' journey. The creation of such a visual representation for each parent's and child's journey serves to highlight the diversity of family members' experiences. For instance, parents may have met at different stages in their journeys (e.g., one parent was in their pre-migration environment when s/he met the other parent, who was in her/his trans-migration environment). Furthermore, children may have been born at different stages of the parents' migration. In addition, children might have been sent to live with relatives in various parts of the world (e.g., sending sons to live with a relative in an area where child-soldier recruitment is not as prominent) before reuniting with their parent(s), either prior to or after their resettlement into Canada. The creation of a visual representation is also helpful for identifying and understanding the similarities and differences between each ecology in regard to political, legal, and social structures.

In addition to creating a visual representation for each family member, is it important to consider each individual's developmental stage and level of integration within each of the ecologies (Stewart, 2011). For instance, a parent who spent 25 years in Eritrea before fleeing to Sudan will have a different experience of adaptation and integration in Canada than the parent who left Eritrea at the age of five and eventually resettled in Canada at the age of 10. Their sense of identity and their parenting approach will most likely reflect the strongest internalized aspect of their cultural heritage, which might differ for the parent who left Eritrea at the age of 25 years when compared to the parent who arrived in Canada at the age of 10.

The influence of an ecology is exemplified when looking at the impact immigrant children's Canadian school experience can have on their families. For instance, as a result of attending school where various educational and social supports are provided, immigrant children tend to learn ways of thinking and doing that are particularly encouraged and valued in Canadian society (Bisson, 2012; Rousseau et al., 1997; Stewart, 2011). Values are a good example in the sense that, although there are many common values across cultures, the way they are demonstrated can differ. Respect, for example, is a value that is important in all cultures of the world. Eye contact or the lack thereof is often an example of how demonstrations of respect can vary across cultures. In some cultures, a lack of eye contact is considered a sign of respect whereas in other cultures eye contact is encouraged. Another example would be that, in Canada, students learn and are strongly encouraged to develop and demonstrate critical thinking abilities in most, if not all, of their school projects. Through the process of developing such skills, children often practice them with their parents (e.g., Why can't my brothers help with the cleaning and cooking? Why is it only the girls who are expected to do this?). Depending on parents' culture and parenting perspective, being challenged by the children may be acceptable or may be viewed as a blatant form of disrespect.

Another dimension of respect relates to societal efforts to ensure everyone feels valued, appreciated, and safe in their community. In Canada, an important aspect of this includes helping people learn to appreciate and embrace diversity in all its forms so that everyone can experience a strong sense of belonging. Such differences in how respect, among other values and ways of life, is demonstrated can lead immigrant children to feel as if they live in two different cultural worlds (Fuligni & Tsai, 2015). Being able to successfully navigate two distinct and possibly overlapping worlds takes time and effort (Baffoe, 2006; Stewart, 2011). Therefore, understanding the nature of the ecologies that have fostered the development, and the formation of each family member's narrative, is imperative to supporting the creation of meaningful bridges between the various perspectives.

The Influence of Narratives

Although creating a structure from which to understand individuals' experiences is important, it is only one part of the equation. People are self-determined beings and as such they are the primary interpreters of their experiences. This is the premise of narrative theory, and culture plays a significant role in the development of people's dominant narratives (Hoshmand, 2005). Listening and paying very close attention to how parents and children interpret situations cannot be overstated. This lesson became very clear to me in the case of a child who had been diagnosed with schizophrenia. The mother had never heard the word schizophrenia before, and her understanding of the disorder was extremely limited. In her cultural perspective, the mother understood the condition to be a curse, which she suspected had been placed on the child by a jealous extended family member. As such, her plan for helping her child included taking her child to someone in her own culture who shared her spiritual beliefs and who could conduct a curse-removal ceremony. On the other hand, the psychiatrist who provided the diagnosis recommended that the child take medication and connect with other forms of support and therapy, such as counselling and recreational and group therapy. The psychiatrist also recommended that the mother connect with parenting supports. In addition to such different perspectives, people tend to hold various narratives about medication. This includes viewing medication as a placebo, a great help, or/and an approach for controlling the mind. This situation required that I take the time to listen to the mother's perspective and offer the family a creative approach that would best serve the child.

Regardless of where people are born or live, narratives exist. No one can live without them. They are simply a part of life, akin to breathing and dying. Immigrant parents and children are no exception. Although the model of adaptation and development (Anderson et al., 2004) helps to provide a structure from which to understand immigrants' journeys to Canada, it is the way parents and children interpret their experiences and reinforce the dominant narratives that carries greater weight. As such, being open to different perspectives and becoming excellent at *suspending judgement* are imperative for psychologists working with culturally diverse populations. This point was strengthened for me when a youth shared with me that Mr. Saddam Hussein, former President of Iraq, had been detrimental to the well-being of his ethnic group. A few days later, an adult shared with me that Mr. Hussein had provided great support to her ethnic group. Although surprised, it became clear to me that, while the content of the narrative is important, paying attention to the impact it has on the person's overall well-being cannot be overstated. This is where openness and suspending judgement can be most helpful.

Counselling Amazingly Resilient Immigrant Families

I have learned a great deal from the immigrant families I have met in my role as a psychologist, including how political decisions can impact vulnerable persons (e.g., how sanctions imposed by one nation on another can negatively hurt people who are just trying to survive). Perhaps, most importantly, I have learned that healing occurs when two or more human beings engage in a purposeful conversation or activity for the benefit of a child, adult, couple, family, or group.

Informed Consent

Not every language has a word or a term that is equivalent to the word *psychologist.* There are some parts of the world where people's knowledge about the role of psychologists is either limited or relatively non-existent. In other parts of the world, the role of psychologists focuses almost exclusively on supporting those suffering from a severe and debilitating mental health disorder. As such, I have found that spending time with parents and children explaining what psychologists in Canada do, and using words that make sense to them, is a crucial part of an ethical informed consent process. An important aspect of this process includes correcting the fairly common cultural/social misunderstanding that psychologists only work with people suffering from severe forms of mental health disorders. Since every culture has some form of counselling system (e.g., via a religious or/and a community leader, a group of elders, family members, or appointed peacemakers), making a conceptual connection between the role of psychologists and that of what the family would have experienced in their pre-migration or/and trans-migration environments can help family members understand how they could benefit from counselling services. In this regard, explaining what psychologists do in Canada is perhaps one of the first cultural bridges that therapists must construct with a family.

Confidentiality

During a first session, a mother once told me that she wanted "the Canadian version of confidentiality." Although I assured her that the Canadian version is the only one I provide, her request made sense because, at the local level, her cultural community is relatively small, and news appeared to travel quickly. There were even instances when the mother would connect with a family member living abroad only to find out that this family member was aware of information about her that was communicated by a local resident. These types of situations can be devastating for parents and families. This is especially relevant when a behaviour that is accepted in Canadian culture (e.g., a man who is cooking or cleaning the dishes at home; a woman who is working as a car mechanic) holds a negative interpretation within a different cultural context.

Explaining what confidentiality means within the Canadian context is extremely important. There are some parents who, due to their pre-migration or trans-migration experiences, may not fully believe that such adherence to confidentiality is possible. This is why it is important to earn their trust by diligently ensuring that words and actions closely match one another. Explaining the meaning of confidentiality also entails explaining its limits. Immigrant parents tend to be most worried about the limit related to child abuse. This is due to the frequent acceptance of corporal punishment as a disciplinary approach to parenting children in some cultures. As such, taking the time to explain the reasons why Canada enforces this limit and to create bridges between the two cultural contexts is imperative. This being said, asking parents to refrain from using an approach to discipline that is culturally appropriate to them can leave them feeling like they have lost a part of their power. Accordingly, bringing forth disciplinary approaches that are in line with the cultural and legal context of Canada can help mitigate parents' perceived loss of power. This is an important aspect of adaptation, which in turn does take time.

Interpreters

Psychologists have knowledge and skills that can be very helpful to immigrant families. However, if they cannot communicate with their clients, their knowledge and skills are of little value. As such, interpreters are a wonderful and indispensable resource in the field of counselling. Interpreters are often mistaken for translators. Although there is an overlap in the two roles and both are essential to the world, interpreters are the professionals who tend to be called in to bridge the language gap between psychologists and families. This is because there are many concepts (e.g., psychologists, some of the mental health disorders) for which no words exist in some languages. As such, an interpreter's role is to find a way to convey the meaning of a message from a psychologist to the person. Their role also is to convey the person's message back to the psychologist. Such messages consist of interpretation of verbal and nonverbal elements such as emotions, body language, gesturing, and facial expressions (e.g., in some of the cultures, raising the eyebrows means *yes*). In this way, interpreters can help psychologists understand and navigate the intricacies of a culture. This being said, the selection process of an interpreter can be filled with nuances.

Respecting families' preferences in selecting an interpreter is very important whenever possible (Kirmayer et al., 2011). Some families prefer to have an interpreter who is from the same country, cultural heritage, or religion as them. Other families prefer to work with an interpreter who can speak their language, but who is from a different region of the world, cultural heritage, or religion. Families' preferences for the latter often relate to their concern over confidentiality, especially when the local cultural community tends to be very small, and everyone seems to know each other. Depending on the presenting concern, it might also be important to consider the gender of the interpreter. For instance, a girl whose presenting concern relates to her experience as a sexual assault survivor might feel more comfortable working with an interpreter whose gender she gets to select (e.g., if the assault resulted from the actions of a male perpetrator, the girl might prefer a female interpreter). Being able to work with the same interpreter for the duration of the therapeutic process, or until the family has developed enough language skills to understand and express themselves in a language in which the psychologist is also fluent, is important. Doing so, I have found, increases consistency, trust, and predictability.

Like psychologists, interpreters also can be impacted by the experiences of families. Many interpreters have chosen this career path to help others, or because they have had the experience of not being able to communicate with service providers themselves when they first came to Canada, or both. For some, elements of a family member's story can serve to remind them of their own past experiences, no matter how long ago. Therefore, supporting interpreters' well-being is essential. One way to do this is to give them advance notice about what the plan is for the session. This is especially important when providing trauma therapy. Another way is to point out the improvements that are occurring from session to session (assuming that it is the same interpreter) and to remind them how their work has contributed in part to the changes. Further, taking the time to foster a positive working alliance is imperative to creating a foundation of trust and openness. This is especially important as it serves to create a safe space for the interpreter to communicate their experience should they happen to feel triggered in a session. Lastly, checking in with the interpreter after the session to find out how they are doing serves to strengthen the working alliance. Finding a professional interpreter who meets the family's preferences, who is consistently available, and who understands the process of counselling is both a gift and a pleasure to work with.

Approach and Interventions

Most counselling programs strongly encourage students to explore and select an approach to counselling that best corresponds to their own perspective of human nature and of healing. This is done for various valid reasons, including the need for therapists to feel in harmony with their approach to counselling (Arthur, 2001). However, I would like to propose that when working with culturally diverse clients, it is also important to select a counselling approach that best corresponds to the person's worldview and counselling goals. Not everyone will respond or benefit from the same therapeutic approach (Meier & Boivin, 2011). As such, it is crucial to develop and strengthen approaches to therapy that best serve the persons in need. In other words, while it is important to feel in harmony with a selected approach to counselling, it is imperative to choose an approach that will be well received by the people who sought support. This is one of the many ways that psychologists can demonstrate attunement and respect.

Selecting a culturally appropriate counselling approach, however, is easier said than done. I was working with a little girl on recognition and expression of feelings. Since she was not fluent in either French or English (the languages I speak), I invited an interpreter to join us to help us communicate. I selected a lovely children's book filled with beautiful and colourful images to help with the child's knowledge and skill development on feelings. The book used an externalization approach that is common in narrative therapy (i.e., the externalization of feelings by attaching different shapes and colours to them). At the end of the book, the interpreter, with a pleading tone, asked me to reconsider my approach. She informed me that in this particular language and cultural heritage, people tend to think more in concrete terms. As such, she went on to explain, externalizing feelings does not make much sense and kind of sounds silly. It then became clear to me why this little girl was giggling the entire time. She probably thought that I too needed help! I was, of course, very thankful to the interpreter for letting me know.

Although this experience continues to make me smile, it demonstrates that selecting a culturally appropriate intervention is more complex than anticipated. This is when having taken the time to develop competencies in a number of counselling approaches can be useful. However, it also is a time when supervision or peer consultation can be very helpful. The following two composite stories illustrate this very point. Specifically, they demonstrate when the interventions that are deemed appropriate in a Canadian context are simply not enough or do not bring the relief that they are meant to bring.

The first story pertains to a mother who managed to end family violence for herself and her children, which had begun after the family's arrival in Canada. The information, which she shared months following our initial meeting, was that she was tired of living in and out of women's shelters, of having to go to Court to obtain restraining orders that did not seem to make much of a difference, and of moving her children from school to school depending on which shelter had space at the time. The mother explained that she finally opened up about her struggles to one of her family members who was still living in her country of origin. She explained that this family member resolved the situation by contacting her husband and threatening to harm one of his family members each time he committed an act of violence against the mother or her children. This family has been living in relative peace ever since.

Another mother in a similar situation decided, with the extensive support of social services, to leave her husband and to live on her own with her children. In making this decision, some key members of her family and community chose to shun her for having left her husband. The mother, who adheres to a collectivist way of life, found the loss of support from her social network to be more painful to bear than the ongoing abuse. The mother felt stuck, discouraged, and confused. As a result of the pressure she experienced from her family and community, the mother decided to reunite with her husband.

Both situations were learning experiences for me. Although peace and harmony are optimal outcomes whenever violence is part of a problem, the actual outcome is influenced by an interplay of a multitude of factors for which psychologists have little or no control or influence. Persons are self-determined beings who must decide what is best for themselves and their families given the knowledge, skills, and resources they have. Interventions and counselling approaches that are deemed appropriate in a Canadian context can at times fall short of producing the optimal outcomes sought. Or, as in the case of the second example, the intervention can produce unintended outcomes that can be perceived by the person as a greater source of harm than the original presenting concern. Hence, there is a need for psychologists to be aware of, and to communicate and prepare clients for, potential unintended outcomes that well-intended interventions can have. In doing so, clients can then choose if they want to proceed with the intervention. Overlooking the importance of communicating, or at least discussing, potentially unintended outcomes with clients can negatively influence the therapeutic alliance. This is when professional experience and regularly connecting with mentors can help.

When People in Need Decline

Research has demonstrated time and time again that the therapeutic relationship plays an essential role in counselling (Norcross, 2010). This relationship serves as the foundation for both parents and children to express their goals and wishes. For instance, many parents will accept counselling for their children in order to ensure that the family's pre-migration and trans-migration experiences have limited impact on their children's development. However, despite feeling emotional pain or distress from their experiences, many parents will decline counselling services for themselves. Although there can be a time, a cultural, a spiritual, or a personal component to their decision, I have come to understand that for some parents, holding on to the pain serves as a reminder of their journey, a connection to their past, and a reminder that not everyone was able to survive or to come to Canada. It also serves as an active connection with local community members. Although it can be a challenge to accept, that pain can have such a uniting role. I find that respecting parents' decisions is key to ongoing collaboration. Perhaps one day they may come to embrace the realization that pain need not be a uniting factor.

Like some of the adults, some of the children also choose to hang onto the pain of their experiences. In such instances, the goal of counselling becomes less about reducing the impact of the painful experiences in their lives and more about how to transform these experiences into a source of inspiration. For instance, a child who struggles with anger as a result of his family having been negatively impacted by an armed conflict could be encouraged to speak up about the importance of peace or, depending on age, to become involved in social justice events. Empowering children to use their time and energy to support peace and justice can show them that their voice matters and that healing can take place on their own terms. Helping children to develop into strong yet peace-promoting advocates can foster their healing and their leadership skills. Psychologists are aptly capable of nurturing the development of peaceful leaders. The world is certainly in dire need of them.

Time and Timing

Time is a culturally driven concept (Fulmer et al., 2014). Psychologists generally structure individual sessions to last approximately 50 minutes. Language variations, however, influence the amount of time a session needs to be. In my experience, a 50-minute session, where English is the language at hand, takes 75 minutes for the same conversation in French (e.g., the French version of an abstract for a paper is consistently longer than the English version). When the session is being interpreted, doubling the allotted time is essential. Allowing enough time for each session is key to helping immigrant parents and children feel welcome to the process of counselling.

In addition to time, self-expression is also influenced by one's cultural heritage. Some people tend to be very direct and to the point. When they present the concern that brings them to counselling, they tend to voice their goal near the beginning of the conversation. Others need to communicate their presenting concern by telling their story from the beginning to the current time. It is only after they have completed telling their story that the goal becomes evident. Individuals who relay information by telling their story from beginning to end tend to need more time. Trying to rush or interrupt them or to find out what their goal is for counselling before they are ready to voice it tends to impact the establishment of a positive therapeutic alliance in a negative way. Taking the time to listen, on the other hand, tends to strengthen the alliance. Although it can feel like a challenge at times since psychologists are also human beings, demonstrating patience, acceptance of a person's storytelling style, and kindness can foster trust and openness. After all, counselling is a process for which time cannot and should not be a restrictive factor.

Conclusion

Counselling is an approach to health that should be both available and accessible to everyone. As this chapter has demonstrated, there are many factors that influence immigrant parents' and children's therapeutic experiences. In respecting Principle I (Respect for the Dignity of Persons and Peoples), psychologists must adapt and respond to the culture and needs of immigrant families. Until such time as they are more fully integrated into Canadian society, immigrant parents and children can be considered particularly vulnerable. As such, they have the right to receive the additional attention they need, including extra time, information, understanding, perspective taking, and empathy. By imagining what it might be like for them within the context of a myriad of situations, the approach to helping them achieve their counselling goals becomes clearer. By connecting with immigrant parents and children, we demonstrate to them that their voice matters, they have choices, we are open to learning from them, and we all are connected in some way or another. The latter is especially important for children to learn and internalize, as they are the leaders of tomorrow. My hope for all children is for them to experience a world in which violence and trauma are not current and are reflected upon only as historical events. My hope is for all of them is to experience an ongoing sense of belonging to their community, peace and joy.

Questions for Reflection

1. What do you think about the model of refugee adaptation and development discussed in this chapter? What do you like or dislike about the model? Can you see yourself using it?
2. You are 14 years old and have been living in Canada all your life. Your family is moving to Baku, Azerbaijan. What would facilitate your successful adaptation? How would you like your public-school teachers to support you? What would facilitate your parents' adaptation?
3. How would you go about creating bridges for differing cultural beliefs and responses to family violence, child expectations based on gender, or serious mental health problems (e.g., a psychotic episode)?
4. What biases do you have that could impact your work with Canadian newcomers? What strengths do you have that would help you meet the counselling needs of immigrant families?

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2

Start with Hospitality: Towards Enhancing the Counselling Experience with Muslims

Mahdi Qasqas

> *My life's journey has given me opportunities to promote aspirational and relational ethics—reaching for the stars, but accepting that what one contributes to the journey may be more important in one's lifetime and more realistic than achieving Utopia.*
>
> Pettifor, 2005, p. 213

Above all other principles, *Respect for the Dignity of Persons and Peoples* (herein referred to as Principle I) "is the most fundamental and universally found ethical principle across disciplines" (Canadian Psychological Association [CPA], 2017, Principle I, Values Statement). If ethics sits at the core of the professional practice of psychology, then, it stands to reason that Principle I lies at the core of our ethics as psychologists. In this chapter, I posit that the virtue and practice of hospitality is advantageous in upholding Principle I and in demonstrating cultural competence; in turn it enhances the likelihood of positive therapeutic outcomes and reduces premature termination, especially amongst underserved populations.

Scholars have identified a range of challenges in relation to accessing and benefiting from mental health services by immigrants, refugees, ethno-cultural communities, and racialized Canadians (Arthur & Collins, 2010; Collins, 2018).

The primary barrier to accessing services is subsumed under the generic category "cultural incompatibility of existing services" (Mental Health Commission, 2016, p. 12). Although Canadian-based research is still developing in this area, the position taken in this chapter is that hospitality, when culturally responsive, can serve to mitigate feelings of cultural incompatibility and build strong bonds of trust and respect early on in the counselling journey. By doing so, the weight of the working alliance is also likely to mitigate minor ruptures in the relationship due to the lack of initial cultural compatibility.

The order of this chapter is as follows: After introducing myself to you, I will explain why I chose to write on this topic and the reasons I prefer to call the recipients of my psychological services guests, over all other terms (e.g., "customer," "client," "patient"). I then analyze the relationship between hospitality and overcoming constraints that are known to prevent Muslims (and likely others) from accessing mental health services or prematurely terminating such services. For those with more limited knowledge and/or experience of working with Muslims, I hope to reduce feelings of inadequacy or assumed incompetence (e.g., impostor syndrome) by offering some practical strategies, using Muslims as the running example.

As an important caveat, despite having over 20 years of experience working with thousands of diverse Muslims in varying roles, I am still passionately learning about the vast intracultural differences. With over one billion Muslims living across the world (Pew Research Center, 2011), and over one million in Canada (a number that is estimated to reach over 3 million by 2030 [Statistics Canada, 2013]), it is essential to know (and I imagine you already do) that Muslims are not a monolithic community. Furthermore, there are no quick fixes or one-size-fits-all practices to working with Muslims (Graham et al., 2009, 2010) or any other groups for that matter. Nonetheless, a practical and essential first step to demonstrating cultural competence and building a therapeutic alliance would be to practice hospitality. I hope to demonstrate through the brief examples of Sarah, Fatima, and Adam how this looks. Although this chapter is mainly focused on Muslims, I believe that hospitality almost always has a positive impact on the therapeutic alliance and thus should be considered an essential micro-skill for psychologists and other practitioners in adhering to Principle I. The reflection questions at the end of this chapter are aimed at providing readers with a strategy to extrapolate learnings from this chapter that can be applied to other culturally diverse populations, while also hopefully deepening your critical thinking.

Positionality and Purpose

Currently, I am a registered psychologist in Alberta with a Master of Counselling degree and PhD in social work; however, my journey to this end was certainly not linear. Rather, I started off in computer science, meandered into the field of psychology, then continued the journey into criminal justice. Eventually completing a Bachelor of Arts in Psychology with a mathematical sciences minor and later a Bachelor of Professional Arts in criminal justice. The intersection between these fields makes issues of social justice and cultural competency important and exciting for me in my practice, education, and research.

At the practice level, as one of the few Arabic-speaking Muslim psychologists in Alberta operating a private practice, I have the privilege of assessing and treating individuals from various cultural backgrounds, with a specialization in working with Muslims. Furthermore, I also have the honour of offering contracted and pro bono consultation with non-profit Islamic organizations and provide train-the-trainer programs that apply much of what I have learned throughout my doctoral research. For example, I often train Muslim clergy and youth workers (male and female) in counselling techniques and support future mental health professionals through mentorship and supervision. I find these roles have helped me to build strategic partnerships towards addressing constraints to services. I believe my specialization is attributable not only to my academic credentials but also has been gradually building over the last 20 years by volunteering in the community as a serious leisure pursuit.

Working *in* the Muslim community as a youth counsellor many years ago was quite eventful and full of learning experiences for me. My first set of activities included giving motivational talks, which were often rehearsed and quite terrible, to Muslim youth in public schools. Over time and through constructive feedback from others, the quality of my talks appears to have improved. I also became more heavily engaged in developing and executing a range of programs tailored for Muslim youth. Ongoing collaboration with community leaders and stakeholders led to the purchase of a building to house a locally funded and operated Muslim Youth Centre in Calgary. As the director of the centre, I had the honour and privilege of working with others to run many programs, with hundreds of Muslim youth being served on a weekly basis.

Student leadership at the post-secondary level was also an important part of my journey. In 2002, my best friend (Moaz Sabbah) and I initiated the first Muslim Students' Organization at Mount Royal College in Calgary (currently Mount Royal University). In 2004, after moving to Edmonton, I launched the first Muslim Students' Organization at Grant MacEwan Community College (currently MacEwan University). Shortly after, I returned to Calgary to bury my best friend. I recall that despite all the leadership activities we had done together, our favourite activity was fundraising to support international orphans. I learned from Moaz (and Jean Pettifor) that collecting pennies was just as satisfying as raising thousands of dollars and that it's the process that matters most. The positive influence Moaz had on my life and the lives of so many other people can be clearly seen and has been paid forward with their dedication to contribute their time and money to the orphan sponsorship program. For me, volunteering for this cause became much more than a leisure pursuit and began to feel like a serious, but volitional, obligation to help others at a deeper level. Although this is not related directly to why I became a psychologist, it certainly laid the foundation to get to where I am today.

Despite these successes, my impostor syndrome would kick in from time to time and I would question how I had acquired the status of being "the youth guy"; that is, the expert on Muslim youth. Anytime a youth issue was brought to community leaders, I was included in the decision-making process and delegated the responsibility of addressing the issue. However, I had not undergone any training or any formal evaluation of my progress. Despite completing course work in psychology, it was not until I engaged in supervised practice at the Calgary Young Offender Centre that I began to truly develop my counselling competencies. Nevertheless, I believe it is important to recall that even though we may never feel truly competent, it is the small contributions to our knowledge and skills development along the journey that really matter. Especially in how we apply our ethics to populations suffering from injustice, something quite pronounced after 9/11.

After 9/11, Everything Changed

When 9/11 happened, everything changed, with Islamophobia and outright hostility to Muslims becoming much more apparent, along with a surge of social welfare and mental health needs amongst Muslims and unprecedented challenges facing Muslim community leaders and activists (Shier & Graham, 2013). Ten years later, the crisis of ISIS (the Islamic State of Iraq and Syria) and the so-called war on terror has aggravated Islamophobia even further and created more complex challenges in the Muslim community. For example, despite the tremendous pro-social activities inspired by their faith, public discourse indicated that the Islamic faith was seen as a primary risk factor to youth radicalization (Qasqas, 2018a). This prompted many others and me to hold a summit on the topic of preventing criminal radicalization. I used the term criminal radicalization for two reasons: (a) to discourage the use of inaccurate, inflammatory, and disrespectful terms like "Islamic radicalization," and (b) to provide researchers and practitioners with clarity on a stretched concept. By doing so, I believe it made it easier for the community to work more interdependently with security officials and law enforcement towards crime prevention under the assumption of respect for the dignity of the Muslim community.

I have been to the Pentagon, toured across the United States in an international visitor leadership program, given testimony to the Canadian senate, and provided keynote speeches at international Universities addressing criminal radicalization. The message I consistently delivered is that there is absolutely nothing wrong with Islam, but that some Muslims need reform. That is to say that, regardless of where I presented, the primary concern was preventing criminal radicalization, which cannot be done by challenging the faith and ultimately alienating its followers. In my opinion, such an approach is insulting and an affront to respecting the dignity of the entire population. Rather, it is important to recognize that adherence to an authentic version of Islam is the key to preventing criminal radicalization and reforming Muslims who are ignorant of their own faith and use it to justify heinous crimes.

Ignorance of the Islamic faith by both Muslims and others is certainly a troubling context and one primary reason behind choosing to focus my writing on this diverse, large, and dynamic topic. However, I also realize that developing cultural competency on any diverse population takes time and a great deal of effort in building a solid foundation. Thus, as a necessary first step, I suggest starting with reflection on what it truly means to respect the dignity of persons and peoples, and on how one's views of Muslims are either grounded in Principle I or perhaps require some reconstruction through a reflexive process. To this end, I suggest considering how the adoption of the virtue and practice of hospitality can be a pragmatic and promising step in this journey.

A Reflection on Terminology: Whom Do We Serve and Why?

In the most recent edition of the *Canadian Code of Ethics for Psychologists* (CPA, 2017), one of the major changes in terminology reflects a higher degree of attention to cultural diversity. I recall, during my master's level education, having fruitful discussions about the most useful term to use when referring to the recipients of our services, and why. For instance, are they patients, customers, clients, or patrons? The purpose, I believed, was to have students think about the importance of language and its influence on attitudes and behaviours. In retrospect, I can see that this exercise offers a rich learning experience as it allows one to bring to consciousness moral sensibilities in relation to our practice.

Let us start from the beginning of the counselling process to answer the question of labels. I find it reasonable that, prior to informed consent for services, and at the most basic level, we are initially a host to a stranger. Engaging in pre-service planning that maximizes the sense of hospitality (so the guest does not feel like a stranger) becomes a primary objective. Making the terms "guest" and "hospitality" applicable is a fundamental component of this process. Various activities can influence the guest's perceptions and, in a small way, enhance adherence to Principle I. The service begins with the initial greeting and, in the sections that follow, I hope to provide you with a deeper and more nuanced cultural understanding of the role culturally responsive hospitality can have in enhancing therapeutic alliances with Muslim guests; which in turn increases the positive experience and decreases the likelihood of premature termination.

Hospitality, Greeting, and Understanding

Hospitality in this chapter is defined as "the friendly and generous reception and entertainment of guests, visitors, or strangers" (Oxford Dictionary, 2020). The greeting phase of the intake process can serve to enhance the guest's perception of the counselling experience; therefore, it is important to reconsider the impact of conventional practices on the sense of hospitality amongst culturally diverse guests.[1] There are many ways of practising hospitality and making people feel safe and respected; however, at times, conventional practices may have the unintended result of hindering such feelings.

Take for example how obtaining informed consent is commonly practiced. Since informed consent is a process and not the outcome of a signed document, this common practice requires some reflection. Furthermore, despite a signature on a form implying a contractual agreement, it is in no way a substitute for the essential process of ensuring that the guest is clearly informed on what they are consenting to. Although a signed document may occur eventually, it can be done more meaningfully after developing a deeper understanding of the guest's worldview, presenting concerns, and expectations. In my opinion, making the process as familiar as possible from the beginning is an optimal practice and demonstrates a higher adherence to respecting the guest's worldview. In the next section, I highlight the importance of matching the greeting phase of counselling with cultural norms grounded in the worldview of the guest. With Muslims, this small act starts with a common phrase and value simplified in two words, *Salamu Alaykum*.

Salamu Alaykum is More than Just a Greeting, it is a Commitment to Hospitality

If you have never heard the phrase *Salamu Alaykum*, then how exciting it is for me to be the first to introduce it to you. It literally translates into *Peace Be Upon You*. It is the common greeting made between Muslims but goes far beyond just a greeting and is understood regardless of linguistic background. Nonetheless, beyond the words themselves, it is the spirit of peace that is a hallmark of this greeting, and subsequently of hospitality.

To go a little deeper into the cultural nuances, by offering a range of exotic teas, coffee, instant soup, or even a light snack, is an effortless gesture that can have profound impact on the guest's experience. Although such offerings are not mentioned in the *Code* or in practice standards, it is here where the practice and virtue of hospitality can be seen as taking on a higher degree of respect for the guest than what is expected. I believe the simple offerings are a basic minimum requirement that has a lot to do with cultural norms in collectivist societies, especially amongst Arabs. To take this a step further, greeting the guest with an offering is filled with cultural nuances. For example, in Arab cultures (even if born and raised in Canada), it is quite common for the guest to reject the first offer for tea or coffee. It is important that such cultural nuances also be understood by office staff. Consider the following scenario:

> *Receptionist* (In Arabic): Would you like tea or coffee?
>
> *Guest*: No, I am Ok, thank you!
>
> *Receptionist*: Are you sure?
>
> *Guest*: Yes, I am sure.
>
> *Mahdi* (After welcoming the guest into the counselling room): What would you like to drink? (Followed by a list of different types of tea in the guest's common tongue)
>
> *Guest*: I am OK.
>
> *Mahdi*: Ok, coffee then.
>
> *Guest*: Actually, tea would be great.

Now, had this been someone who clearly did not want anything to drink, it could have been perceived as annoyingly pushy. However, this act alone has a tremendous amount of utility, as it not only relaxes the guest but also enhances rapport and provides opportunities to begin the counselling process more naturally. That is, it often leads to a smooth transition into exploring the guest's worldview and thus transitioning quickly into developing a deeper understanding of their lived reality. By making the first few minutes more familiar, it is also likely to reduce their uncertainty and, ultimately, their anxiety. At that point, I believe the bonds of trust and respect begin to form.

I also found that by learning as much as possible outside of the counselling session about common terms used for simple day-to-day activities in different cultures, can send a strong message of familiarity. For example, there is a well-known drink amongst Lebanese people called *matte*. Each time I offer something, and they refuse, I say something like "I'll bring you *matte* next time." It *always* results in a chuckle. Although having a high degree of knowledge of the cultural nuances and micro-details related to the guest may feel overwhelming at first, it is more reasonable to view it as a cumulative process that builds over time. Also, starting from the position that hospitality is critical encourages the psychologist to keep developing this area of knowledge. As you develop a deeper understanding of the guest's unique experiences and strongly held values, infusing these values into each stage of the therapeutic process is more likely to enhance satisfaction, commitment to therapy, and therapeutic outcomes (Arthur & Collins, 2010). In the next section, I provide an example of how this can be done with Muslims during the essential informed consent process phase.

Informed Consent, Privacy, and Confidentiality

When discussing issues of confidentiality and anonymity, I find it advantageous to integrate evidence from the guest's strongly held beliefs. With Muslims, integrating Islamic sources bolsters the centrality of these ethical values and likely adds an extra level of reassurance to the guest that their private life will not be leaked to their community. With one guest who came to me for help with a very sensitive and unique case, I added to the conventional discussion on privacy and confidentiality that breaking confidentiality would be tantamount to hypocrisy from an Islamic perspective. In the Islamic faith, hypocrisy is regarded as the worst possible sin and based on Prophetic communications (called *Hadith* in Arabic[2]), the signs of a hypocrite include lying, breaking a promise, and violating trust (*Sahih al-Bukhârî*, 3: 847).

Therefore, breaking confidentiality without agreed-upon rules and standards would be tantamount to lying to the guest, breaking the promise, and destroying the trust. By grounding the informed consent process in the guest's worldview, it is likely to send the message that the trust in the relationship is built upon more than just conventional practices known to the psychologist and that are possibly foreign to the guest. The issue of incompatible views on ethical dilemmas is even more complicated when it comes to dual-role relationships amongst smaller groups that resemble rural communities, and these dual relationships are discussed next.

Dual Relationships

Dual-role relationships can be harmful. However, I do believe that not having a deeper understanding of this ethical issue and assuming that dual-role relationships are always unethical is a misreading of the underlying values involved. As one of the few Arabic-speaking psychologists in Alberta, I have spent a lot of time and energy on preventing ethical dilemmas from arising due to my active involvement in the community. However, despite the differences accepted by the regulatory bodies related to psychologists working in rural or small communities, preventative steps are important to consider and well worth the perceived personal sacrifices.

For example, when working with Muslim guests, even in large cities, the likelihood of running into them in the Mosque during *Eid*[3] (a major celebration), weekly congregational prayers, a wedding, or even at the local supermarket is high. Thus, I usually explain to my Muslim guest that, if I see them in the community, I will intentionally not approach him or her, but if they happen to approach me, I will not ignore them. Attending to this issue in the intake session can reduce their worries about having their privacy violated in those various scenarios and prevent a situation that may have the guest feeling disrespected or ignored. Furthermore, addressing this issue reinforces respect for their moral right to privacy and adds another potential factor to a building rapport early on.

Furthermore, I have reduced many of my social activities in the community and appear in public primarily only when I am in a teaching or in a public-figure role. This is a lifestyle that I have accepted as I believe that the duty to the guest comes first, far before my own personal benefits. Psychologists who take up a trailblazing role in non-dominant populations may have to do much more than other psychologists working in the mainstream. It may sound unfair, but personally I do not see it that way. Rather, I believe it to be part of the higher duty of care that psychologists have to their guests and is rooted in both the values espoused by the *Code* and the psychologists' personally held principles. In relation to the virtue and practice of hospitality, there is an old Arabic adage that establishes the degree to which hospitality is applied. It states that if you are happier with a guest taking something from you rather than bringing you something, then you are truly hospitable. I like to believe that I fall under the latter group. As such, it is easier to reframe the costs not as sacrifices, but as small contributions to the requirements of hospitality which can be very beneficial in helping to overcome challenges related to premature termination and poor therapeutic alliances. In the next section I will shift the focus towards integrating the guest's worldview as an important factor related to Principle I and to ameliorating two types of constraints.

Overcoming Constraints Through a Deeper Understanding of Principle I

Barriers are assumed to be insurmountable challenges (Crawford et al., 1991), whereas constraints are defined as aspects that limit the "use of services, and satisfaction or enjoyment of current activities" (Scott, 2003, p. 75). Therapy constraints can be structural (e.g., cost of therapy and language barriers), intrapersonal, or interpersonal.

"Is He Pushing Religion on You"

Applied to counselling, the attitudes people hold about mental health, as well as how therapists evaluate the worldviews of others, can both be seen as intrapersonal constraints (Scott, 2003). One area where I have found Principle I to lead to positive therapeutic outcomes in many guests is related to integrating faith-based concepts into practice. Early in my counselling practice, I would always hold back from integrating faith-based concepts with guests due to not being able to directly point to any evidence in the literature to support that exact intervention (which I now know is an area of research with many opportunities). Although I assumed it was competence holding me back, when I reflect on this issue, I realize that part of the problem is related to how faith, especially the Islamic faith, is perceived by other professionals. I recall one experience that still pops up in my mind from time to time that I would like to share with you.

Sarah (pseudonym) was a pleasant young girl enrolled in a highly prestigious private school. Her parents had reached out to me for support. After meeting her and building a strong rapport, she began to make considerable progress. The school psychologist who had been working with Sarah had said to her "Is he pushing religion on you?" Sarah was offended by this and informed her parents, who relayed the information to me. My response to them was that "I am sure she is just looking out for her best interest." But deep down inside I was troubled, and still am. It made me think a lot about the first ethical standard in Principle I, respecting the dignity of other professionals and how this simple question can be perceived as a disrespectful.

Although Sarah's school psychologist's views of Islam were unknown to me, the socio-political climate surrounding Muslims may have had something to do with it. Nonetheless, when it comes to integrating faith into counselling, despite ample evidence to support such a practice (Gonçalves et al., 2015), I approach this issue with careful consideration and engage in a series of techniques to ensure that doing so is in line with the guest's right to self-determination. I also believe that pushing religion on anyone is morally wrong, especially when such a power differential exists in therapy. In training Mosque staff and clergy, I often quote a verse from chapter 2, verse 256, in the Quran to support this view. The quote declares that there should never be any compulsion in religion (Khattab, 2017).

Over time I have developed many strategies to explore the guest's worldview and to explain my approach during the informed consent process, looking for cues as to whether they want the integration of faith into the evidence-based practice I use. Initially, I do not ask explicitly if they prefer a spiritually integrated approach as I worry that it may be perceived as a form of coercion. After all, if the individual perceives themselves to be a practising Muslim, they may feel that it somehow may be wrong to decline. It is also possible that guests may feel obligated to present as religious when in fact they are not. Regardless, as complicated as this strategy may appear, it should be noted that these issues are related to specialized practice and thus not expected by all therapists, whereas core skills that lead the guest to feel safe enough to speak freely and without judgement or criticism would be expected.

"What! I'm Not Crazy!"

Interpersonal constraints also can emerge from social interactions such as a loved one or a trusted figure having a negative view of seeing a stranger for counselling. Such challenges are common amongst Muslims (Saleem & Martin, 2018). It is not uncommon for Muslim guests (and many other cultural groups I work with) to hold the belief that seeing a psychologist somehow indicates that one is "crazy." At the greeting phase, overcoming this constraint goes something like this:

> *Mahdi*: Have you ever seen a psychologist before?
>
> *Guest*: No!
>
> *Mahdi*: When they referred you to me, what did you think?
>
> *Guest*: . . . (with eyes wide open and looking at me as though I was offended)
>
> *Mahdi*: Let me guess, you probably thought, "What! I'm not crazy!"
>
> *Guest* (Bursting out in laughter as the "Ha-Ha" enables the "Ah-Ha"): Yah, Yah!

This exchange quickly transitions into challenging the stigma, explaining what they can expect in therapy, and making the therapeutic process seem as though it is something already inherent in the guest's worldview rather than foreign to it. However, normalizing the process requires an understanding of what is normal for the guest. This may require us to go beyond our own assumptions of normalcy. After all, our world may be totally foreign to the guest, and vice versa. Paying careful attention to possible cultural mismatches is key to preventing ruptures in the relationship.

"I do Not Want Western Psychology"

Interpersonal constraints also can emerge from previous negative experiences with counselling. I recall a guest from several years ago who was referred by her physician with concerns of possible post-traumatic stress disorder. Fatima (pseudonym), a married woman in her sixties, was born in Africa and had moved to Canada over 10 years before. She had seen a therapist and was displeased with the service, returning to her physician in disappointment. Knowing that I am a Muslim, she felt more comfortable trying again, but was still reluctant. She was brave enough to attend the session and assertively stated in the first few minutes of our Interaction, “I do not want Western psychology. I am a Muslimah[4] and I want Islam.”

For Fatima, it was not the first time she had seen a psychologist. Whereas the stigma may be common to those who have never seen a psychologist due to the uncertainty of what to expect, she had been referred to a therapist and was displeased with the service. Without exploring her experience in detail here, it was apparent that her view of the field was shaped by her negative experience. I was able to discern with a reasonable degree of certainty that the issue she had with her previous psychologist was primarily due to a clash of worldviews. By the end of our journey together, she became convinced that what we had been doing in-session was indeed Islamic from her perspective and evidence-based from mine. For example, when the session was structured around spiritual development, she felt safe and would engage in the techniques we would discuss, with no hesitation. Even if such techniques required challenging some of her religious perspectives (this will be discussed in more detail later in the chapter with a different client). Furthermore, she would complete the homework with pleasure, despite being so busy in her personal life, and she was adamant about returning—all positive indicators.

I believe that it was the feeling of being respected that solidified the bond. In turn, this contributed to the positive therapeutic relationship and outcomes. Irrespective of one’s expertise in interventions, if Principle I is not upheld, premature termination is more likely. Whereas others may have a general reluctance and anxiety stemming from uncertainty or stigma, Fatima had had a negative experience with another therapist that made her feel disrespected. It is reasonable to conclude that such a poor previous relationship would make challenging dysfunctional patterns of thinking that were grounded in religious beliefs practically impossible and that questions and comments to this effect could be experienced as offensive, even if challenging the patterns was evidence-based, rational, and necessary.

Challenging Religious Views

Cultural competency is necessary, as adherence to Principle I may lead a therapist to not challenge dysfunctional religious views due to a fear of offending the client. One frequent concern Muslim guests express about seeing a non-Muslim psychologist is that they are worried their religion will be seen as contributing to their pathology, will be excluded from the process, or will be misunderstood. Although this is usually a misconception, it can be true. This is perhaps where Islamically integrated therapy is most applicable but also most dangerous if the therapist is not competent in such therapy, even if the therapist is Muslim (See Principle II for more information on the importance of competence.)

For example, with Adam (pseudonym), the primary concern was obsessive compulsive disorder of the Islamic variety (not an actual type of OCD, but a phrasing that I find useful). When he engaged in the ritual ablution or washing up before prayer, he obsessed over whether he did it right or not and would repeat the ablutions several times. There were other problematic areas, including his fixation on whether the detergent his mom used had by-products that came from pigs (a religiously prohibited animal to consume in Islam) or whether his ill-feelings towards others would somehow cause them harm, and his excessive search for the right way of doing things from an Islamic perspective. These behaviours were causing him extreme distress and problems with his family. Although many different interventions were used in a culturally adapted format, the excerpt below demonstrates one reframe that opened the door to challenging the errors in his Islamic understanding as it related to his compulsive behaviours:

> *Mahdi*: What is the purpose of Islam?
>
> *Adam*: Uh . . . to guide us, tell us what is right and wrong . . .
>
> *Mahdi*: All that sounds like control.
>
> *Adam*: . . .
>
> *Mahdi*: You see, all that is a function of Islam that leads to the ultimate purpose, which is to know God.
>
> *Adam*: I never thought of it that way.

This type of dialogue has been well received by many of my Muslim guests and helps to differentiate between extrinsic and intrinsic forms of religiosity. Extrinsic forms of religiosity focus mainly on obligations and include a sense of external or internal pressure. The intrinsic form of religiosity includes a feeling of volition and wanting to engage in a religious act because the guest values it, or it is internalized into their sense of self. If the guest is motivated to practice their faith at a stronger level, adding a more spiritual dimension to their religiosity is warranted. If religiosity is seen as objective behaviours (e.g., prayer and fasting), then spirituality is the unseen quality of those behaviours based on the intention and sincerity of the act (Qasqas, 2018b).

Focusing on the ultimate purpose of Islam was not an attempt to suggest in any way that what Adam believed to be obligatory should be dropped; rather, it was to help him shift his motivation from extrinsic to intrinsic and from religious to spiritual. Utilizing the Islamic concept of intentions was essential and advantageous to move this line of thinking forward. Contrary to what might be assumed, freedom and self-determination are fundamental concepts in Islam.

Furthermore, the same concept can apply with Muslims parents who often are distressed over whether their children will keep their Islamic identity strong or not in a Western environment (Yousif, 2008). When the guest's faith is integrated into the process, it allows for stronger relationships to be built between family members as they begin to drop dysfunctional ways of unknowingly using religion as a form of control rather than a tool for liberation and happiness. Not having a deep understanding of the Islamic faith may not be something that most current and future psychologists need to stress over; instead, they can rely on their unconditional positive regard, openness, and effective listening. However, having a negative view of Islam and Muslims with no rational justification or concern for addressing such views, may not only be a direct violation of Principle I, but also a symptom of Islamophobia.

Limitations to Hospitality

Although being hospitable may be something that a guest expects or becomes comfortable with, it should not be assumed that it is universally acceptable. Some guests may conflate formalism with professionalism and not interpret the act in the same way. In addition, it should not be held as a virtue that always has benefit. If the construct of hospitality is to be studied further, possible negative aspects certainly should be explored. There may be times when being hospitable can have negative impact. For example, being hospitable may come off as insincere or manipulative. It also may run the risk of the guest-host relationship becoming overly familiar rather than friendly. As such, establishing clear boundaries becomes paramount—another area related to the informed consent process. There are likely many more limitations, but for now, culturally responsive hospitality does not require an unreasonable degree of work.

Nonetheless, I believe with reasonable evidence that integrating the guest's worldview into therapy is very advantageous and that it is supported by Principle I and ample research. This, in my view, is the hallmark of respecting the guest's inherent worth, dignity, and right to self-determination. Furthermore, gaining a broad level of knowledge about various cultures and the many intracultural differences is one important aspect of developing cultural competency. However, knowledge is necessary but not sufficient for competency. Skills, judgement, and diligence are also necessary and are likely to develop over time. Starting with culturally responsive hospitality may prove to be a great step.

Recommendations Towards a Deeper Understanding of Muslims

To develop a deeper understanding of the lived reality of Canadian Muslims, visiting a Mosque or getting connected to a post-secondary Muslim Students' Association is strongly recommended. If neither of these practical strategies work for you, a third could be offering your Muslim guest a free session for you to ask questions about their lived reality (with their consent, of course).

Mosques and Muslim Students' Associations

If you have never visited a Mosque before or have apprehensions about it because you would feel like a stranger, I hope this section will change your mind. By visiting a Mosque, you may be able to get a better sense of how it may be useful for your Muslim guests. Of course, not all Mosques are the same and some may not have an open-door policy—not for any specific cultural reasons but primarily due to the lack of staffing. Keep in mind that most Mosques are grass-roots associations that are usually made up of volunteers. To increase the likelihood that your initial attempt is successful, search online for the term "Muslim cemetery" and identify the Mosque associated with it. The reason for this is that they are often the Mosques with the longest heritage in Canada (or other Western nations) and tend to be more open to outsiders dropping in. In such Mosques, hospitality is key, and you will be able to gain access to the list of open houses or other outreach programs they have.

More importantly, go with the attitude of being an invited guest and expect hospitality. Furthermore, allow the anxiety or excitement before going to add to your empathic understanding of how someone who may have a negative view of the field of psychology would feel meeting a psychologist. To be better prepared, perhaps ask about their hours of operation and book an appointment to meet someone. That is, apply everything you would do before visiting someone whom you do not really know well—yet!

If the Mosque is inaccessible, then know that nearly every post-secondary institution has a student union (or association) of Muslim students. There you will find a fruitful source of cultural informants who, in my experience, often are delighted to talk about their faith and lived experiences. In fact, on a yearly basis, Islamic Awareness weeks are common. Perhaps finding out when the next one occurs would be a great contribution on your part to get connected. You may find one or two students who are majoring in psychology (but do not be surprised if they are mostly Engineering students); these students would benefit from your knowledge and experience as well.

Conclusion

Principle I, *Respect for the Dignity of Persons and Peoples*, was the focus of this chapter, primarily as it relates to cultural competence and the virtue and practice of hospitality. Principle I is far too sophisticated and complex to summarize in one chapter. In fact, hundreds of books have been written on the topic and I encourage you to read the works of many others to arrive at your own conclusions and practical strategies. This chapter, albeit a brief introduction, was intended to provide a foundation for working with persons from other cultures or faiths by expanding your understanding of hospitality. Although the focus was on Muslims, the concepts explored can be extrapolated easily to other cultures and faiths. This is something that I intend to continue to learn about and build upon for years to come, and I hope you will to, one small contribution at a time.

Stigma is often cited as a fundamental barrier to accessing services by immigrants, refugees, ethno-cultural and racialized communities (Mental Health Commission, 2016). However, this claim, supported by some evidence in Canada, still requires both more research and deeper thought. In my opinion, the stigma is a major red flag. As a field, we need to be doing more towards making the field seem more familiar to the worldviews of non-dominant populations. Understanding the high dropout rates and negative experiences of such populations when they receive services, as well as enhancing research and education about these populations (while not forgetting that each individual is unique) are steps in the right direction. Furthermore, respecting the dignity of Muslims or any other peoples should not be considered aspirational, but fundamental as an inalienable right that needs us all to reflect on our assumptions, biases, and prejudices. I can only hope that this humble submission can contribute to that truth and enhance our own attitudes, knowledge, and practices towards respecting the dignity of all those we come into contact with, professionally and personally.

Questions for Reflection

1. Within the context of Principle I, this chapter has placed a high degree of focus on the construct of the client as a guest. What are your thoughts about this construct?
2. Recall Fatima who said, “I do not want Western psychology. I am a Muslimah and I want Islam.” What would be your response to that statement? How would you demonstrate respect for her right to self-determination?

3. Although it is common for therapists to learn about the guest's culture in the session, it can be argued that depending on the guest to provide all cultural information could be an ethical problem. What are some arguments for and against this claim?
4. What are some benefits and challenges when working with someone of a different culture? Do you sense a conflict between holding to your own beliefs and respecting and utilizing the guest's beliefs?

NOTES

1 It should be noted that once bonds of trust and respect are formed (i.e., therapeutic alliance), the perks that go with hospitality would probably be far less important to the guest than the therapeutic relationship.

2 The two primary sources of Islamic doctrine are found in the Quran and the Hadith. However, it is important to note that Islamic studies is an entire field and thus there is much more to it. Also, sectarian differences may mean that individuals do not necessarily agree, and this is yet another testimony to the diversity of Muslims.

3 Eid is celebrated twice a year, after the month of Ramadan (a month of fasting from dusk to dawn) and after the greater pilgrimage called Hajj.

4 *Muslimah* is the term for a female Muslim and although the term Muslim is gender neutral, I wanted to honour her voice by not changing it.

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3

Ethically Addressing the Employment Needs of Adults Living with Developmental Disabilities

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As practitioners, we aspire to a world in which each person with a developmental disability (DD) has an opportunity to participate in a broad range of employment possibilities and is not limited to traditional options such as sheltered workshop employment (Lotan & Ells, 2010; Mank, 2007). Thirty years ago, when two of the chapter authors, Barry and Shelley, first started working in the field, it was assumed that individuals with a DD would be limited to such segregated work settings. Today, we celebrate the fact that research indicates that supported integrated employment, customized work settings, and self-employment opportunities can provide sustaining, productive, and satisfying careers; careers that not only provide meaningful work with adequate income, but that can also benefit the employment setting (Mank; Nützi et al., 2017; Telwatte et al., 2017). Although such goals are realistic, working toward or accessing them can be both personally and ethically challenging not only for the individuals experiencing a DD, but also for their families and the professionals who advocate for these same persons and opportunities. In our day-to-day work, Principle I (Respect for the Dignity of Persons and Peoples) of the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association [CPA], 2017) guides psychologists' efforts to work from a place of respect and dignity for all persons. It is through this lens that we focus this chapter. Through our diverse involvement in this field, we have experienced the challenges and the heartaches, but also the opportunities and the rewards, of working with individuals from this vulnerable population. In this chapter we share some of our stories from a place of lived experience.

Who Are We and What Do We Bring to the Chapter?

We are rural-based interprofessional practitioners who collectively have extensive experience in generalist practice. We have known each other and have worked together to varying degrees over a span of two decades and are accustomed to working collaboratively in interprofessional teams. We possess both urban and rural experience as academics, clinicians, parents, and researchers. Shelley is a doctoral-level psychologist with a general independent practice and has experience working with youth and adults with a DD in employment settings. She holds an adjunct university appointment and has conducted research that looked at the efficacy of autism spectrum disorder screening instruments in rural Canada. Barry also is a doctoral-level psychologist with a lengthy career in hospital-based mental health, and has volunteer leadership experience related to employment and DD. Carol is a masters-level school psychologist who also has a general independent practice and is a parent of a youth with a DD. Lisa is a masters-level registered nurse who teaches undergraduate nursing, is active in interprofessional education and has a child with a DD. Jaqi is a masters-level clinical social worker, with experience in hospital and community-based mental health. She works with many adults who have a DD and are experiencing mental health issues, often as a result of such things as harassment or discrimination in the workplace, and has previously worked with children, youth and their families where DDs are presenting factors—both in the community and in mental health offices. Nora has a bachelor's degree in Community Studies and has worked with individuals with DD in the community and schools for over 15 years. Jessica is a bachelors-level trained registered nurse who has an interest in community engagement. She is planning to pursue her master's degree and has an interest in working with young adults with disabilities. Although we have varied clinical backgrounds, in this chapter, we share our passion for promoting employment equity for individuals with DD.

Most young adults dream of having a job that they like and of being able to live independently. This includes persons with DD. Meaningful employment is a significant factor influencing one's quality of life (Mank, 2007). However, for persons who have been diagnosed with a DD, finding and maintaining satisfying employment is often challenging. Through the lens of Principle I, we examine the ways professionals can ethically support and advocate for these opportunities, together and in co-operation with individuals with a DD, and consider the inherent value of this labour. This frequently means looking to persons with DD for guidance, and often inspiration, in developing creative and contemporary options.

Our embrace of inclusive and diverse employment experiences must at times be tempered by the challenges of matching suitable employment with equitable financial compensation to a client's job preferences and potential. As professionals, we also each must maintain practices consistent with our respective ethical responsibilities (Canadian Association of Social Workers [CASW], 2005; Canadian Nurses Association [CNA], 2017; CPA, 2017). In fulfilling our ethical responsibilities, we believe it is inaccurate to focus solely on the punitive aspect of ethics (e.g., what might I be disciplined for?) rather than on the positive aspects through attention to ethical values, virtues, and principles. As a former police officer, Shelley recalls earlier in her psychology career thinking of ethics as a dichotomous choice—meaning it is either ethical or it is not. As she matured in her psychology career, she eventually became less rigid in her view of ethics as always right or always wrong. As we have advanced through our careers and become more familiar with ethics, we have come to realize that Shelley is not the only one of us to have first approached ethics in this rigid manner.

In writing this chapter, we wish to share our enthusiasm for ethics, and to inspire readers to spark their own ethical conversations. We see this chapter as an opportunity to explore the perspectives of Canadians with DD, including considerations about where they are working, and how guidelines and codes of ethics may be used as part of their professional foundation to support these individuals in their employment of choice. As we work from an interprofessional collaborative practice (ICP) perspective, we include ideas that can encourage future practitioners to engage with other practitioners in client-centred care. As we discuss scenarios to illustrate practical approaches to ethical decision making, we will be referencing Principle I (Respect for the Dignity of Persons and Peoples) of the *Canadian Code of Ethics for Psychologists* (CPA, 2017). This Principle will be reflected in each scenario as well as in the reflective queries at the end of the chapter, which are meant to stimulate further critical thinking and dialogue.

Canadian Perspective

The Canadian Survey on Disability (Bizier et al., 2015) reported that in 2012 13.7% of Canadians living in the community aged 15 or older self-identified as experiencing some type of disability, and 160,500 (0.6% of Canadian adults) were noted as having a DD. This study surveyed persons with DD to understand their employment experience. The most prevalent developmental disabilities reported were Down syndrome, autism spectrum disorder and cerebral palsy. Interestingly, one in five (20.4%) Canadian adults with a DD reported that their employer was not aware of their condition. Sixty-one percent reported that they felt disadvantaged in their employment setting, and "more than a third (34.6%) believed that they had been refused a job; 31.4% felt that they had been refused a promotion; and 28.3% believed they had been refused a job interview due to their disability or disabilities" (2015, p. 6). There is often an assumption that individuals with a DD work in sheltered employment settings. As can be seen from the statistics above, that is not always the case as people with DD work in many types of employment settings. When we allow for the freedom to set personal goals, we allow for "differentness" and rich diversity.

A recent development in the Canadian employment sector is what is called *the social enterprise*. This is defined as "a business venture owned or operated by a non-profit organization that sells goods or provides services in the market for the purpose of creating a blended return on investment, both financial and social/environmental/cultural" (Elson et al., 2016, p. 8). Examples of Canadian social enterprises include restaurants, upcycle stores, and coffee houses. According to the Canadian National Social Enterprise Sector Survey (CNSES) Report (Elson, Hall, & Wamucii, 2016), approximately 31,000 Canadians are employed in social enterprises, and this includes the full range of employment experiences from full- and part-time, to seasonal, contract, and freelance (Elson et al.).

In our rural hometown, The Shanty Café and The Store Next Door are examples of social enterprises that provide employment for persons with DD. One of the chapter authors, Barry, had the privilege of sitting on the board and executive of the non-profit organization that developed these social enterprises while they were doing so. The Shanty Café is not just any restaurant—it serves up fresh homemade style bread, vegan options, and ethnic food with flavour but also with a social conscience. The store located next to the café, aptly called *The Store Next Door*, sells upcycled items that have been crafted from repurposed materials, such as broken hockey sticks that are now tables, coat racks, and furniture. It also provides retail space for their environmentally friendly all-natural products that are produced under their label "All-Ways-Us." All their activities and products aim for what is called a *triple bottom line*, which means benefiting people, profit, and the planet.

The 2016 Canadian National Social Enterprise Sector Survey Report (Elson, Hall, & Wamucii, 2016) indicated that there are a number of individuals with a DD who work successfully in traditional and social enterprise employment settings. Other local examples include "Tall Boys," a social enterprise that delivered Tim Horton's coffee to local establishments and a sign-painting enterprise that paints nautical scenes and sayings on recycled wood for tourists and cottage owners and that are sold on Etsy (an e-commerce website that caters to homemade items) or at the local farmers' market. However, successful employment for persons with DD is often not captured by data collection agencies, nor in this case, the CNSES. Because of the difficulty in obtaining accurate numbers, statistics may be "broadly but not precisely encompassed within the count of paid employment" (Bizier et al., 2015, p. 31). This highlights the challenge of obtaining accurate data regarding those working in the different types of employment sectors, and their prevalence. This may also be an indication of the stigma still associated with having a DD in our society.

Interprofessional Collaborative Practice (ICP) and Ethical Perspectives

The importance of the integration of an ethical ICP approach is illustrated by Dianne, who has a chromosomal disorder that affects her physical mobility. After enrolling in a Human Services program at the local community college that her parents suggested she try, she has decided that she is not interested in working with people and wants to explore other options. Dianne's psychologist has encouraged her to do this through the local Nova Scotia (NS) Works Employment Centre. This Centre helps people with DD prepare for the work force. Dianne now has an NS Works caseworker as part of her team. They realize that some of the jobs Dianne is interested in will require an occupational therapist to assess her functional abilities, including physical strength. This is a great example of how matching an individual with a DD to their preferred employment often requires an interprofessional collaborative practice (ICP) approach for best results. It also reflects the importance of practicing from a respect-for-person perspective where the client's self-determination is respected and valued. When the recommendations came back that several of Dianne's choices could work, the ICP team met with Dianne to navigate the logistics related to having her work in one of her chosen areas.

The concept of ICP is entrenched in Canada's health care system (Canadian Collaborative Mental Health Initiative, 2006; Commission on the Future of Health Care in Canada, 2002) and appears in the codes of ethics for psychology, social work, and nursing (CASW, 2005; CNA, 2017; CPA, 2017). The ICP team is made up of many partners, including the individual with a DD and their family, paraprofessionals, students, employer-based support staff and community professionals such as mental and physical health care providers, and occupational and physical therapists (Canadian Interprofessional Health Collaborative, 2010). This places the client at the centre of the ICP team, thus fitting well with the client-centred perspective of rehabilitation psychology, the branch of psychology within which employment practices for persons with a DD would best fit (Commission on Rehabilitation Counselor Certification, 2017; Mank, 2007).

Scenarios

In our advocacy work, we acknowledge the importance of interconnecting social networks in small, close-knit communities such as those found in rural and northern settings (Goodwin et al., 2016), but that also occur in urban settings (e.g., cultural, policing, LGBTQ, and DD networks) (Schank & Skovholt, 1997). We recognize the challenges of such small communities, particularly with issues of confidentiality. However, we also have come to realize that the strengths of an ICP team—having the ability to collaborate, intervene, advocate, and share resources within the ethical parameters of confidentiality and informed consent—are critical to helping persons with a DD to obtain fulfilling employment.

The scenarios in this chapter are a compilation of various experiences encountered by the authors and represent how they have approached the ethical dilemmas involved. Identifying details have been disguised and altered to ensure confidentiality. The scenarios represent experiences across the lifespan, including late adolescence, early adulthood, and middle adulthood. They address issues related to employment choice, workplace promotion, and workplace harassment. Our goal is to raise the reader's awareness of how we have found that sound ethical practice requires familiarity with our own ethics codes as well as those of other professions, agency policies and recommendations, and provincial and federal statutes.

Scenario 1

One such scenario concerns Natacha, a school psychologist who has just returned from a 12-month maternity leave. During this time, she was not replaced, and teachers in her school attempted to fill in for her, as is common in rural locations where staffing resources can be limited. Prior to leaving she had worked with Adam, who is 17 years of age and has a diagnosis of autism spectrum disorder, with moderate social communication and behavioural challenges. Natacha originally received consent from Adam's parents to work with him and has had a positive working relationship with him for several years. He frequently stops by her office and chats about what is happening in his life and has always engaged respectfully and thoughtfully about decisions he is making. Natacha believes that Adam has the competence to make his own decisions. As such, despite still living at home, and being financially and emotionally supported by his parents, Natacha believes that Adam has the moral (and in many jurisdictions, the legal) right to make decisions about his future. Protection for vulnerable individuals and groups is a primary concern in Natacha's decisions in this scenario and, as such, she has placed Adam's wishes at the forefront of all decision making (CPA, 2017, Ethical Standards I.32-35).

Adam currently is completing a work term arranged by his school at a local café, taking food orders behind the counter. During peak times in the café, Adam has experienced communication errors with orders and has, at times, become verbally aggressive towards unhappy customers. The owner of the café has mentioned these issues to Adam on several occasions and notified him that if a change in behaviour does not occur, he will be removed from this position.

Natacha recognizes that this could have been avoided if additional supports had been put in place at the beginning of his placement. Unfortunately, she feels that he has “fallen through the cracks” in her absence.

Natacha is planning for an upcoming meeting with Adam, his parents, a school placement co-ordinator, and his employer. She is apprehensive because Adam’s parents want him to work full time at the café and not attend college after he graduates. Adam’s parents have left Natacha a telephone message requesting her help in convincing Adam to work instead of going to college. She believes the motivation is their belief that he would be better suited to an unskilled work environment and that continuing to work at the café would increase his chances of finding employment in this type of work after high school. Adam, however, has expressed an interest in attending college. Natacha knows he would require a psycho-educational assessment to attend, and his parents have not given consent for this. The educational system in her province requires parental consent for this until the age of 18. Although she has not completed a full competency assessment, Natacha has explained the process to Adam in words he understands and she believes that he has the capacity to make a fully informed decision about his career choices—specifically, comprehension, judgement, and expression of his wishes. In preparation for the meeting, Natacha ponders how to best balance their differing goals.

Natacha considers making a referral to Akira, an independent practice psychologist in the community, who has provided psycho-educational assessments pro bono in the past. Akira would not need the consent of Adam’s parents for the assessment, as she does not work for the provincial school board and is not bound by the school board’s age limit. Natacha deems Adam competent to give his own consent. This would respect Adam’s dignity and the right to make the decision for himself, independent of his parents, if he wishes to do so. Natacha wants to ensure that her approach respects all parties and takes their concerns into consideration but gives priority to protecting and supporting Adam’s self-determination. However, she acknowledges that this option may negatively affect the relationship between Adam and his parents and may damage her working relationship with them, and recognizes that sometimes ethical interventions can have unintended negative outcomes, such as fractured relationships. Natacha decides to consult a mentor to discuss relevant legislation, the *Code*, practice guidelines for determining competence, and developments in the ethics literature related to giving consent for health decisions (e.g., MacIntosh, 2016; Steinberg, 2013). This provides her with a solid understanding of her options, and she feels better prepared for the next steps.

Prior to the meeting, Natacha meets with Adam and explains the situation, including potential unintended consequences; he confirms that he wants to proceed with the assessment. She recommends that they meet with his parents to enlist their support. With Adam's permission, Natacha holds a family meeting with Adam and his parents. She advises that a psycho-educational assessment may have value not only for college but also for the work environment. She explains the risks and benefits, the option to withdraw at any time, and available alternatives (CPA, 2017, Ethical Standard I.23). She also discusses the importance of respecting Adam's wishes, opinions, and ideas, and how this connects to the concept of decision-making competence, and her ethical obligation to support Adam as he navigates this process. Adam and his parents consent to the psychological assessment, agreeing that it may provide insight into his overall cognitive functioning and, potentially, his ability to attend college. Natacha could have referred Adam for a more formal assessment for competency to make decisions if she felt this was in question, or if his parents challenged his competence. However, given his level of functioning and ability to understand the ramifications of his decisions, this did not become an issue for her.

It is with attention to these multiple layers—Adam's aspirations, capabilities and age, his parents' concerns, everyone's emotions, financial concerns, and awareness of community resources—that Natacha must view and balance her ethical obligations in this not uncommon ethical dilemma.

Scenario 2

What happens if a traditional work setting or a social enterprise does not interest the person with DD? Twenty-one-year-old Jesse characterizes the challenges experienced by persons with a DD diagnosis who seek less traditional employment, as well as the determination it can take to overcome those challenges. Jesse opened one of our office doors a few years ago and has been determined to open many more doors since. As someone who views hirself as nonbinary, Jesse prefers to be identified by the pronouns ze and hir as these pronouns are the ones with which ze is most comfortable. As we will see later in the chapter, Jesse is an example of how making vocational choices when one has a DD often requires balancing physical health problems, parental pressure, personal ability, and new technologies. It is a dynamic process that expands employment opportunities for workplace success in ways never imagined previously. In viewing these issues from a Principle I perspective, we also consider self-determination, self-expression, gender identity, and the social aspects of the person.

Jesse knows Ted, a rural-based psychologist, who works as part of an ICP team at a local youth centre. To address clients' employment challenges, Ted collaboratively works with other professionals, including Myra, a registered nurse and community support worker. Ted also provides therapy at the centre and has a separate filing system to ensure client confidentiality. Ted explains this to Jesse when ze arrives for hir first session. Ted collects only the information needed as part of the intake process. As part of his practice, Ted regularly engages in self-reflection and ongoing professional development to better understand how his heteronormative experience influences his clinical practice, and as such, he also utilizes gender neutral record forms (Ethical Standard I.3). During the first session Ted learns that Jesse enjoys making things from material found in nature and from second-hand stores. Jesse is tech-savvy and has been successful in selling hir creations through social media and online trading/selling websites. Ze would like to continue to sell hir creations online. Ze lives with hir parents, and hir father has recently been laid off work, which has caused financial difficulties for the family.

Jesse is deemed competent to consent to treatment, which becomes relevant as Ted and Jesse discuss the conflict between Jesse and hir parents. Hir parents want Jesse to work at the sheltered workshop, yet Jesse wants to sell hir creations online while living at home and, to some degree, under their rules. However, hir parents disagree and would like Jesse to find employment doing woodworking in a locally supported employment workshop. They feel that ze would adjust to this different medium of creating, and they also like the idea of Jesse being in a typically male workshop environment. They believe that hir gender neutral identity is just a phase and being in the carpentry section of the workshop will help Jesse identify more with a masculine gender identity.

After the session, Ted wonders whether he should ask his cousin, who works at the employment workshop, to see if he would consider selling Jesse's products online. Ted realizes that if he asks his cousin, although not intentional, he may risk incidentally revealing confidential information about Jesse, breaching hir respect for the moral right to privacy. Given this, Ted decides not to pursue this option. Alternatively, Ted could obtain Jesse's consent to ask his cousin (Schank & Skovholt, 1997). Ted considers having a discussion with Jesse and hir parents about the potential isolation of online employment and to consider accessing community options to socially support Jesse while supplementing hir employment.

As part of the ICP team, Ted consults with Myra about potentially approaching community partners, such as a local business networking group (e.g., Canadian Business and Developmental Corporation [CBDC]) or the local inclusive employment centre, to help Jesse meet hir goals. They also consider speaking with Jesse's parents about the potential of online social networks as avenues for employment. Myra additionally connects with the LGBTQ2 community to see if there is a local parent support group, as the urban-based parent support group is too far to travel on a regular basis.

Finally, Ted talks with Jesse's parents about the pros and cons of Jesse being employed somewhere that ze does not enjoy and how this may have negative consequences on hir life and employment success. All these concerns fall under Principle I and Jesse's desire for self-determination and the importance of Ted respecting hir desire and right for employment choice. This also means that Jesse is able to make an informed choice knowing both the intended and potential unintended consequences.

Scenario 3

Employment challenges are not limited to persons who are leaving high school or in early adulthood. They also include persons who are well established in an employment setting. Several of us have worked with individuals in their fifties who have encountered difficulties because of changing technology requirements in the workplace. They have found their adjustment process challenging, even though they had no difficulty in their previous multi-decade employment history. Others have told us how they have experienced employment discrimination in the workplace because of their DD. As noted in the previously discussed Canadian Survey on Disability (Bizier et al., 2012), many employers may not even know that their employees have a DD.

Alicia, who is in her late thirties, has been employed as an administrative assistant in a non-unionized position for eight years. She has witnessed a number of her colleagues with less seniority being granted better hours and promotions. As a person who lives with cerebral palsy, Alicia has a doctor's certificate from when she began employment limiting her work hours to no more than 80% of a full-time position. Her last performance evaluation was six years ago and contained performance concerns related to sick time usage while awaiting required surgery. This issue was successfully resolved after surgery. Alicia feels frustrated by many of the interactions she experiences at work and feels she receives minimal and ineffective support. She reports that her co-workers and managers have treated her poorly, including expressing concerns about her workplace accommodations (e.g., space for her mobility aid, and reduced hours).

As the only child of deceased parents, Alicia lives independently and mortgage-free in her inherited family farmhouse that is a thirty-minute commute to work. She likes her home but it requires ongoing maintenance and unexpected repairs such as a new roof. She experiences constant anxiety over the instability of her pay as she feels her work hours and employment are tenuous. She is looking forward to an appointment with Sara, a psychologist at the local mental health centre, as she is questioning her ability to cope with her frustrations and feelings and is seeking support and guidance.

During the initial sessions, Sara assesses how well Alicia is coping emotionally and provides Alicia with strategies to help her deal with the difficulties and lack of respect she is experiencing in her workplace. Although recognizing that Alicia's mental health is the stated reason for the referral, Sara also explores the extent of Alicia's employment concerns as well as other determinants of health that may be impacting her mental health, such as finances, social support networks, housing, and health care supports system.

Sara realizes the importance of understanding Alicia's worldview as a young adult growing up with cerebral palsy while facing numerous issues regarding finances, social supports, relationships, and the early loss of her parents. Additionally, Sara researches cerebral palsy in order to better understand how this may uniquely affect Alicia. Gaining this broad understanding demonstrates respect for Alicia and acknowledges differences and similarities in personal and professional life between Alicia and Sara, based on their respective life experiences and Sara's privilege of physical health (CPA, 2017, Ethical Standard I.1). Sara recognizes that Alicia faces a number of determinants-of-health issues such as poor housing, social isolation, insufficient social safety net, inadequate income, and lack of employment stability, and that research shows these problems increase the likelihood of physiological and psychological distress (Pan-Canadian Public Health Network, 2018; Raphael, 2009). If the difficulties of her work situation can be addressed, then aspects of these determinants of health can be more effectively addressed. Sara also realizes that, as a psychologist in a public mental health setting, it would be easy to address Alicia's presenting issue of requesting coping strategies and discharge her. However, when seeing Alicia as a vulnerable person, Sara recognizes the responsibility to respect Alicia by taking a broader view and offering additional options in services.

As Sara and Alicia develop a stronger therapeutic alliance, Alicia becomes more open about sharing incidents where some of her co-workers and managers have been demeaning, disrespectful, and harassing toward her. From these conversations, Sara is becoming more aware of her own anger regarding how Alicia has been treated at her workplace and recognizes the need for healthy processing of this anger. Sara also recognizes how it can contribute in a positive manner to her commitment to promoting equality, diversity, and inclusivity in her practice. Ethically, Sara knows she must not project her own feeling, beliefs and expectations of workplace treatment on Alicia. Instead, she must provide Alicia with the information to make her own choices and that she then needs to respect those decisions, even if she disagrees with them. She also realizes that Alicia's workplace experiences violate a number of the underlying ethical values of Principle I of the *Canadian Code of Ethics for Psychologists*, particularly "Non-discrimination," "General respect," and "General rights." Alicia's employer, however, is under no obligation to adhere to the ethical principles and values of the ethical code of any health care profession. Nevertheless, Sara, according to Ethical Standard I.10 (under the value of "Non-discrimination"), has a responsibility to "Act to correct practices that are unjustly discriminatory," as well as a responsibility, according to Ethical Standard I.46 (under the value of "Extended responsibility") to "Encourage others, in a manner consistent with this *Code*, to respect the dignity of persons and peoples.” Sara initiates a discussion with Alicia to see what her wishes are; this includes asking Alicia if she even wishes to know what her options are. Respecting Alicia and her response is all part of respecting her dignity.

As Alicia is in a non-unionized position, she believes that her employer would not support her rights and might even dismiss her if she complains too much. Sara reminds herself that she needs to be cautious in advocating for Alicia. Sara recognizes that Alicia could seek advice from, or file a complaint with, her province’s Human Rights Commission as well as consult with her provincial/territorial Labour Board/Labour Standards Department. A labour lawyer could be of significant help for Alicia, but most likely would not be affordable. Sara may be able to access limited legal advice through her company’s Employment Assistance Program, or through provincial/territorial legal aid programs if she qualifies for services. In some provinces each person is entitled to one hour of free legal advice regardless of income through legal aid services. If the city where she lives has a university law school, they might provide pro bono services.

Sara asks Tomika, who is a social worker with the mental health clinic, to work with Alicia to determine what social benefits would be available, including grants for a new roof for her house. Tomika helps Alicia to contact a provincial/federal employment support program to determine what employment supports and programs may be available. Tomika could also suggest that Alicia apply for the Disability Tax Credit and help Alicia find a health practitioner who can complete this form for her physical disability. Offering these options is in keeping with Principle I of the *Canadian Code of Ethics for Psychologists* (CPA, 2017) and Value 1 of the *Canadian Association of Social Work Code of Ethics* (CASW, 2005), both of which promote respect for Alicia’s inherent dignity as a person.

Sara is pleased that she can provide some help for Alicia to deal with the effects of how she has been treated in her workplace, as well as connect her to other resources and sources of support in collaboration with Tomika. But it is through reflecting on Principle I (Respect for the Dignity of Persons and Peoples) that Sara more fully realizes the unfairness and inappropriateness of how Alicia is treated in her workplace. Sara’s impulse is to directly advocate for Alicia at Alicia’s workplace. But again reflecting on Principle I, Sara realizes that she can best respect Alicia’s dignity by providing her with the information, support, and resources she needs so that Alicia can make her own best decisions on how to proceed.

Summary and Future Directions

As we hope to have shown in this chapter, employment opportunities for people with DD have gradually expanded into more mainstream, new, and integrated employment sectors. For example, in Jesse’s scenario we hope we have shown how advances in technology, although sometimes a challenge, also have opened many doors for expanded employment options. Through integrated work settings, the workplace culture of acceptance and respect for persons with DD has evolved to embrace more inclusivity. We see these expanding options as exciting developments in this field. Although opportunities continue to grow, we are realists and recognize that, even with more fully equitable employment opportunities, there will continue to be ethical issues for all professionals working in the field. We believe there is a continued need to advance a culture of inclusivity and respect for all employees with DD, and that this can only occur with the willingness to acknowledge the equal worth and dignity of all persons. We also believe that this ongoing evolution of workplace cultures that support respect, inclusive employment policies, and human rights legislation must continue to advance. For example, we view the upcoming revision of the *Canadian Labour Code* as a promising opportunity in which to address workplace harassment, and it also may be an opportunity to take a further step in supporting workplace stability for persons with a DD.

Our three scenarios have illustrated that it is not just policies and laws that need to evolve, but also a systemic culture of integration and respect, and a change in attitudes of persons closest to us. At first, neither Adam nor Jesse was supported by their parents to take what were once considered non-traditional steps for persons living with DDs—in their situations, towards continuing education and online employment. In the case of Alicia, it was her co-workers and managers who presented the biggest challenges for her to have fuller and more satisfying employment. The professionals working with Adam, Jesse and Alicia, staying true to the aspirations of Principle I to respect dignity and self-determination, focused on and collaborated with others to support greater options for their clients. This was done through education and support for these clients and their families, through knowledge and potential use of policies or laws, and by supporting Adam, Jesse and Alicia to make decisions for themselves that would allow them more control over their own destiny. Having an awareness of our codes of ethics has helped to guide us, the authors, as we continue to make decisions of when and how to educate, advocate for, and/or support people consulting with us who have been diagnosed with a DD.

Codes of ethics are a product of their time, and as societies evolve, so do their ethical dialogue and mores. This, in turn, influences ethical professional practice. The publication of the 2017 *Canadian Code of Ethics for Psychologists* reflects this evolution, including the clarification of the applicability of ethical principles when psychologists use electronic and digital technology in their practice, clarification of boundaries relevant to rural and cultural practices, and an emphasis on ICP as it relates to clinical practice and research. As we have witnessed in our careers, progress will continue, and we are confident that this will involve more employment opportunities that are meaningful and equitable for persons living with DD.

Questions for Reflection

1. Imagine yourself as an adult with developmental disabilities. Describe one or two situations that would make you feel that your dignity as a person is being respected. Describe one or two situations where you think you would feel that your dignity is not being respected.
2. In what ways do you think employment contributes to a sense of dignity for adults? Are there exceptions?
3. As a practitioner or researcher, how have you balanced respecting dignity and taking care to be of benefit and avoid harm, especially when a person's ability to protect their own rights and their own well-being might be compromised?
4. Speak with someone who works with adults with developmental disabilities. What community resources do they use in addressing employment needs? What works well? What does not work well? Why?

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4

Psychological Services for Transgender Youth: A Push towards Better Language and Understanding of Gender Issues

Sybil Geldart

My Background and Interest in Gender Issues

Everyone has a gender identity—an internal sense of maleness or femaleness that forms during socialization in the early years of life (e.g., Diamond, 2002). Many of us do not ponder our gender identity or give it conscious attention. But for some persons, the biological sex to which they were assigned at birth does not correspond with their experienced gender, nor does it fit with how they visibly express themselves. Such persons are referred to as transgender or gender diverse (American Psychological Association, 2011; Gay and Lesbian Alliance Against Defamation [GLAAD], 2007).

Let me introduce this chapter with some general information about me and my professional interests, as well as my rationale for writing about psychological services for transgender youth. It is my intention that, by the end of this chapter, I will have connected Principle I (Respect for the Dignity of Persons and Peoples) of the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association [CPA], 2017) to current issues facing transgender youth. The *Canadian Code* comprises a broad set of ethical principles, with several ethical values and standards subsumed within each principle. It has the goal of guiding psychologists in their conduct and attitudes, and in the resolution of ethical dilemmas. Principle I of the *Code* speaks to the importance of advancing moral rights to privacy, confidentiality, self-determination, liberty, and social justice for all persons with whom psychologists interact, including primary clients, clients' familial systems, research participants, students, and supervisees.

I am a research psychologist employed in an academic setting full time, with research interests broadly based in developmental and health psychology. I have published papers ranging from bullying in the workplace to facial attractiveness and its effect on teen attitudes and self-perceptions. My responsibilities also involve teaching, and I typically instruct undergraduate courses in perception, abnormal psychology, clinical psychology, and exceptionalities during childhood and adolescence. I am also a clinical and counselling psychologist, with a part-time practice in Brantford, Ontario. I became registered with the College of Psychologists of Ontario in 2014 (one might say, at mid-career!), having been trained in school psychology (Thames Valley District School Board, London), child-clinical psychology (Madame Vanier Children's Services, London), and cognitive behavioural therapy (Halton Centre for Cognitive Therapy, Oakville). My clinic work is rewarding for two reasons. For one, I am honoured to help individuals resolve mental health problems and self-actualize—individuals who reside in the small city of Brantford and its surrounding rural communities. It allows me to support a vibrant community that, despite having rapid growth and positive change over the past decade, continues to lag behind larger cities in health services and special education. Second, by virtue of being a trained therapist, I like to think that I listen to concerns and validate problems facing the persons I meet in my work. In my practice, my utmost intention is to offer a respectful, welcoming environment and to give clients and their families the space they need to voice concerns. A related goal is to provide warmth, sensitivity, and advice for persons in my care.

Both in teaching and practice, it is my job to equip persons with a toolbox of life skills to cope with the stressors they face in occupational, educational, and other settings. What has prompted me to compose this work in respect of transgender youth was not so much about showcasing a set of cognitive behavioural therapy skills that could be relevant for this population. Rather, I was inclined to write about experiences in my clinic after having noticed over time an increase in the number of adolescent clients who publicly identified as transgender. These are teenagers who report that they were assigned a sex at birth—based on the reproductive system, sex hormones, and sex chromosomes, that does not match up with how they view their gender (American Psychological Association, 2011; also see Rosenthal, 2016 for a comprehensive review).[1] I found that teenagers describing themselves as transgender often seek help to navigate social relationships better, repair family relations, overcome stigma and bullying behaviours and, in some cases, share traumatic experiences of harassment and discrimination. By exploring these issues, the intention of this chapter is to highlight some of the important needs of transgender youth. I believe that this information is important and timely when we consider the fact that transgender individuals—at least those willing to self-identify (i.e., identify to others that they are transgender)—make up 0.5% of the adult population (Conron et al., 2012).

Format of Chapter and Topics

In three separate sections, this chapter delves into pertinent issues facing transgender youth in the context of psychological services, namely: (i) the need for privacy, confidentiality, and informed consent; (ii) the need for adoption of gender-nonconforming language that conveys general respect; and (iii) the need for promotion of trans-equality and advocating against discrimination. In an effort to make the material educational and meaningful, each section contains a discussion box with exercises and reflective questions. I ask the reader to think about transgender issues in reference to the *Code*'s ethical principles, values, and standards, and to apply such thinking to one's own practice, as relevant. The chapter ends with concluding remarks and four profession-related questions for you to mull over based on the contents of this chapter.

In keeping with the Principle I values of "Informed consent," "Privacy," and "Confidentiality," all the clients mentioned in this work willingly (and happily) gave their consent to share non-identifiable information about themselves. No client information is described in such a way that a given person can be named or otherwise identified. Any first names that appear in this paper were invented by me for ease of illustration and cannot be linked with any actual person or real-life setting. As some clients come from rural communities in southwestern Ontario, I deliberately have chosen scenarios and examples to discuss in general terms in order to help preserve anonymity, and at times have incorporated samples from the academic literature and public health websites to elucidate broader themes and topics.

The Need for Privacy, Confidentiality, and Informed Consent

Before probing the processes in psychological services, it is useful to ask what prompts persons to seek the help of a psychologist. It is important to highlight that persons who identify as transgender seek professional help for issues that are no different from the general population, including anxiety, depression, substance abuse, and relationship problems (Shipherd et al., 2010). Persons who are transgender increasingly have been willing to identify themselves openly. By doing so, transgender individuals help to mobilize their community and government agencies to pay attention to the dimensions of gender and to accept a broader range of individual differences and diversity in humankind. Once they self-identify, however, the unfortunate reality is that transgender persons can develop anxiety, depression, and self-harm behaviours as a result of being marginalized (American Psychological Association, 2015). This is what prompts many to seek counselling. I recall that some of my adolescent clients were ambivalent about *coming out* (i.e., self-identifying) for fear of being judged by classmates and friends; their decision to seek professional help stemmed from fears of being bullied, ostracized and socially isolated. Some clients who attend therapy are given a diagnosis of *gender dysphoria*—a mental disorder that involves ongoing, significant distress and/or impairment in day-to-day functioning caused by the knowledge that one's gender identity does not align with one's biological sex (from the Diagnostic and Statistical Manual of Mental Disorders, 5th ed. [DSM-5]; American Psychiatric Association, 2013). In this case, such persons seek out advice about how to resolve the mismatch between their assigned sex and experienced gender—usually by asking a psychologist for emotional support, and possibly a medical referral to enable (or at least consider the possibility of) transition from one gender to another.

Regardless of the reason for seeking psychological services (and in line with the *Code's* Principle I), psychologists are obligated to ensure that personal information disclosed by their client remains *private and confidential*. For each client, the psychologist keeps a private and confidential record containing billing information, appointment dates, signed consent forms, and session notes (among other items). In addition to the values of "Privacy" and "Confidentiality," another value subsumed under Principle I of the *Canadian Code of Ethics for Psychologists* is "Informed consent"—the notion that psychologists seek full participation from clients in decisions that affect them, including the decision to partake in counselling. This may sound like an obvious detail, but it is possible for clients to be pressured or ordered to see a psychologist because someone has deemed that treatment is in their best interests. For adolescent minors brought to my clinic reluctantly, customarily it is their parent(s) who enticed, convinced, or forced the visit because they believed that their child was in distress, not functioning well, or not behaving *as they should be behaving*. The latter point is illustrated by an adolescent client who self-identified as lesbian. Although sexual orientation is not equivalent to transgender, I assume that the following example can be applied to any client who does not fit stereotyped social roles.

After Carrie revealed to her family that she had romantic interests in women, Carrie's mother booked an appointment at my clinic. Carrie attended the initial session on her own and was vocal that she did not want to be in attendance. By her own admission, Carrie was bitter about being portrayed as melodramatic and attention seeking, and for being told that her sexual preference was wrong. That being the case, Carrie was relieved and more inclined to talk after realizing that she herself has the authority to act on behalf of her own needs and cannot be forced to participate in counselling sessions with me. It was easy to establish rapport with Carrie because she ultimately understood that I respected her ideas and decision. It is interesting to note that Carrie voluntarily agreed to continue counselling for help with social relationships at school and to lessen daughter-mother tensions at home.

Even before providing services, psychologists are required to explain the purpose of obtaining informed and voluntary consent from each client and must discuss limits to confidentiality. As far as breaches to confidentiality are concerned, the client is informed at the outset that, rare as it is, it may be necessary to disclose confidential information under such conditions as: (a) the client poses a danger to themself or threatens to harm someone else; (b) it comes to the attention of the psychologist that a minor is in need of protection by Child and Family Services (with the reporting of potential child abuse being mandated by law); (c) there is reason to suspect client abuse by a regulated health professional, which necessitates an investigation by their respective College; and, (d) the psychologist has been ordered by the court to release professional records, in accordance with a legal case involving the client. As a side note, in none of my cases thus far involving transgender individuals have I had to breach confidentiality for any of the aforementioned reasons.

How I determine whether a substitute decision-maker is required to provide informed consent on behalf of an adolescent client depends on my judgement as to whether the young person is capable of understanding the nature of counselling and can foresee the risks and benefits. I practice in the province of Ontario and, in my jurisdiction, the *Substitute Decisions Act* (1992) maintains that a person 16 years of age or older is presumed to have the cognitive capacity to appreciate the nature of treatment unless the psychologist suspects otherwise. In Ontario, individuals who are 16 years of age and older must be asked explicitly whether they give voluntary and informed consent to counselling before they partake in this service. However, even a person younger than 16 can understand the purpose of counselling and therefore need not get permission from a guardian to participate. In my clinic, I ask the custodial parent(s) of children under the age of 12 to give informed consent on their child's behalf. In cases where parents share custodial rights to their child, I ensure that consent is obtained from both parents. For adolescents between the ages of 12 and 15 who I think are capable of understanding the nature of counselling and its risks and benefits, I give them the option of consenting to participate in counselling themselves rather than having the parent do so on their behalf. Any adolescent client who provides their own consent is assured that their personal information will not be shared, not even with the parents, unless they provide written and verbal consent to release the information. (Let me add here that I use consent forms to supplement the informed consent process and consider it legitimate for a client to sign the consent form using their preferred name rather than their legal name given at birth.) At the same time, I ask those who have legal custody of the child to agree that their child is consenting for treatment on behalf of themselves and that parents understand and agree with the parameters for sharing information. In essence, my goal is to ensure that clients and their parents are aware of how personal information about my clients is collected, used, and disclosed.

When I ask parents to agree, my intent is to be respectful of the legal rights of parents to safeguard their child's interests, while at the same time encouraging families to be respectful of the rights of their child regarding treatment. The latter point relates to the ethical value "Extended responsibility" in Principle I of the *Canadian Code of Ethics for Psychologists*. Extended responsibility implies that the psychologist should do what it takes to encourage those involved in the lives of the client to respect their dignity as a person. That being the case, caregivers, who many times happen to be the motivating force behind seeking out therapeutic services for their child, often have a strong desire to be privy to information discussed in one-to-one sessions between their child and the psychologist. During my telephone intake (before any counselling sessions begin), I note that it is often the parent who has screened their child for possible mental health issues and identified a problem. It is the parent who often expresses concern for their child, enquires about fees and payment, schedules the appointment, and arranges transportation to my clinic. Therefore, in light of parents' vested interest in their child's progress, I usually ask adolescent clients—those who have consented to participate in counselling on their own behalf—for verbal permission to provide brief summaries of sessions to parents on an as-needed basis. I do so primarily as a way of offering strategies and helpful tips for supporting their child at home. Because some clients are known to have persistent difficulties with their family's adjustment to their gender and sexual orientation, I find they generally welcome the opportunity for family members to join the end of some of their sessions for education and feedback.

Review and Discussion Question:

Informed consent, privacy, and confidentiality are ethical values subsumed under Principle I of the *Canadian Code of Ethics for Psychologists*, and each has the purpose of respecting the dignity of persons.

Suppose your 14-year-old client, John, shares with you that they are unsure about their own gender identity. Maybe they are trying to figure it out and say they would like to keep their gender identity private from their parents for the time being. How would you handle this scenario? Is it ethical to disclose John's personal information, or the personal information of any adolescent client for that matter?

Adopting Language About Gender That Conveys General Respect

As a backdrop to how we can be more sensitive to labels and develop better language for transgender youth, let's consider some definitions and basic assumptions held by the lesbian, gay, bisexual, transgender, queer (LGBTQ) community. It is important to distinguish between sexual orientation (i.e., one's preferred gender in terms of sexual attraction or love) and gender identity (i.e., the internal concept of being masculine or feminine) (Diamond, 2002; Israel, 2005). To be precise, gender is not a binary construct; rather, it constitutes a range of gender identities. Because gender identity appears on a continuum, it may or may not differ from the sex assigned at birth. The basic tenet is that individuals' experience of gender is what matters and, consequently, persons have the right to decide their gender identity without any reference to the category of sex. In actuality, the gender chosen—man versus woman versus *other*—need not be a permanent entity for individuals who classify themselves as gender diverse or gender queer. Rather, they consider their identity as being fluid over their lifetime. Therefore, psychologists who work with transgender and gender-diverse individuals must be cognizant of the terminology used by the LGBTQ community and guard against pathologizing gender that is non-traditional and nonconforming. Instead, in line with Principle I of the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association, 2017) and with the *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* (American Psychological Association, 2015), it is expected that practitioners will offer safe spaces and respect for persons to explore how they wish to express their gender.

When transgender individuals are in "transition," this marks a change in gender expression that parallels their experienced gender identity. The ways in which transition can be achieved include:

- coming out to persons involved in their lives, including parents, friends, teachers, and employers;
- altering their first name and/or sex on legal documents;
- changing pronouns used to describe themselves (e.g., he/him, she/her, they/them);
- initiating hormone therapy, either because they wish to produce desired secondary sexual characteristics or because they hope to decelerate or eliminate the development of secondary sexual characteristics that otherwise would occur during the pubertal period; and

- undergoing surgery to make physical appearance match up with gender identity.

Each transgender person must make a personal choice about how to express their gender. Although fewer than 25 percent of transgender individuals take the step of undergoing permanent changes to the body (Scheim & Bauer, 2015), one can appreciate that for some, surgical removal of breast tissue (from female-to-male, called transgender male) or the reduction of the testicles (from male-to-female, called transgender female) might go a long way in attaining self-acceptance and individuality. Strictly speaking, however, gender transition is primarily a psychosocial process. What this means is that, more frequently than not, transgender individuals articulate their gender publicly by verbal labels and how they choose to dress (Bockting, 2008; Bockting & Coleman, 2007).

Changing one's given name is a big personal decision for transgender individuals, and it can be a challenge to enforce because it relies on other persons to fulfill one's wishes about being understood and accepted. Principle I of the *Canadian Code* outlines ethical values of "General respect" and "Extended responsibility," implying that psychologists must not only adopt language that conveys respect for the dignity of persons and peoples themselves, but should encourage others to do the same. I have seen that transgender youth often express frustration, anger, and despair when confronted by persons who refuse to call them by their chosen name or preferred pronoun. Below are some examples:

1. Siobhan (transgender male) expressed mixed emotions in describing his relationship with his parents. On the one hand, Siobhan felt empathy because, as older parents, they lacked present-day knowledge about gendered pronouns, and understandably had trouble switching from the formerly used pronoun "she" to using Siobhan's preferred pronoun "he." On the other hand, Siobhan felt undermined because his parents, Dale and Norma, seemed glib in conversations with him, which was uncharacteristic of his view of them as cultured and otherwise caring persons. For example, during one exchange between Siobhan, Dale and Norma, Siobhan corrected Norma:
   Norma:"Dale, listen to her . . .
   Sibohan: Him.
   Norma: . . . I mean him. You never seem to listen when she . . . oops, your kid . . . tries to tell you how he's feeling."
2. Jamie (who never actually adopted the label "gender queer," yet appeared to identify with this gender identity), requested that friends use the pronoun "they" because this term captured

> Jamie's identity as a person better than did pronouns like "she" or "he." However, Jamie was hurt and resentful when friends did not take the request seriously enough to change their wording.

One way that I have supported gender transition is to offer family-based sessions involving the client and significant others. A family-based session can be useful to caregivers because it permits support and encouragement towards change. Likewise, a counselling session with family members gives clients an opportunity to learn about obstacles from another perspective and can reveal that family members have a genuine desire to help the development and growth of their child (See Brill & Pepper, 2008 and Torres Bernal & Coolhart, 2012 for the value of family therapy in fostering acceptance and understanding of transgender children). As much as possible, I provide education to clients and families about each person's moral right to be addressed by their chosen name and preferred pronouns.[2] And, when needed, I address what is often a complicated term for most persons, i.e., gender fluidity—namely, that individuals who identify as gender diverse or queer often resist traditional pronouns such as *he* and *she* because these labels thwart the expression of a nonbinary identity. So, while he/him/his and she/her/hers are masculine and feminine pronouns, respectively, some persons prefer to use more than one set of pronouns and opt for gender-neutral pronouns instead. The most common gender-neutral pronouns are they/them/theirs—used in this context to describe a single person who does not want to be gendered. Newer gender-neutral pronouns being recognized today include: *ze/hir/hirs* (pronounced zee/here/heres) or *ey/em/eir* (pronounced ay/em/air). These new pronouns can be used by anyone and can be used interchangeably, although they are most often used by gender-nonconforming persons. The central point is that transgender individuals should be treated with respect—which in this case means the rest of us using the name and pronouns individuals have decided to use on themselves.

A related issue has to do with the recording of names and pronouns in the psychologist's client files. As mentioned previously, files are required for every client, and each contains records of sessions as well as contact and other information. My recommendation is that psychologists document somewhere in their files the chosen name and preferred pronoun of their transgender client(s)—to increase the probability that the language is accurate and used consistently. At the same time, one must address the ethical question of whether it is in the best interests of our clients to record demographic information such as gender on a form, particularly when gender was never disclosed. (Let me emphasize here that most of us do assume gender merely by taking a glance at someone's physical appearance or hearing a given name.) Also, I believe it is disrespectful to ask a client to divulge a legal name when they explicitly have requested the use of a preferred name (unless, for some reason, the legal name is pertinent for sharing information from the case file with a legal guardian or the courts).

Review and Discussion Question:

LGBTQ is considered an umbrella acronym for homosexual, bisexual, transgender, and gender-nonconforming individuals. It is important to understand that sexual orientation (gay, lesbian, bisexual, asexual, heterosexual) and gender are not synonymous terms. Nor are they binary constructs (e.g., boy vs girl). Think of some disadvantages to the therapy process when a clinician inaccurately applies the binary model of gender in their work with transgender clients. In what way(s) might a practitioner's biases and stereotypes regarding gender affect the quality of care provided to clients?

Promoting Trans-Equality and Advocating Against Discrimination

Discrimination can be based on a number of characteristics (e.g., age, gender, weight, ethnicity, religion, among others), and is the outcome of prejudice—a preconceived judgement or negative attitude about individuals or groups. People who are prejudiced against individuals or groups view themselves as being superior, which then can lead to acts of disrespect, mistreatment, and even violence. Transgender adults have been known to face discrimination from all types of individuals in the community—co-workers and supervisors at their place of employment, fellow patients and medical personnel at health clinics, and even doctors and police officers (e.g., Clements-Nolle et al., 2001).[3] Systemic discrimination against LGBTQ individuals has been known to occur in religious organizations, including faith-based schools (Liboro et al., 2015; MacDougall & Short, 2010), where administrators blatantly have opposed LGBTQ issues and neglected the Canadian Charter of Rights and Freedoms. Transgender youth face discrimination at different levels—by their classmates, their teachers, and even by members of their family. In fact, transgender teens have been assaulted physically by schoolmates because of their gender identity (e.g., Greytak et al., 2009). I have seen first-hand clients who are saddened, depressed, and anxious after having faced rejection by their peers, derogatory remarks by caregivers, and physical altercations by classmates, as these examples demonstrate:

- Kevin (transgender female) felt betrayed by her mother who denied her gender identity. Reportedly, Kevin's mother refused to come to terms with the fact that wearing skirts and blouses, letting her hair grow long, and wearing nail polish and necklaces comprised a constellation of features that enabled Kevin to express a female gender. Kevin decided to keep their birth name after having been ridiculed by younger siblings when she asked them to start calling her "Kara." What hurt Kevin the most was that her mother did not back her up in the presence of family members and did not support her gender expression.

- Fae (transgender male) reported that cousins gossiped and called Fae a homosexual after he cut his hair short, started wearing boys' clothes, and dated a female student. Fae always had thought that he had a close relationship with extended family, but that all changed after having self-identified. Relatives did not comprehend the difference between homosexuality and transgender, nor did they accept diversity in gender. It was common for family members to make disparaging remarks about persons who chose same-sex partners—insinuating that their cousin was stupid and deviant. Fae's relatives were especially prejudiced against men who wore women's apparel, saying that they were "weak and unmanly." These attitudes about gender identity left Fae feeling hopeless and depressed.
- Justin (gay), from a rural community, complained to the high school principal when former friends repeatedly bullied him after he had opened up about being gay. Justin was the victim of harassment and violence over many months, with fellow students waiting until after classes each day to gang up on him with insults and physical fights. In Justin's mind, his teachers, administrators, and the school counsellor all had failed to support him. Consequently, Justin felt terrified to attend classes and had regrets about remaining a high school student. He tried to avoid physical assaults by skipping classes, but then was the one who was reprimanded for recurrent school absences.

In the case of Justin (above), one could argue that it was the lack of support from the school counsellor and the lack of change in attitude by his teachers and fellow students that made him begin to feel hopeless, depressed, and panicky in social situations. In research conducted within Canadian schools, it has been shown that almost 75 percent of transgender youth report verbal harassment by their peers and just under 40 percent have experienced physical violence (Taylor et al., 2011). Almost identical statistics have been found in the U.S. for verbal and physical abuse by the caregivers of transgender youth (Grossman & D'Augelli, 2007).

A remarkable *and* disheartening finding is that transgender individuals also have reported negative experiences with their therapists in the course of psychotherapy. In a qualitative study (i.e., using one-to-one interviews) with 45 transgender adult clients (Mizock & Lundquist, 2016), it was reported that psychotherapists overemphasized gender in therapy sessions by treating it as a pathological condition and as the cause of the client's anxiety. In addition, psychotherapists were described as uneducated in gender issues, and were criticized for avoiding or denying gender altogether, perhaps because of their lack of expertise and/or low comfort level with the topic.

Taken together, all these examples bring to light the ethical standards in Principle I that pertain to maintaining general respect and ensuring non-discriminatory practices and attitudes. The House of Commons Bill C-16, otherwise known as the Gender Identity Bill, was created to support the inclusion of gender-diverse persons and provide protections against alienation, discrimination, and violence. The bill amends the *Criminal Code of Canada* by listing transgender and other gender-diverse persons as an identified group that should be protected from hate propaganda. According to the *Criminal Code*, any degrading comments, harassment, and violent acts centred around gender identity or gender expression is considered a hate crime and a prohibited ground for discrimination in the *Canadian Human Rights Act*.[4] In essence, the introduction of Bill C-16 in 2011, which subsequently was passed and approved in 2014, is intended to provide members of the transgender community better protections of their moral rights.

Let me add that even in my own clinic, I recognize that I inadvertently have made mistakes in my role as therapist when working with gender-diverse clients. This is an important issue to me as it speaks to the ethical value "Fair treatment/due process" in Principle I of the *Canadian Code of Ethics for Psychologists*. This is exemplified by a therapy session I had with an adolescent client, which turned into an assessment session.

I had been working with a 14-year-old female client, named Madeline, over nine weeks to resolve persistent motor tics and social anxiety disorder. Then, at our 10th session, my client self-identified as a transgender male and asked to no longer be called Madeline. Instead, he wanted to be called Kai (pronounced |Kye|). Because the client, as Madeline, had previously disclosed being a lesbian, I was surprised to hear the disclosure of transgender. In fact, you could say that I had some doubts about my client's understanding of concepts like transgender and homosexuality. As such, I began taking on the role of "assessor" (not therapist or advocate) and queried whether Kai met DSM-5 diagnostic criteria for gender dysphoria. I questioned whether Kai was, in fact, experiencing a change in gender given that it had never been mentioned until now. I asked Kai to give retrospective reports from childhood about whether he had expressed a desire to wear apparel typical of the other gender (e.g., jeans, sweatshirts, ball caps), and to recount the times he had preferred to play with toys typical of the other gender (e.g., trucks and action figures instead of dolls). I can see now that using this type of assessment—whether intentional or not—I attempted to confirm gender identity rather than simply accept at face value Kai's gender experience.

It has been noted that assessing clients in this way takes away from providing support to clients in need and emphasizes a diagnosis of a psychological disorder (www.transhealth.ucsf.edu/guidelines). As an alternative, it has been suggested that a *transgender affirmative approach* in counselling is more appropriate and involves the following affirmative actions: (i) permitting the client to articulate the gender experience, and then reflecting that experience back; (ii) developing rapport by asking the client to talk about experiences growing up and how this was handled by their caregivers; (iii) determining the needs of the client regarding self-acceptance and well-being; and, (iv) establishing a good support system for the client (e.g., parents, extended family, friends, teachers, and counsellors). (For details of transgender affirmative therapy, refer to the American Psychological Association's (2015) *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, or see Mizock and Lundquist (2016).)

Review and Discussion Questions:

1. Legislative changes that promote trans-equality are a good start in informing the public that it is *unacceptable* and *illegal* to target people with verbal and physical assaults because of how they choose to identify or express their gender. Even so, there can be repercussions when one decides to self-identify as transgender or gender diverse. Imagine what it would be like to be told that you must be a particular gender (e.g., the one you were assigned at birth), when you feel that you are not that gender. How might it make you feel if people in your life—your parents, your siblings, your long-time friends insisted that you change your ways and conform to their opinions instead?

2. Imagine you are employed as a school psychologist for the local school board, providing support and guidance to students and consultation to school staff for student development and learning. A student approaches you and says that she wishes to change her gender, via physical appearance and given name.

- Of teachers, principals, and the student body, who might you expect to be more or less supportive of this transgender youth?
- How might you deal with potential harassment and bullying?
- In what way(s) can (fellow) students and school staff persevere in the fight for equal rights and treatment?

In rare circumstances, you may need to deal with suicidal ideation, suicidal thoughts, and/or self-harm—which has been known to follow from discrimination and bullying. What might be some ways to intervene, and thereby promote the health of your client?

Concluding Remarks

A basic need of transgender youth, as is true for all human beings, is to find and use language that conveys respect for their dignity—one that is not dependent on culture, race, religion, sex, gender, or sexual orientation. This chapter described scenarios involving transgender youth (and, in some cases, homosexual adolescents) that point toward lack of respect, as well as discrimination, harassment, and violence. The intent of these clinical presentations was to draw attention to current ethical issues in working with a vulnerable population. I am hopeful that the chapter content, including the exercises and discussion questions, is helpful for those working with gender-nonconforming persons, and of some help for those working with other vulnerable, and often marginalized, groups. For clinicians and students of clinical and counselling psychology, I hope the information in this chapter leads you to assess your level of understanding of transgender issues, to consider your level of competence in working with transgender youth at this moment in time, and to ponder the extent of empathy and interest you have towards the subject matter. For some of you, specific training and professional development in the area of psychological services for transgender youth may seem challenging, but also worth exploring.

I took the opportunity to explore gender issues within the context of my own experience as a provider of psychological services, and I believe that it goes without saying that the next step for us as scholars and practitioners is to develop better ethical practices. In my opinion, to do so effectively means that continuously referring to the *Canadian Code of Ethics for Psychologists* is very helpful whenever ethical questions arise. Psychologists must be vigilant in evaluating our own conduct in the same way that we—sometimes vehemently—challenge the stereotypical behaviours and attitudes of others. My hope is that one day we will develop ideal solutions for clients who utilize psychological services, while simultaneously eradicating discrimination and harassment, and putting an end to ignorance from others.

Lastly, although this chapter explicitly addresses current issues facing transgender youth within the context of Principle I (Respect for the Dignity of Persons and Peoples) of the *Code* (CPA, 2017), I would be remiss if I did not acknowledge that some of these same issues could easily benefit from application of many of the values subsumed under Principle II (Responsible Caring) and Principle IV (Responsibility to Society). It is impossible to ignore the sizable number of transgender youth in our country and abroad who suffer from emotional problems and psychiatric disorders (e.g., Becerra-Culqui et al., 2018; Clark et al., 2014; Grossman & D'Augelli, 2007; Veale et al., 2017).[5] Using large-scale population surveys, Veale and colleagues reported that only 25 percent of Canadian adolescents identifying as transgender actually reported having good or excellent mental health. On the contrary, transgender youth in Canada have a higher risk of reporting psychological distress, self-harm, major depressive episode, and suicide attempts compared to the general population. As emerging adults (19 to 25 years of age), transgender individuals were found to have eight times the risk of suicidal thoughts and 16 times the risk of a suicide attempt compared to the general population. As such, Veale et al. concluded that there is inadequacy in existing mental health services in Canada. The authors articulate this problem movingly by suggesting that mental health training of practitioners must progress from being *transgender friendly* to becoming *transgender competent*. In a similar vein, Becerra-Culqui et al. (2018) contend that clinicians ought to be responsive to current statistics of mental health problems facing gender-nonconforming youth and be able to provide social and educational support to those who are exploring their gender identity. I give credit to these experts for recognizing the need for enhanced training, education, and support. As I work more and more with transgender youth, it is important that I evaluate my competence, that I seek professional development, and that I remain open to understanding gender variance. It also is important that I serve willingly and competently what often is deemed an underserved and misunderstood segment of the population.

Questions for Reflection

1. After receiving a request for support for a transgender youth, you think it best to refer the youth to another therapist. How do you select the therapist to ensure a positive match?
2. In the faith-based school in which you work as a school counsellor, there is an internal policy stating that the principal must be made aware of students who do not identify with their assigned sex. In light of Principle I, what do you do?

3. What are your strengths and biases with regard to working with gender-diverse clients?
4. What competencies do you think you need to be able to work confidently with gender-diverse clients?

NOTES

1 For comparison, *cisgender* is a term used to describe individuals who identify with the gender assigned to them at birth.

2 The issue of respecting what individuals prefer to be called and being sensitive to offensive labels is not limited to gender. The *Publication manual of the American Psychological Association* aims to help scholars write scientifically and objectively in describing persons and groups using a set of "General Guidelines for Reducing Bias" (see Chapter 5, American Psychological Association, 2020, p. 131). According to the manual, some examples of avoiding biased language include: describing people without objectifying them (e.g., expressing "the child with a disability" or "the man with schizophrenia" rather than saying "the disabled child" or "the schizophrenic"), keeping descriptors specific and avoiding vague terminology (e.g., describing "Chinese Canadians" rather than referring them to as a "minority group"); and keeping abreast of up-to-date labels (e.g., using "lesbian, gay, bisexual, LGBQ," etc. rather than "homosexual").

3 It is interesting to note, however, that the Canadian Department of Public Services and Procurement recently developed a new workplace guide for both workers and managers, with the intent of supporting transgender employees. For a look at the guide online, visit https://www.tpsgc-pwgsc.gc.ca/apropos-about/guide-et-te-eng.html.

4 For details, refer to: Department of Justice, Government of Canada (2017), *Protecting against discrimination, hate propaganda, hate crime on the grounds of gender identity and gender expression*. https://www.justice.gc.ca/eng/csj-sjc/pl/identity-identite/techpaper-papiertech.html

5 For interested readers, there is a wealth of data emerging on the prevalence of psychiatric disorders among transgender and nonbinary adults. For example, Beckwith et al., 2019 and Hanna et al., 2019 discuss the prevalence of psychiatric (including Substance Use) disorders among transgender adult patients in the United States. See Chen et al., 2019 for a look at the first national study on suicidal ideation and attempted suicide rates (comorbid with mental illness) amongst Chinese transgender adults.

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PART B

PRINCIPLE II

Responsible Caring

5

Caring Responsibly in Long-Term Care: Ethical Considerations for Psychologists

Rebecca Lalonde, Fern Stockdale, Paulette Hunter

Long-term care (LTC) is a diverse and complex setting. LTC residents are both young and old, come from a variety of cultural and socio-economic backgrounds, and have a wide array of physical and mental health conditions. Unique ethical challenges are bound to surface for psychologists practicing in such a setting. Scarcity of resources, multiple value systems, and interprofessional collaboration and conflict all combine to make for an environment in which a psychologist needs to give ongoing consideration to ethics, consult regularly, and acknowledge the limitations of any decision. All in all, long-term care is a rich environment in which to hone ethically informed practice. In this chapter, we will share our experiences of this environment from our unique perspectives as an early-career clinician (Rebecca), an experienced clinician (Fern), and an early-career researcher (Paulette). But first, let us briefly introduce ourselves.

Rebecca: As a recent graduate of a master's program in Educational Psychology, I have been in my position as a psychologist in long-term care for about a year. I am currently provisionally registered and am continuing to obtain the supervised experience that will allow me to become fully registered. There is much to be learned over a full career in psychology, and I hope that readers (particularly those who presently are completing training or supervised practice) will benefit from my attempts to find balance during my first year of practice.

Fern: I have worked as a clinical psychologist for the past 20 years and have spent most of that time working in health psychology, with a focus on seniors. Currently, I am employed as a psychologist on an interprofessional team in a physical medicine and rehabilitation unit. I have had opportunities to consult in LTC settings, and to practise within community and acute care contexts, and have appreciated the honour of assisting individuals and family members in their personal-change stories. I also have tried to encourage system change by serving on the board of the Mental Health Commission of Canada, and by authoring *Working together for change: The mental health and addictions action plan for Saskatchewan* (Stockdale Winder, 2014). Advocacy for improved access to services for mental health and addiction issues, and for improved service provision for seniors in LTC facilities, is a passion that has continued throughout my career. I hope that my experiences will offer readers an opportunity to further reflect on their own experiences of interprofessional work and advocacy.

Paulette: During the years I was in graduate school, I witnessed science-driven initiatives positively influence LTC practice. These included the introduction of a system-wide brief quarterly assessment (interRAI.org, 2016), and improved attention to pain assessment and management for older adults, including those with dementia (e.g., Hadjistavropoulos et al., 2007, 2009). The success of these initiatives inspired me to follow a career in research. Now, as a clinician scientist employed in a university setting, my work includes research, teaching, and other contributions to university life. My research on quality of life in LTC brings me into contact with LTC facilities on a regular basis. I hope that my experiences will help readers to reflect on the ways they strive for strong professional relationships to enhance their efforts to provide responsible care for the clients they serve.

The Canadian Long-Term Care System

LTC is an environment that provides many opportunities for psychologists to practice responsible caring. Since many psychologists do not have much experience of LTC facilities, we would like to tell you a little more about this environment before we share our own experiences with you. Residents arrive in LTC because they can no longer live independently, and because they have outgrown the supports available to them in their own homes (e.g., family help and home care services) or in other community settings (e.g., assisted living facilities). Most LTC residents are from the oldest age segment of Canadian society; that is, over age 85 (Pitters, 2002). Still, it is possible to find people of any age from childhood through older adulthood living in this setting. Some LTC facilities are small and intimate, with just over a dozen residents. Others feel like a small town unto themselves, housing hundreds of people. For most residents, LTC will be considered home for the rest of their lives. Some find the transition difficult (Gruneir et al., 2012; Presutti, 2007; Sury et al. 2013). Others transition fairly easily and maintain a high quality of life. Increasingly, care is taken to create a homelike environment where residents are able to direct their own lives as much as possible. But these efforts do not fully ameliorate the challenges of living in LTC, which include accepting support for one's physical and/or mental health conditions, receiving care from a revolving group of health care providers, and getting along with neighbours that one would not necessarily have chosen. The services psychologists provide in LTC often are related, either directly or indirectly, to these challenges.

Psychology in Long-Term Care

LTC residents have many mental health needs. According to Canada's *National Guidelines for Seniors' Mental Health* (Canadian Coalition for Seniors' Mental Health [CCSMH], 2006), between 80% and 90% of LTC residents have a mental health condition at the time of admission. Dementia is the most common primary diagnosis (approximately 65% of residents; Ontario Long-Term Care Association, 2016; Rovner et al., 1990), but other psychiatric disorders, including mood and anxiety disorders, are also prevalent in LTC, affecting 40% of residents (Ontario Long-Term Care Association). Many residents have more than one mental health condition. For instance, about 40% of residents with a dementia diagnosis at admission also have comorbid depression, delusions, or delirium (Rovner et al., 1990).

In this environment, there is a great need for the services that psychologists are trained to provide, including cognitive assessments, behavioural support, and counselling or psychotherapy (CCSMH, 2006; Seitz et al., 2010). Still, the reality is that most residents do not have reliable access to these services. In the Canadian LTC system, the availability of therapeutic services averages just 14 minutes per resident per day (Berta, et al., 2006). This time is spread across all other therapies (e.g., physiotherapy, occupational therapy, behavioural support), and includes indirect service time such as travel between facilities, attending meetings, and charting.

As you can see, the current level of public resources allocated to psychosocial and behavioural support in LTC does not permit psychologists to serve all residents who have a mental health condition, nor yet all who would benefit from psychosocial support as they cope with loss or adjust to significant changes. The needs that exist in LTC, as well as a sometimes-poor match between needs and available resources, demand a broad range of skills and expertise from psychologists, including ethical decision making. In the remainder of this chapter, we hope to give you a glimpse of some of the common ethical issues we have encountered in our efforts to provide responsible caring in long-term care. The case stories you will read are amalgamated examples, in which presenting problems and circumstances have been adjusted. While not true in historical detail, these stories are representative of our professional experiences.

An Early-Career Clinician’s Perspective (Rebecca)

In my work as a psychologist in LTC, I serve a population of over 2,200 residents in 30 LTC facilities. Roughly half of the facilities to which I consult are in Saskatoon, Saskatchewan, and the others are in the surrounding rural area. Within my position, I have two major roles. The first is to provide psychological services within one large LTC facility in Saskatoon. In this role, I spend time with clients who require ongoing individualized services, including residents living with dementia, acquired brain injuries, physical disabilities, and longstanding mental health conditions. The second is to provide psychological consultation to 29 other LTC facilities in Saskatoon and the surrounding rural area. Most consultation requests are for behavioural consultation. This means that I am responsible for evaluating and advising on behaviours that convey possible distress (e.g., pacing, calling out), or may be disruptive to others (e.g., repetitive vocalizations), or are potentially unsafe (e.g., refusing support with hygiene). Typically, this includes providing information to support a better understanding of the resident’s needs, as well as advising on potential strategies to address the needs. The level of service I provide to meet each request ranges from a one-time call to multiple visits when more extensive intervention planning and evaluation are needed. More complex consultations can include several visits, including speaking with the individual, observing their environment, interviewing the person’s family members and care staff, providing education to caregivers, and following up after recommendations are implemented.

Special Considerations for Rural Settings

With a population of over a quarter million people, Saskatoon has many of the amenities of a larger city, but my work offers regular reminders of its relatively small population size. In the first few months of my position, I realized that it was not unusual for residents, families, and staff to have multiple (i.e., overlapping) relationships. For example, sometimes a staff member was also a resident’s family friend. When I began to consult to the small rural communities outside Saskatoon, such relationships were even more pronounced.

In rural communities, multiple relationships between staff, residents, and rural community members are particularly likely—even inevitable (cf. Campbell & Gordon, 2003)—and these relationships sometimes raise important questions about responsible caring. Consider the example of “Linda,” a care aide who supports a group of eight residents, one of whom is her “Aunt Ethel.” This raises a number of ethical questions surrounding Ethel’s care. For instance, might there be a difference in the way Linda provides care to Ethel, compared to her care for other residents? If so, how might other residents respond? What about Linda’s co-workers? Would either the residents or the staff treat Ethel any differently due to her familial relationship to a staff member? What pressure might Linda be under from extended family members when caring for Ethel? Could these pressures ever work against Linda's professional judgement in her care for Ethel? How might members of the community feel about their own loved ones' care, knowing that Ethel is receiving care from her own niece?

Psychologists are encouraged to maximize the benefits of their activities by ensuring they have a good working knowledge of the communities in which they work (Ethical Standards II.13 and II.14). In my practice, this includes developing a better understanding of relationship networks within rural communities, such as the relationships between Linda and Ethel, Linda and other staff members, and Ethel and the other residents. Multiple relationships, or situations in which professionals have multiple roles with respect to their clients, have often been discussed as ethically sensitive situations to be avoided when possible, or carefully monitored when it is not possible to avoid them, as is often true in rural work (Ethical Standards III.30–III.31). However, over time, there has been a shift toward examining the potential therapeutic benefit of carefully managed multiple relationships (Younggren & Gottlieb, 2004).

It has been my own experience that sometimes providing the best possible care for those in need (Ethical Standard II.18) is most readily achieved by making use of the benefits of pre-existing relationships. Imagine that a staff member observes Ethel, who has dementia, engaging in what seems to be a bizarre behaviour, removing leaves from indoor houseplants, and using them to wipe herself after relieving herself in an inappropriate location. Linda, who has overlapping roles with respect to Ethel, has a great deal of knowledge of her aunt's life before LTC. Linda hears of this behaviour and recalls that her aunt spent most of her working life as a farmhand, spending nearly all her time outdoors. The only chance to relieve herself in this environment was to enter a wooded area and use a leaf instead of toilet paper. Knowing this, Linda does not see the behaviour as bizarre; rather, she realizes that it is important to watch for signs that her aunt needs the washroom and to find an effective way of directing her there. She also explains her understanding to other staff, who find the information very helpful to their care for Ethel.

Now consider an alternative possible scenario in which Linda learns of her Aunt Ethel's behaviour and becomes incredibly embarrassed. She thinks the behaviour is inappropriate and does not reflect well on her family. In turn, she feels ashamed and guilty. These feelings lead her to scold her aunt when this behaviour occurs. Linda believes she is doing Aunt Ethel a favour by discouraging a behaviour her aunt would have been ashamed of before the onset of dementia. On the other hand, my behavioural observations show that Ethel's agitation and confusion worsens when she is scolded, and I know that this could further contribute to problematic behaviours.

Both scenarios represent real possibilities in rural LTC facilities. In each scenario, both Linda and I have relevant knowledge—Linda about Ethel's history and preferences, and I about behaviour management. In the first scenario, Linda and I happen to draw a similar conclusion about Ethel's needs. In the second, we understand the behaviour differently and have identified incompatible strategies to manage it. Clearly, the second scenario is more difficult to navigate. Nevertheless, I have come to realize that in either scenario, the greater my understanding of the qualities of resident-staff relationships within rural LTC facilities, the more tools I have to intervene. In the first scenario, Linda and I see eye to eye, and the intervention I offer might be as simple as documenting the positive effects of Linda's approach, providing a further rationale, and encouraging other staff to use this approach, too. In the second scenario, by working to appreciate how Linda understands the situation, I can describe the rationale for my proposed intervention in a way that better addresses her concerns, and this makes it more likely that my recommendation will be accepted.

Through working with residents like Ethel and family members like Linda, I have learned to be cautious when I encounter multiple relationships, recognizing that it is an area in which ethical tensions are more likely to arise (Ethical Standards III.30–III.31), and that I have much to learn (Ethical Standards II.9 and II.10). Nevertheless, I also have learned that paying attention to multiple relationships can be extremely valuable. More and more, I find myself using my knowledge of multiple relationships to "tune my dial" to potential problems with the implementation of my proposed intervention. This helps me to balance the technical aspects of behavioural interventions with more practical human considerations, such as whether the intervention is acceptable to those who will ultimately implement it.

Special Considerations for Consulting Work

In a perfect world, each LTC facility would receive far more support than I can provide. In an imperfect world, the reality is that I must be very efficient with my consulting time in LTC, always knowing that there is another LTC facility patiently awaiting my visit. Given the brevity and infrequency of many consultations, particularly in rural communities, it can be challenging to develop quality interventions and monitor the outcome of my services (Ethical Standard II.22). From an ethical perspective, if I am not able to meet requests for needed service alone, the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association [CPA], 2017) advises me to give reasonable assistance (Ethical Standard II.33) to find appropriate resources to meet the client's needs. In considering this dilemma of responsible caring as it intersects my practice, I have developed a keen appreciation of the clinical knowledge of other members of the care team, including unlicensed providers (Ethical Standard II.19). Since I have only a few hours at most to spend on any given consultation, a few minutes of discussion with a consistently scheduled care aide can provide me with information that I might otherwise not have access to. For instance, many staff members can provide me with vital information about what is normal or what is an important change for a resident.

I once was asked to assist in identifying the cause of a recent increase in the agitation of a male resident with Alzheimer's disease. Upon arriving, I was informed that one particular care aide was most informed about the resident's care, having worked regularly with him for three years. Unfortunately, that same care aide had just begun a month-long vacation. For several reasons, including the resident's level of distress and the urgency of the consultation for the LTC facility, I completed the consultation based on the information that was available. My recommendations helped the facility to manage the agitation while the care aide was away, but the problem was not fully resolved. When the care aide returned, I visited again, and a much better solution to the problem was identified. Although it was not documented anywhere in the chart, the resident had poor hearing, and wore hearing aids purchased a few months prior by a family member who visited infrequently. The resident had misplaced his hearing aids, and not realizing the importance of the hearing aids to the resident, none of the staff members had made a concerted effort to look for them. On the care aide's arrival from vacation, she opened a drawer in his closet and simply stated, "Oh, sometimes he puts them in here when he comes back from church service." With his hearing restored, the facility staff did not observe any additional increased agitation. To prevent future recurrences of the problem, I documented the reason for the behaviour in the resident's chart and collaborated with the care aide to share her insight with other staff who were working that day. When residents cannot adequately communicate their own needs and preferences, they rely on others. Often, those who work most closely with a resident, as this care aide did, possess extremely valuable information. However, they are not always aware that they possess special knowledge. As a result, an important part of my role can be to affirm the importance of this knowledge and to support communication.

Although the above approaches do not apply to every situation, they prove very useful when they do. The biographical information that is sometimes shared by caregivers who have extensive knowledge of the residents helps me to develop my own knowledge quickly and assists me in maintaining a person-centred approach to consults (Clarke et al., 2003). In addition, it is often other team members, rather than me, who will be employing the intervention strategies I recommend, and perhaps even monitoring them for effectiveness. For this reason, I find that developing effective working relationships with LTC staff, collaborating in the development of interventions, and extending my responsibility to residents through other staff (Ethical Standard II.55) is a very efficient and caring way for me to respond to requests for service. This is particularly important for any rural LTC facilities that I cannot visit regularly.

The Needs of the Individual Versus the Needs of the Many

Interpersonal conflict exists wherever people live in close quarters. It is part of human nature. Regardless of the setting, we all can relate to the challenges of living and working in shared spaces with others. But given the vulnerability of LTC residents, it becomes critically important to find a balance between addressing the needs of one resident and the needs of others around them.

Many times, this situation presents itself as a dilemma in which respecting the well-being of one resident (Ethical Standard II.1) could potentially impact the well-being of others (Ethical Standards II.1 and II.2). For example, if John always sits at the dining table for dinner and regularly uses vulgar language in this social context, this may bother other residents and their families. It is not necessarily illegal, immoral, or wrong for John to swear, but it could have a negative impact on other residents. Consider a more serious situation, in which a person living with quadriplegia uses their motorized chair in an unsafe manner. Here, the needs of the individual (i.e., mobility, independence) and the needs of others (i.e., safety) are potentially at odds.

Dilemmas in which resident needs compete feature prominently in my work, and often involve weighing the risks and benefits of change for multiple parties. Consider Gloria, a woman living with dementia who is referred because she calls for help repeatedly. As I explore the concerns with staff, I realize they are worried about adequately meeting Gloria's needs and also about whether her calls are compromising others' quality of life (e.g., loss of sleep, increased agitation) and contributing to safety risks, such as the risk of another resident striking her in frustration. After obtaining consent from Gloria's designated family member(s), I begin by reviewing any medical concerns with Gloria's physician, assessing whether there are unmet physiological needs (e.g., hunger, rest, pain), and working collaboratively with the care team to address those needs. If I discover that the need is psychological (e.g., loneliness, boredom), I might encourage planning for more time with friends and family, or in scheduled programs. Additionally, or alternatively, I might recommend increasing the frequency of very brief check-ins and visits from staff. If this proves insufficient or unfeasible, and there are still significant risks to Gloria's quality of life or that of other residents, I might recommend a more structured plan that is more labour-intensive to implement. For example, I might collaborate with the home's manager to routinize 5-minute visits from staff every 30 minutes, while also emphasizing the importance of *not* responding to calling out in between (and still providing unobtrusive supervision to be confident that Gloria is safe). Over time, by replacing visits prompted by Gloria's calling with frequent scheduled visits, Gloria will ideally come to trust that she will not be left alone for long, even if she does not call out. However, there can be a temporary increase in calling out during the initial period where Gloria is not feeling confident about the change. Because of the work involved, the transition period for Gloria, and the potential consequences of the temporary increase in behaviour, this approach is not typically the first choice. At every step, careful consideration of the risks and benefits to all involved guides whether and how best to intervene (Ethical Standard II.17).

Self-care in a High-Need, Resource-Scarce Context

As reflected in the above scenarios, I find that I often am confronted with the dilemma of a higher need for my services than I am able to provide. As a psychologist, I grapple with how to best serve my clients in the limited time I have available. I find myself wondering if I could do it all, thinking to myself "maybe if I just worked a bit faster," or "maybe if I was more efficient with my time." I sometimes think about what life would be like in a perfect world, where every person would have access to psychological support to the degree that they need.

As a new practitioner, I have found it helpful to keep the *Canadian Code of Ethics for Psychologists* (CPA, 2017) close at hand. In considering how it speaks to the demands of my work, I am particularly drawn to the standard that describes an ethical obligation to take care of oneself as a psychologist (Ethical Standard II.12). Practitioners are encouraged to be aware of burnout, and the potential for it to affect client care. The best approach for managing the workload is to balance providing service with care and attention while considering the limitations of the setting. In looking for that balance, I find myself asking, "Should I prioritize the number of people I see, to give my time and attention to those who have the highest need? Or do I spread myself thin, respond to every request for services, and provide the best service I can with the time I have?" In my own journey to becoming an ethical practitioner, I find it important to manage my caseload effectively to protect my mental health and the quality of the care I provide. When my skills are of value to more residents than I can serve, I must make difficult choices, allowing myself only a certain number of consultations per week, and be mindful of the temptation to push myself to do more, knowing that an unsustainable workload will undermine my effectiveness over the long run. Sometimes, I think it is easier to be aware of the potential for burnout than to take note of the subtle moments along the way that indicate the need for more attention to self-care.

As a new member of the profession, I also have found consultation with others about ethical dilemmas (Ethical Standard II.8) helpful to my professional growth and self-care. Consulting with more experienced psychologists (Ethical Standard II.9) when I experience ethical dilemmas helps me become more confident in applying ethical principles in the real world. Knowing that I am not alone in managing difficult situations also helps me to manage the inevitable stresses associated with clinical practice. In striving to be the most ethical practitioner I can be, I know that my learning will be ongoing, and I am comforted by the knowledge that I can turn to others in the profession for guidance.

An Experienced Clinician's Perspective (Fern)

Over my career, I have had many and varied connections with long-term care facilities. When I think about those experiences, stories that involve ethical dilemmas and opportunities for learning and growth as a professional stand out. In the following stories, I share a couple of my key lessons: interprofessional respect and advocacy for residents.

"Claws In"

I love interprofessional work. I love the camaraderie and sense of team that I have with my colleagues. I appreciate the rich diversity of our views, and the fact that I learn something every day from my colleagues. I find great satisfaction in working together from different perspectives to bring about the best possible care for a patient, resident, or client. Earlier in my career I also enjoyed interprofessional work, but sometimes the differing perspectives on situations led me to believe that there were ethical contradictions in our views. This is a common experience (McCullough et al., 2002).

At one point, I was working on an interprofessional team at a facility that included physical therapists, occupational therapists, nurses, physicians, recreation therapists, and psychologists. We were all eager to work together, and to become a high functioning team. Nonetheless, I was taken aback when one of the physical therapists said to me, "I'd like to talk to you about cognitive behavioural therapy. I've been reading a book about it. I really like the principles of it, and I'm starting to incorporate it in my physical therapy sessions with clients." My internal ethics alarm sounded. I had visions of this physical therapist practicing psychotherapy without sufficient knowledge or training and I was worried about potential harm to residents, in keeping with the strong admonition in Principle II (Responsible Caring) to protect the welfare of clients and to avoid doing harm (CPA, 2017). I was also worried about how I was going to confront this colleague without damaging our interprofessional relationship, or the friendship that had started to emerge.

Fortunately, at the time, I was working with a more experienced psychologist. I went in and breathlessly recounted this potentially harmful situation to him, waiting for him to tell me what I might do to address it. So, I was surprised when his initial response was just these two words: "Claws in." "What?" I said, not at my eloquent best at that moment. "Claws in," he responded again. The response still did not make any sense to me, and I looked at him with a blank yet earnest expression. He then very calmly explained to me that it was likely that my physiotherapist colleague had discovered some basic useful principles of cognitive behavioural therapy. He noted that my colleague was likely just trying to encourage his client to think positively about their progress in the therapy exercises, and to set reasonable goals. He encouraged me not to think of the situation as an ethical dilemma, with psychology clearly the ethical superior, but rather as a chance for a discussion and exploration of how cognitive behavioural principles could be used in a variety of situations and how we could reinforce each other's work. I went back and talked to my colleague and discovered that it was in fact as my psychologist colleague had hypothesized. This opened a very rich discussion, and eventually led us to practicing more closely together and providing better care.

It has taken me a while, but now when an ethical flag waves in my mind in an interprofessional context, I ask myself if it is simply a difference in perspective from professional worldviews. As Burck and Lapidos (2002) state, "provider cultures have their own specific perspectives on this good [for a particular patient] and their own ideas of what the various disciplines contribute to it" (p. 44). When ethical issues arise, I now seek out how I might be able to resolve the issue with my colleague, respecting that their ethical framework is not identical to mine. This interdisciplinary respect is emphasized in the *Canadian Code of Ethics for Psychologists* (CPA, 2017). For example, under the Values Statement for Principle I (Respect for the Dignity of Persons and Peoples), interdisciplinary members are included in the list of those persons and peoples whose dignity we must remember to respect, and the Values Statement associated with this principle states, "In these contacts, psychologists strive to develop and maintain constructive and collaborative relationships that reflect the fundamental principle of respect for dignity" (para 2).

These collaborative, team-based relationships result in more co-ordinated and valuable services when teams are working effectively (Zwarenstein et al., 2009). Co-ordination of service is emphasized in the standards within the principle of Responsible Caring. For example, the *Canadian Code of Ethics for Psychologists* advises psychologists to engage in "consulting or collaborating with service-providing organizations in the community, members of other disciplines, individuals and groups relevant to the culture or belief systems of those receiving or being subject to services" (Ethical Standard II.18). It also recommends that psychologists "make themselves aware of the knowledge and skills of other disciplines (e.g., law, social work, medicine, business administration), and make referrals or advise the use of such knowledge and skills where relevant to the benefit of others" (Ethical Standard II.19). When we understand both the skills and the ethical frameworks that each profession brings to the care team, and we include the resident at the centre of the team, we position ourselves to provide more co-ordinated and responsible care.

Bulldozer at the Door

The introduction to this chapter describes the scarcity of mental health resources within LTC. Experiencing this scarcity of resources and a high level of need has also made me wonder how I might best advocate for the needs of residents in LTC. For me, this advocacy awareness came early in my career, when I had the opportunity to train with a supervisor who was keenly aware of the need for psychologists to not only work with individuals, but also to advocate for social change. We were working at a facility that was close to 80 years old, and it had not been kept up or renovated the way it needed to be to provide the best quality of care. For example, it included a ward that had been partially damaged long ago and had simply been closed up rather than repaired, and this was indicative of a state of crumbling infrastructure and disrepair in many parts of the facility. I still clearly remember the day that we learned government officials were coming to discuss the future of the facility, including the possibility of renovations, or tearing down and rebuilding. My supervisor believed that it was incumbent upon us to advocate for residents, who could not readily speak for themselves. When my supervisor was asked by government officials when he would believe they were serious about wanting to transform the facility, he replied, "When I see the bulldozer at the front door." He was speaking out about what he saw as a violation of responsible caring of the residents of the facility. This taught me that sometimes we may need to challenge "the system" in order to advocate for needed change. My supervisor's approach that day was a very direct one, but I have since discovered that there are many ways to approach advocacy, including a collaborative relational approach. At this later point in my career, I see government officials as part of the team for change—often, in fact, having chosen public policy or serving as elected officials in order to effect positive social change despite personal cost. But my supervisor's bold confrontational approach has stayed with me, emphasizing the need for not just individual action, but social action.

The scarcity of resources in LTC continues to the present time, as does the lack of sufficient services for mental health and addictions issues in general (Mental Health Commission of Canada, 2013). At times it can seem that our responsibility for providing quality care to individuals rightly consumes all our professional time. In a context of substantial unmet need, there is no time left for advocating for system change. Yet, without the voices of people with lived experience (including those who work in LTC), it can be difficult for change to happen. The need for advocacy in LTC is so great that Lichtenberg et al. (1998) included it as one of the "standards" for providing psychological services in LTC facilities, and this call was more recently echoed by Karel (2009). In the language of the Responsible

Caring section of the *Canadian Code of Ethics for Psychologists*, we are advised to "strive to provide and/or obtain the best reasonably accessible service for those seeking psychological services . . . [including, among other actions] advocating on behalf of a primary client when appropriate and needed" (Ethical Standard II.18). Under Principle IV (Responsibility to Society), we also are encouraged to "contribute to the general welfare of society . . . and/or to the general welfare of their discipline, by offering a portion of their time to work for which they receive little or no financial return" (Ethical Standard IV.12). For me, this has taken the form of volunteering personal time and/or accepting professional opportunities that would potentially help to move change forward. Examples include serving on the board of the Mental Health Commission of Canada, creating a committee of managers in my workplace to advance Seniors Mental Health across points of care (e.g., community, acute, and LTC), and supporting the work of the Canadian Coalition for Seniors Mental Health. Some of my managers supported the use of my paid work hours to advance these causes, but I also have volunteered my time. This has been a very rewarding experience that, I believe, has resulted in changes for the better in my local community and in Canada nationally.

An Early-Career Researcher's Perspective (Paulette)

As a clinical researcher working in partnership with LTC organizations, there are many meaningful opportunities to contribute to the growth of knowledge. My research program focuses broadly on person-centred care and explores the attitudes and values of care providers (Hunter et al., 2013; Hunter et al., 2016a). It also examines the extent to which these and other factors, such as organizational factors, might influence how care is offered (e.g., Hunter et al., 2016b), and tests specific clinical interventions that might contribute to person-centred care. When I consider how my experience has intersected the domain of ethics, three things strike me: (i) research introduces new demands in a resource-scarce context, (ii) a community-based approach can extend the benefits of research, and (iii) clinical researchers must be prepared to navigate ethical dilemmas in this context.

Research in a Resource-Scarce Context

Psychologists are advised to express caring by promoting well-being and avoiding harm to those with whom they work. This includes research participants as well as other residents, family, and staff members (Ethical Standards II.1, II.2, and II.30). However, the day-to-day practice of research in busy LTC settings raises dilemmas about how best to exercise responsible caring. For instance, a long-term goal of working to improve the well-being of LTC residents through research often has shorter-term costs, such as an increase in work for LTC staff, who may feel they are at the limit of what they can give (Bowers et al., 2000; Lopez, 2006; Mallidou et al., 2013). Additionally, in an environment already taxed by low resources, there is some risk that these short-term costs might be transferred to residents (cf. Ethical Standard II.30). For example, when my research team introduced a program to enhance psychosocial support for people living with late-stage dementia, staff and family caregivers at a participating LTC home raised concern that since there were no extra resources to introduce the program, residents without dementia, or with dementia at an earlier stage, might receive less attention (Hunter et al., 2017). In the face of such concerns, research can seem an unaffordable add-on, or a risk. This is particularly true when the benefits are intangible—and unfortunately, there is seldom a guarantee that innovations in practice will succeed (Damschroder et al., 2009). In the above situation, with no way to fully mitigate the identified risks, our research partners consulted carefully with the resident and family council (Ethical Standard II.23), decided on strategies to reduce the risks (Ethical Standard II.30) and took the chance to proceed, giving priority to the most vulnerable group (Principle I Values Statement, and Ethical Standard I.11). In a resource-scarce context, questions about the relative risks and benefits of research (Ethical Standards II.13–II.17; II.30) are always at the forefront of decisions about whether or not to initiate a clinical research project.

Partnerships or Parachutes?

Given the additional demands that research presents to LTC staff, when I first began to conduct LTC research, it felt most natural to adopt a "parachute research" approach—jumping into the setting to conduct an intervention, and then leaving to analyze and publish the results. This seemed the best way to offer the potential short-term benefits associated with intervention research, while minimizing the burden of the extra work involved in research participation for LTC staff. However, as I continued to reflect on what was happening in my research practice, I began to notice that at some LTC facilities, despite very busy schedules, clinicians wanted to be more involved than my parachute-style plans allowed. By relieving them of extra work, I was preventing them from finding ways to build the intervention into their ongoing practice. Yet, other LTC facilities preferred lower levels of investment and seemed better matched to a parachute approach. I came to realize that in either case, a parachute approach made it unlikely that a successful intervention would ever be sustained locally, even if there was potential for short-term contributions to a broader momentum for change.

This dilemma came into clearer focus when I considered the residents participating in unsustained interventions. The *Canadian Code of Ethics for Psychologists* advises psychologists to prioritize responsible caring for those in the most vulnerable position (Principle II, Values Statement)—in this case, long-term care residents. It also advises psychologists to be reasonably assured that discontinuing a service will not cause harm (Ethical Standard II.36). This suggests that clinical interventions introduced in the context of long-term care research, and found to be effective, should ideally be sustained. Yet, translating this standard as an absolute rule within a resource-scarce context would likely limit willingness to participate in clinical research. If researchers and their clinical partners choose not to allow for uncertainty about benefits to residents or sustainability of interventions, it could be a great loss, since research has contributed to beneficial changes in LTC practice, such as improved attention to pain assessment and management, implementation of routine comprehensive assessments, and enhanced mealtime assistance (Hadjistavropoulos et al., 2007, 2009; interRAI.org., 2016; Kayser-Jones, 1996, 2003) (cf. Ethical Standards II.18, IV.1, IV.6). On the other hand, ignoring the standards is not ethically responsive. With this in mind early in my career, I began to question what it meant to care responsibly as a clinical researcher, and to wonder about the balance of risk and benefit when an intervention is introduced for a time and then withdrawn once the research data have been collected.

Engaging LTC Communities in Research

As I further considered the ongoing needs of LTC residents, and the level of interest of some clinical partners in being more directly involved in developing and evaluating new interventions, I became more aware of community-based research as an expression of responsible caring. Consider this quotation:

> "I'm telling you about myself. You don't even bother telling me about yourself, you just wanted to know about myself. I don't think it's fair. I would like to know about your parents, and I would like to know about other things. I am an old man now and I am curious" (Akuliaq, Inuit Elder, 1967, as cited in Bielawski, 1995, p. 219).

The Elder's statement clearly conveys that the relationship between the researcher (whose main goal is to seek knowledge) and the community (here, the object of knowledge) was not reciprocal. Over time, an approach called *community-based research* developed as a way to rectify this imbalance. Community-based research emphasizes cultivating mutually beneficial partnerships to promote social change at a local level (Wallerstein & Duran, 2010). Common to all community-based approaches is the view of the community sharing responsibility for the research and having a strong voice in the research process. This naturally shifts the focus to sustainability. For instance, in the LTC context, it allows LTC communities to take fuller ownership of the research process and identify ways to sustain helpful interventions, avoiding the researcher's parachute dilemma.

Nevertheless, community-based research is not a cure-all for ethical issues in LTC research. In fact, it creates several ethical issues of its own (e.g., Moretti et al. 2006). For instance, to ensure local acceptability of the intervention, experimental controls often are compromised, and the work is frequently evaluated using methods that are considered to represent a lower standard of evidence. This may reduce the potential for broad impact on global LTC practice, even though it may contribute to a stronger local impact (Wallerstein & Duran, 2010). Thus, it is much too simple to say that one approach to research is more ethically responsive than another. Rather, it is important for researchers to cultivate awareness of the short- and long-term risks and benefits associated with carrying out their research programs in particular LTC environments and to factor this into their decision-making (Ethical Standards II.9-10; II.13-II.17). Risks would include short-term demands on staff and long-term risk of permanent disengagement from research if research is perceived as too demanding. Benefits would include short-term therapeutic effects and long-term potential to stimulate change in practice.

Everyday Dilemmas in Long-Term Care Research

Although community-based research is intended to increase the potential that research will directly benefit local communities, it also comes with its own set of ethical challenges. Perhaps one of the biggest such challenges in my clinical research experience is that I sometimes have clinical or other knowledge that could help to relieve the suffering of a resident enrolled in the research. However, since I am not in a direct service role, there are obstacles to bringing this knowledge to bear.

Consider the following example. Ursula and Heinrich were two cognitively impaired residents participating in a clinical research program designed to promote quality of life. The two were constant companions to each other. The more time I spent completing assessments for the research project, the more I realized how much Ursula and Heinrich benefited from their relationship. Spending time together was deeply comforting to each of them. As they conversed in their mutual first language, German, they provided each other with cultural solidarity and promoted each other's cognitive functioning. Yet, as I came to appreciate these benefits, I also began to realize how deeply distressing this situation was for Ursula's son and substitute decision-maker, Kurt. Earlier in her life, Ursula had described Kurt's father as her one true love. Seeing the new couple together concerned Kurt greatly. He worried that this situation was contrary to her values, and felt responsible. Because of the obvious pressures on Kurt, I began to wonder how this situation would play out for Ursula. For instance, would she ultimately be prevented from spending time with Heinrich? How would this affect Ursula and Heinrich? Since my research protocol and consent process allowed for mutual sharing of relevant clinical information to promote residents' quality of life, I offered to share my observations of Ursula with staff members who played a key role in managing this situation. However, the offer was not responded to, and the conversation never took place. I suspect it may have been difficult to include me in an approach to care that is, often by necessity, highly routinized (Daly & Szebehely, 2012; Mallidou et al., 2013). Employees must be very efficient in order to accomplish their work, which can limit relationship-building (Mallidou et al., 2013). In addition, it is likely that staff members protected the boundary between research and clinical work for other reasons, such as feeling uncertain about mutual responsibilities for confidentiality, and wishing to prevent accidental disclosures of confidential information to me.

When I later analyzed the data my team had gathered, I learned that Ursula had once described Heinrich as her brother. By the time I learned this, Ursula had been transferred to another facility. My heart sank. Although transfers occur for many reasons, I wondered if Kurt had requested the move in an attempt to reduce his father's distress over Ursula's new relationship. Was the move in Ursula's best interests at this time in her life? Given Ursula's vulnerability, should I have been more assertive in my attempts to share my observations about her relationship with Heinrich? Should I have maintained a more consistent connection to the project data, given its potential clinical relevance? Perhaps this information about my understanding of the relationship would have been reassuring to Ursula's family members, had it been presented earlier. Perhaps it also would have proven relevant to deciding whether relocation was in Ursula's best interests.

Rapid action and transparent communication on behalf of LTC residents can be slowed by blind adherence to legal and ethical standards intended to safeguard their interests. In the story of my encounter with Ursula and Heinrich, a strong emphasis on patient privacy (Ethical Standard I.38) and confidentiality (Ethical Standard I.45) promoted boundary-keeping between those who had clinical responsibility and those who did not. In addition, when evaluating risk (cf. Ethical Standard II.17), I did not attend as closely to the risks associated with lack of more assertive action on my part, especially given that the LTC facility carries the primary responsibility for making and implementing clinical decisions. Ultimately, such dynamics can operate to prevent appropriate boundary crossings that involve advocating for residents' needs.

Preparing to Encounter Ethical Dilemmas

Dilemmas about the extent of the researcher's role are ubiquitous in LTC research (e.g., Kayser-Jones, 2003; Morse, 2005). There are inevitable tensions when third parties, including researchers, become involved in situations such as Ursula's. Further, these tensions are exacerbated by the likelihood of encountering ethical issues in resource-scarce settings, where the needs of residents have increased at a steeper rate than funding support (Canadian Institute for Health Information, 2011; Jansen, 2010). These tensions may be especially challenging for clinical researchers to negotiate, as they often have relevant skills or knowledge to bring to bear.

Take for example the work of American LTC researcher Jeannie Kayser-Jones, who was concerned about the poor nutritional status of LTC residents with dementia, which, at the time, had been attributed in the literature to the progressive nature of dementia (Kayser-Jones, 2003). Kayser-Jones used research to demonstrate that inadequate staffing ratios in many American LTC facilities had a great deal to do with the serious weight loss of many LTC residents. Her research ultimately contributed substantially to policy changes, including the implementation of minimum staffing ratios. Yet, as Kayser-Jones interacted with people living in LTC, documenting unmet nutritional support needs, she sometimes felt compelled to act (Ethical Standards II.1, III.9). She tells the story of encountering a blind and hard-of-hearing resident who had only two lower teeth and no dentures:

> One day, I stood in the hallway and observed as [Mrs. Altman] tried to eat her lunch. She struggled to get spaghetti from the plate to her mouth. Most of it fell onto her clothes and into her bed. As a research scientist, I should not have intervened. I should have observed the natural situation, but I felt compelled to assist her. "I'm in a bad way," she said. "I'm blind and almost deaf. It's very hard when you can't see. I'm so hungry, I'm so hungry!" she kept repeating. I stayed to help her, and she ate her entire lunch (Kayser-Jones, 1996, p. 1397).

Kayser-Jones crossed a boundary, knowing that Mrs. Altman needed support (Ethical Standard II.1), and taking action to provide that support, even when it was beyond the scope of her role (Ethical Standards II.17, II.19, III.30, III.37, III. 39).

One might wonder whether Dr. Kayser-Jones more reasonably could have identified a fuller range of potential responses to Mrs. Altman's expression of need (e.g., notifying a staff member; escalating her concern to the care director), particularly since most would agree this situation was not an emergency (Ethical Standards I.46, III.30, IV.18). Indeed, another experienced health researcher, Janice Morse (2005), argues that those who conduct research in LTC must resist a range of pressures that operate to censor their concerns, and act to prioritize the well-being of vulnerable residents. When they have concerns about residents' well-being, researchers must take action (cf. Ethical Standard II.41)—ideally, collaboratively and diplomatically (cf. Ethical Standard II.8)—to ensure effective resolutions to the concerns.

And yet, Kayser-Jones' research has illuminated that this is not straightforward in practice. Scarce resources had rendered dilemmas like the one she encountered ubiquitous in LTC, leaving it impossible to take for granted that necessary solutions would be quickly identified. When she attempted to have a staff member intervene directly ("but she is hungry" Kayser-Jones, 1996, p. 1397), she was put off ("I have to leave now"; "I have to put someone to bed"). She realized a dilemma—although acting to ensure timely support meant exceeding her role (Ethical Standards III.30, IV.18), it was unlikely, given her research experience in this setting and in general, that Mrs. Altman otherwise would receive consistent timely support, even with attempts to negotiate it (Ethical Standard II.55). In the short term, this might not result in imminent risk (Ethical Standard II.42); however, in the long term, her research had demonstrated a cumulative risk of malnutrition, dehydration, and weight loss (Kayser-Jones, 2003) (Principle I Values Statement, Ethical Standards II.43, IV.22). Although it would be easy to conclude that the facility should improve its standard of care, the very fact of the facility's partnership with Kayser-Jones suggested that her organizational partners shared her deep concern about the inadequacy of support for residents' needs yet felt ill-equipped to negotiate the level of resources required to adequately meet the needs.

Within this story, Kayser-Jones can seem to be a sort of Robin Hood of LTC, bending the rules to serve up dinner to those in need, and ultimately coming to the rescue with more staff for meal service in LTC. Yet surely, exceptionally few people would see it as appropriate for researchers to be serving the dinners in LTC or providing other forms of direct care. Dr. Kayser-Jones openly confesses that she exceeded her role, seemingly because of the pressures operating on Mrs. Altman, on the staff, and on her (Ethical Standards III.9, III.16). Despite Dr. Kayser-Jones' successful advocacy for change through research, the level of need in LTC remains such that other researchers and visitors will certainly face similarly compelling ethical dilemmas. The question is, what should one do about it? Beyond taking action to prevent serious dilemmas like this from becoming normalized (Ethical Standards IV.22, IV.27), Dr. Kayser-Jones' experience indicates that researchers need to prepare carefully for work in the LTC environment. To care responsibly, they must know what kinds of ethical dilemmas they are likely to encounter (Ethical Standards II.9 & II.10), develop strong relationships to support resolutions (Principle I and III Values Statements), engage in continuous reflection on their practice (Principle III, Values Statement), and consult actively before and during their work (Ethical Standard III.35).

Summary and Conclusion

By reflecting on the experience of responsible caring in three different roles and at three different points in our career trajectories, we became aware that each one of us had faced some distinct ethical challenges as a psychologist working in LTC. Nonetheless, we also recognized three common themes: complex relationships, scarcity of resources, and a call for advocacy.

Complex relationships abound in LTC. There will be times when residents' goals are in competition, as in any close community environment. Psychologists also need to skilfully navigate multiple relationships with residents and other health providers, particularly in smaller or rural centres. Furthermore, they are challenged to care responsibly by collaborating effectively with health providers trained in other disciplines. All these interactions double as opportunities to develop new areas of professional competence that will contribute to LTC residents' well-being.

The scarcity of resources in LTC caused each of us to consider how best to position our work. For instance, Rebecca attempts to strike a balance between more intensive service and brief consultations across multiple facilities, while Paulette carefully considers what type of research is most likely to provide maximum benefit in facilities that have staffing at minimal levels. As with most ethical dilemmas, there are no easy answers. These situations require an ongoing assessment of risks and benefits of each possible course of action.

Advocacy is a natural outcropping of our mutual concern about the risks induced by resource scarcity. It is an expression of our general caring, and a way that we work to maximize benefit by extending responsibility. But different opportunities for advocacy are afforded by different roles and career stages. Early in a career as a consulting psychologist, Rebecca has advocated most by encouraging other professionals to care responsibly; in other words, by extending responsibility. Early in a research career, Paulette has recognized that research can promote social change. On the other hand, Fern has found it more natural to respond to a call to advocacy later in her career, when her experience and professional relationships opened windows of opportunity for influencing policy changes that contribute to the well-being of LTC residents.

LTC residents can be very vulnerable due to such factors as health status, social stigma, and scarcity of resources. The ethical principle of Responsible Caring (CPA, 2017) asks psychologists working in this environment to attend to residents' well-being. Internalizing and expressing ethical values such as general caring, competence, analyzing risks and benefits, maximizing benefit, minimizing harm, and extending responsibility can help psychologists working in this environment keep residents' well-being in focus. In conjunction with the other three principles of the *Canadian Code of Ethics for Psychologists*—Respect for the

Dignity of Persons, Integrity in Relationships, and Responsibility to Society—the Principle of Responsible Caring provides a valuable basis for making decisions about a variety of complex questions that arise in this diverse and rewarding work.

Questions for Reflection

1. Imagine you have a health condition requiring the support offered in a LTC facility. What services do you need/want? What choices do you want to have?
2. How should psychologists balance each LTC resident's freedom to create an environment that meets the needs of all residents? If long-term care is my home, should I be able to smoke marijuana in my room? Or listen to music at the volume I prefer?
3. In rural settings, staff can share close ties with LTC residents. How might those multiple relationships across family members, residents, and care staff affect work as a psychologist? How would this influence the way you share information with interprofessional team members?
4. Interprofessional teams are essential to the care of residents. What challenges in communication might there be? What could you do to promote good communication with other professionals? How would these efforts contribute to the management of complex problems or ethical dilemmas?

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6

The Call to Engage in Inner Work as Therapists

Toupey Luft, Nan Stevens

Imagine increasing your capacity as a therapist and maximizing benefit to your clients and society in general. This is what we are called to do by the ethical standards of the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association [CPA], 2017). The *Code*'s Principle II (Responsible Caring) speaks to the importance of enhancing benefit and minimizing harm to the people we serve. All helping professionals, regardless of discipline, would likely endorse the philosophy of this Principle. However, we also might struggle with how we can put this Principle into practice. Using our lived experiences, we offer some ideas about one important way of putting it into practice.

Introductions

Dr. Toupey Luft: I am a registered psychologist in Alberta and hold a PhD in counselling psychology from the University of Calgary. I am also an assistant professor in the Faculty of Education at the University of Lethbridge. My research program involves examining the practices of mindfulness and self-care for clinicians and how these are important for ethical practice. Like Nan, I identify as an integrative therapist and appreciate drawing from humanistic, feminist, family systems, cognitive-behavioural, and Jungian approaches.

Dr. Nan Stevens: Nan is a certified art therapist in British Columbia and holds a doctorate in education (EdD) from the University of Calgary. Nan is also an associate professor in the School of Education and Social Work at Thompson Rivers University. Her specialty area is teacher education, specifically inclusive and special education. Her scholarly work intersects with her passion for self-study, professional identity, diversity, and arts-informed research methods. Her art therapy background informs her present research and commitment to art-based methods.

Below we outline our initial experiences with inner work in our lives that influenced us to continue such practices in our graduate training and beyond. We also briefly identify turning points; that is, moments in our professional lives when things *got real* for us in terms of the link between inner work and our ethical responsibilities.

Becoming Aware of the Call to Inner Work

We entered the helping professions of counselling and art therapy because we wanted to help people transform and heal. This is a motivation we find echoed by almost all our colleagues. Early in our careers, we were less aware of how our own experiences in life and subsequent patterns of interacting with others may have driven our decision to become helping professionals. However, along the way, we came upon Jung's notion of the *wounded healer*, which held that all therapists have their wounds, but that those wounds can be transformed through inner work in a way that provides personal healing and can be used to assuage the suffering of others (Cvetovak & Adame, 2017). In this chapter, we describe our personal journeys as wounded healers and the inner work processes that resulted and subsequently informed our service to others. We also outline how the habit of inner work is important for helping professionals at all points of development and how this work can contribute to our ability to uphold our ethical responsibilities. Below we define inner work and then outline how inner work has played a role in our personal and professional lives, including delineating some ethical standards unique to the practices of psychology and art therapy.

Defining Inner Work

Inner work, sometimes referred to as *process work* (Mindell, 2016), can be accomplished through many different forms. Essentially, inner work involves looking inward at the self, and includes such practices as guided meditation, individual or group therapy, personal counselling, art-making, dream work, journaling, spiritual ceremonies, and mindfulness training. Ratner (2015) describes inner work as leading to "the place of *presence* [emphasis added] and being both in psychotherapy and in one's life as guiding principles" (p. 2). She refers to the power of presence as a way of being whereby one sits with one's experience and can express caring for oneself and for another. Others have underscored the importance of various types of inner work for maintaining one's self-awareness and competence as a therapist; including the importance of personal counselling or therapy (Loewenthal, 2019); prayer, meditation and other spiritual practices (Mensah & Anderson, 2015); the use of journaling (Gibson, 2018); and the relationship between art-making and self-care (Riedl, 2015).

Inner Work and Presence

Ratner is but one of many to write about the power of presence in the therapeutic environment. The idea, although somewhat hard to define (Geller & Greenberg, 2002), was first proposed by humanistic therapists as a fundamental component of therapy and the building block for all therapeutic change. Bugental (1978) wrote that the nature of presence was to be as attentive in the moment as one can be with another human being.

Rogers wrote about the core conditions of empathy, genuineness, and unconditional positive regard for building healing relationships with clients (Corey, 2017). In his later writings, he began to discuss the importance of the therapist's presence for accessing these core conditions (Rogers, 2007). We are drawn to these ways of being in therapy as we have both seen the power of presence with our clients and believe that inner work has played a key role in facilitating our ability to engage this presence within the therapeutic relationship. These humanistic descriptions of presence resonate for us as we see how presence provides a connection to how we cultivate and express empathy and compassion for clients (presence in *psychotherapy*) as well as a way to show this empathy and compassion to ourselves and others (presence in *life* as guiding philosophy) (p.2). Most recently, Bourgault and Dionne (2019) defined psychological presence as "the capacity to bring one's whole self into encounters with clients by being present on multiple levels" (p.50). We were encouraged to read this definition from 2019 as it brought together much of the humanistic descriptions we outline above.

Siegel (2010) also emphasized the need for presence in all our human interactions, not just our professional therapeutic ones. He calls presence a state of "being open and creative with possibilities . . . being aware of the present moment without grasping onto judgements" (p.1). Siegel posits that the practice of *mindfulness* is a cornerstone of developing one's ability to be aware, open, and creative. For Siegel and for us, mindfulness is viewed as a practice that can cultivate a state of presence. We have found, in our experiences as therapists, that it is difficult to be present to what is unfolding at the moment with a client unless we are mindful of the moment. We also agree with Siegel's idea that greater presence in our interactions with others, particularly our clients, can assist us to have reflective responses (where we can take a moment to decide what we want to do or say) instead of reactive responses (where we say or do something without thinking it through, which is more likely to harm others). In line with the notion of self-reflection, we also see the practice of mindfulness as an important component of inner work practices.

Inner Work and Ethical Practice

In addition to its connection to presence, inner work involves questioning and examining one's life and oneself in an open manner (Bernhardt et al., 2019; Ratner, 2015; Salter & Rhodes, 2018). It also can include self-reflection via the means mentioned above (meditation, therapy, etc.), and can involve becoming aware of one's biases, values, and identity (Andrews, 2009). Inner work fits well with the Principle II "Values Statement" of the *Code* (CPA, 2017, para 5), which emphasizes the key importance of self-knowledge and self-reflection to Responsible Caring. It also fits well, in particular, with Ethical Standard II.10, which emphasizes becoming aware of one's own experiences, background, beliefs, and values, and integrating this awareness into our efforts to benefit and not harm others. The reader is referred to Table 1 below, which outlines relevant excerpts from both Principle I (Respect for the Dignity of Persons and Peoples) and Principle II (Responsible Caring). Principle I and its application will become relevant later in the chapter.

As Nan is a certified art therapist, Table I also contains some relevant standards from the Canadian Art Therapy Association's (CATA) Standards of Practice (CATA, 2004), outlining art therapists' responsibilities to maximize therapeutic benefit to their clients while minimizing harm, particularly the standards outlined in Section C. It also contains excerpts from CATA's Educational Standards, which encourage students in training to be involved in their own therapy, with the aim of fostering "deep personal awareness and understanding of the therapeutic process" (CATA, 2015, Standard 2.3b).

Table 6.1: Relevant Principles and Standards

Canadian Code of Ethics for Psychologists **(CPA, 2017)**	***Canadian Art Therapy Association Standards of Practice*** **(CATA, 2004)**	***Canadian Art Therapy Association Educational Standards*** **(CATA, 2015)**
Principle I. Respect for the Dignity of Persons and Peoples	C. Professional Competence and Integrity	2. Admission Prerequisites
I.38 Respect the moral right of research participants, employees, supervisees, students, and trainees to reasonable personal privacy, and take care not to infringe, in research, teaching, supervision, or service activities, on the personally, developmentally, or culturally defined space of individuals or groups . . . unless clear permission is granted to do so.	C.3 Art Therapists seek appropriate professional assistance for their own personal problems or conflicts that are likely to impair their work performance and their clinical judgement. C.5 Art Therapists shall maintain professional competence by utilizing such means as ongoing self-evaluation, peer support, consultation, research, supervision, continuing education, and personal therapy to evaluate, improve and expand their quality of work with clients, areas of expertise, and emotional health.	2.3(a) Where provincial standards for public institutions allow, programs promote participants' personal therapy with an art therapist or certified counsellor. This may involve individual or group process. (b) When possible, the personal therapy will be done during the course of training and prior to completion of the program. However, it may be done prior to entering the program. Sufficient hours may vary at the discretion of the school, but should be enough to foster deep personal awareness and understanding of the therapeutic process.

Table 6.1: (*continued*)

Canadian Code of Ethics for Psychologists **(CPA, 2017)**	***Canadian Art Therapy Association Standards of Practice*** **(CATA, 2004)**	***Canadian Art Therapy Association Educational Standards*** **(CATA, 2015)**
Principle II. Responsible Caring		
Values Statement (para 5): "psychologists recognize the need for competence and self-knowledge. . . They also engage in self-reflection regarding how their own values, attitudes, experiences, and social context (e.g., culture, ethnicity, colour, religion, sex, gender, sexual orientation, physical and mental abilities, age, socio-economic status) influence their actions, interpretations, choices, and recommendations. This is done with the intent of increasing the probability that their activities will benefit and not harm the individuals and groups . . . with whom they relate in their roles as psychologists.		
II.8 Take immediate steps to obtain consultation or supervision, or to refer a primary client to a colleague or other appropriate professional, whichever is more likely to result in providing the primary client with competent service, if it becomes apparent that a primary client's issues or problems are beyond their competence.		
II.10 Evaluate how their own experiences, attitudes, culture, beliefs, values, individual differences, personal needs, and historical, economic, and political context might influence their interactions with and perceptions of others, and integrate this awareness into their efforts to benefit and not harm others.		
II.11 Seek appropriate help and/or discontinue scientific, teaching, supervision, or practice activity for an appropriate period of time, if a physical or psychological condition reduces their ability to benefit and not harm others.		
II.12 Engage in self-care activities that help to avoid conditions (e.g., burnout, addictions) that could result in impaired judgement and interfere with their ability to benefit and not harm others.		

We found that the process of personal therapy provided us both with a helpful vehicle to develop greater empathy and compassion for our clients. However, we acknowledge that personal therapy is only one of several options for engaging in inner work. Further, we maintain that personal inner work for the helping professional can be both preventative (helping us become more self-aware so we can integrate this with our knowledge and skills to be present and helpful to our clients) and responsive (helping us when something happens in the counselling hour that may overwhelm or trigger us). Overall, we see inner work in its many forms as the process of connecting to our mind, heart, and our body in ways that inform how we respond to others and ourselves. We believe that involvement in inner work has helped us to be less reactive to issues that arise with clients, as well as ultimately being better helping professionals. Consistent with the Canadian Psychological Association's Mutual Recognition Agreement (CPA, 2004), we also believe that the self-knowledge that can result from inner work is a key component of competency for our interpersonal relationships as therapists, and that this helps increase our presence with ourselves and with our clients (Ratner, 2015).

Our Early Experiences with Inner Work

Below we outline key experiences with inner work in our lives that have influenced us to continue such practices in our graduate training and with our work as practitioners. We also briefly identify turning points; moments in our professional lives when things *got real* for us in terms of the link between inner work and our ethical responsibilities.

Nan Stevens, Certified Art Therapist (British Columbia)

One of the primary ways I have engaged in inner work has been through the art therapy process. I learned about art therapy when my younger brother, at the age of 20, was diagnosed with terminal cancer. At that time, my family explored numerous interventions to assist in his treatment, one of which was art therapy. While my brother was taking part in art therapy sessions, I became curious about the processes used in art therapy and began exploring art-making as it related to my own emerging feelings of grief and loss. I was so impressed by the impact that art therapy was having on my brother and me, that I enrolled in the two-year graduate training program at Vancouver Art Therapy Institute. During my time in the program, both my brother and father passed away.

Participation in group therapy was a requirement of the Art Therapy Institute training program. It proved invaluable in helping me to cope with my recent losses. Through the group process, I was able to work through the issues related to grief and loss, including my feelings of anger, sadness, and guilt. In retrospect, I realize that having such a supportive place to seek help was invaluable to my work as an emerging practitioner. As a result of the quality of my experience with the mandated group therapy, I decided to continue to engage in personal therapy after completing my training.

TURNING POINT

The importance of helping professionals engaging in some type of inner work during preparatory training became evident for me during my early days as an art therapist. A client came to me for help with processing her grief and associated conflicts regarding her dying mother. Having worked through conflicts in my personal situation (losing two close family members), I was better prepared to facilitate the client's process. During art therapy training, I had become aware of the impact of my own life experiences and had the opportunity to process many of my feelings around these experiences. Rather than getting caught up in my feelings of grief, I felt confident that I could assist the client by focusing on her story, not my own. As CATA Standard of Practice C.5 (CATA, 2004) indicates, there are a number of ways to maintain professional competence, including ongoing self-evaluation and personal therapy, among other choices (See Table 1). For me, I found evaluating my reactions and drawing upon the learning I had done during group and personal therapy to be helpful to me during the above ethical challenge of my life circumstances interfering with my ability to be of benefit to the client.

Toupey Luft, Registered Psychologist (Alberta)

I came to inner work by seeing it modelled in my family of origin. My parents attended spiritual and self-awareness workshops and they were both in the helping field. Our family engaged in family therapy at one point due to a crisis when I was a teenager. At that time, I already knew I wanted to be a psychologist. However, I still felt somewhat uncomfortable with attending family therapy. I think I was embarrassed that my family and—by extension—I required help. Later, as a young adult, I sought personal therapy and worked through some of the stumbling blocks related to being more *present* (Ratner, 2015) with myself and others in my life. Despite encouragement from a select number of friends and family for engaging in inner work via therapy, I did not share this information with many others early in my undergraduate years as I thought I may be stigmatized and judged harshly. I was under the common misconception that therapists (and therapists in training) have all the "answers" and have worked out all of their issues; thus, to have to admit to inner work in the form of therapy felt like a failure. I eventually came to embrace talking about these issues, and this will be outlined further below.

WOUNDED HEALER

Another important concept related to inner work for me is that of Jung's *wounded healer*. I came upon Jung's notion of the *wounded healer* when studying goddess spirituality as part of preparation for a paper in my graduate counselling theories course. I was inspired by the Greek myth of Asclepius, who after acknowledging his unconscious wounds, became a *wounded healer* who helped others heal (Jung, 1954/1966). Jung maintains that communication between patient and therapist (or analysand and analyst) is a balancing act for the analyst in terms of remaining open to hearing about the wounds of the analysand and monitoring their own wounds that may be activated during this interaction (i.e., counter-transference). This framing fit well for me as a developing clinician who was learning about counter-transference and the importance of self-reflection in interacting with clients and others.

TURNING POINT

The importance of inner work and how it can influence our ethical engagement with clients became more evident to me when I began to work with several people who triggered negative reactions in me. I noticed that these reactions were similar to those I had with several important persons from earlier times in my life. Drawing upon the foundation of inner work I had undertaken, I found I was able to manage these negative reactions and not get stuck in my counter-transference issues. My understanding of the wounded healer and monitoring one's own wounds was helpful here as well. Although I do not have an objective way to measure the impact of this understanding on the clients I was working with, I feel confident that I was better able to assist them and provide responsible care after engaging in self-reflection about my initial reactions, and by monitoring these reactions to keep communication open during counselling sessions.

Encouraging Graduate Students to Answer the Call

Since we are both educators, and we are passionate about the importance of inner work in the development of helping professionals, we would like to share some key considerations and our own stories regarding how to broach and facilitate the topic of inner work with graduate students studying in the therapeutic helping professions. We also discuss some ethical considerations regarding implementing these ideas with students.

The Wounded Healer and Ethical Practice

Some research indicates that graduate students who enter the helping professions are drawn to help others because of their own distressing life experiences (Messina et al., 2018; Rønnestad & Skovholt, 2003). However, there also is some research that demonstrates there remains strong stigma regarding graduate students' disclosure of their past or current struggles with distress or what Jung would call "wounds" (Spence et al., 2014). One of the ideas that we utilize in teaching graduate students, which seems to encourage consideration and discussion of inner work, is Jung's notion of the wounded healer. Contemplating the idea of the wounded healer and counter-transference often requires graduate students to let go of the idea that therapists are the ones with all of the answers, and the belief that they can hold all of their past experiences at bay to assist their clients.

Jung indicates that clients may activate our own wounds, even if we have done some inner work regarding them. Thus, he cautions healers to remain *conscious* of their reactions and to what degree these are shared with others. For us, the others we might share with include both our clients and our students. In discussing the concept of the wounded healer, Zerubavel and Wright (2012) also acknowledge that, although we may be aware of our reactions, it may not always be beneficial, as therapists, to share our reactions with our clients, as this may detract from our presence, or our ability to focus on the client and be helpful. It is only when our wounds move from unconscious awareness into conscious awareness that we can truly assist in healing others' wounds (Jung, 1954/1966). In our opinion, Jung's description of this transformation is consistent with the notion of invoking psychological presence (Bourgault & Dionne, 2019; Ratner, 2015; Siegel, 2010). Further, we believe that these descriptions of being conscious of our "wounds" and taking time to reflect on what we will do with this information parallel nicely with ideas of self-awareness and self-reflection as key components of ethical practice (CPA, 2017).

Introducing Inner Work in Graduate Discussions

As mentioned above, we have engaged in inner work practices to both enhance our therapeutic work with clients, but also to minimize harming them. We believe that learning about inner work and the *wounded healer* is important to introduce with training helping professionals so that they might understand how these concepts can help build ethical awareness as a developing practitioner. We have witnessed students expressing relief at the direct addressing and exploration of these concepts in graduate training. We concur with Bearse et al. (2014), who indicate that these types of topics are important to bring up during graduate training of helping professionals.

We encourage students to discuss as well as document their reactions to the concept of the wounded healer; to examine the stigma that may surround admitting one has experienced mental distress in the past or currently; and to understand how professional ethics encourages self-knowledge and awareness of issues such as counter-transference and burnout, and how stress or a personal crisis might impact our ability to practice therapeutically. In a way, we are asking our students to begin or continue a form of inner work by reflecting on their responses to the above activities, and how their own experiences have influenced their thoughts and reactions to the topic. We also look at the relevant ethical standards of the *Code* (CPA, 2017) and/or the CATA Standards regarding maintaining competency (CATA, 2004). We have encouraged students to write reflections regarding how inner work and the concept of the wounded healer support the values statement and relevant standards for Principle II, as well as the CATA Standards C.3 and C.5 (please refer to Table 1). Toupey also has encouraged students to use the ethical decision-making model associated with the *Code* (CPA, 2017) to examine the benefits and risks associated with inner work.

Turning Point and Other Ethical Considerations

Our graduate students have shown us that discussing the overlap between our personal and professional lives is necessary for contemplating how inner work might be applicable. However, we also realize the essential need for creating ground rules and guidelines for safety, disclosure, and confidentiality for learning to be effective for those in training. Several of our students have shared over the years that they have sometimes felt "shut down" by the comments of others in the classroom or by a vague sense of not wanting to engage in conversations about inner work; sometimes due to fears of being stigmatized. We also recognize that, like our clients, students have a moral right to choose what is healthy and appropriate to share with their peers, as per the *Code's* Principle I (Respect for Dignity of Persons and Peoples), specifically Ethical Standard I.38 (CPA, 2017).

In considering the rights of students to protect their own privacy, we have heightened our teaching practices to closely attend to ethical concerns in the classroom. Several writers in the field (Luft et al., 2016; Pope et al., 2006) maintain that a sense of safety is paramount for students to discuss sensitive topics such as how they might engage in inner work or how the concept of the wounded healer fits with their lives.

Ultimately, this sense of safety may be both difficult to establish and maintain in the graduate classroom. Students may state that they feel safe when in fact they do not. This may occur for a variety of reasons, including wanting to please the leader/instructor. Students may initially have a sense of safety, but have it eroded over time due to interactions in class or online. Students may fear an erosion of boundaries, a sense of shame, or both, in disclosing their experiences with inner work. They might begin to compare their experiences with others and determine they are not at the same level as their peers, which may be problematic. There is already a general sense of academic competition among students for scholarships, practicum placements, etc., and we find it takes delicate skill for us as instructors to be aware of this context in moving the conversation about inner work forward. In essence, we need to be mindful of how to responsibly care for our students. However, we believe that encouraging them to continue or begin inner work habits at this stage of their development will ultimately help them serve their clients-to-be more richly and responsibly, and this is why we continue to facilitate inner work as a focus for our students. We encourage our students to explore inner work practices by introducing them to the general idea as well as by utilizing reflection exercises and discussions such as those found at the end of this chapter to encourage critical thinking and decision making for each student.

One of the practical steps we have taken is to monitor our own statements and disclosures in the classroom or online very carefully so that we are balancing the principle of Responsible Caring with the principle of Respect for Dignity of Persons and Peoples. We do not wish the students to feel coerced into inner work (or disclosure around this). Contributing to that type of environment would represent poor ethical modelling on our part. Part of our monitoring includes deciding whether self-disclosure regarding having engaged in inner work will help the student group if we sense that they are struggling with some of the stigmas around helpers not having any personal struggles or issues. Furthermore, any self-disclosure on our part is not meant to pressure students to disclose their own inner work experiences or plans; rather, it is meant to model the fact that we as instructors and senior clinicians value inner work and its potential for helping us be ethical, reflective practitioners. We have found that co-constructing group guidelines around confidentiality and group norms for what people choose to share are foundational cornerstones for facilitating these important conversations and learning moments. Further, peer-to-peer sharing (such as the reflection questions at the end of the chapter) may help facilitate sharing within a smaller group compared to a larger group (e.g., the entire classroom).

Continuing the Practice of Inner Work Beyond Graduate School

Toupey's Journey

One of the areas in which inner work helped me immensely as a newer therapist was in balancing *impostor syndrome* (Clance & Imes, 1978) with the limits of my professional competence. Early on in my career as a post-master's degree therapist, I often suffered from worrying that I did not know how to help clients. In sessions, I frequently would run some of the scripts in my mind that Clance and Imes (1978) identify as associated with *impostor syndrome*. Some of my favourite scripts centred around being worried that I would be found out by my clients for not knowing what I was doing, and around my belief that at one level I was fooling them and, if they looked deeper, they might notice that I did not really have any business being a therapist. To say that this detracted from my ability to be present and helpful to my clients at the time is an understatement.

To help me with this issue, I sought the advice of a more senior therapist, who was also my supervisor. She objectively reviewed the issues and the methods I was using and indicated that she believed these were within the scope of my competence. She helped clarify that my self-doubt was probably getting in the way of my ability to serve my clients. She gently encouraged me to seek support through inner work practices and spoke openly about how engaging in her own therapy at various times in her life had helped her overcome roadblocks. I decided at that juncture to seek out further therapy (it had been several years since I had attended therapy as an undergraduate). The application of the *Code*'s Ethical Standard II.8 (CPA, 2017), regarding seeking supervision and/or consultation if one is concerned that client issues are beyond their scope of competent practice, became part of my lived practical experience.

TURNING POINT

Another situation where the helpfulness of inner work became very relevant was when I lived through a health crisis when practising as a psychologist full-time in private practice. I had to be hospitalized and was very worried about myself and my ability to function in the future. In reflecting, I realized that the situation represented, in a very real way to me, what the *Code*'s Ethical Standard II.11 (CPA, 2017) states:

> Seek appropriate help and/or discontinue scientific, teaching, supervision, or practice activity for an appropriate period of time, if a physical or psychological condition reduces their ability to benefit and not harm others (p. 20).

It was not until I experienced such a personally impactful health event that I fully understood what this Ethical Standard meant. I had to take a break from seeing clients and to communicate this to them, as well as provide access to alternate resources. This was difficult for me to accept, as I perceived my inability to continue to see clients as a failing. I also experienced a great deal of worry about the future and how my health condition would affect my future in all realms, including the personal and professional ones. I engaged in many inner work practices to assist me with the personal healing process, and again attended therapy to deal with my anxiety about the future and to move through some trauma associated with the crisis. I also used meditative practices to help calm my fears, and journaling and art-making to help me make sense of what happened and to help me see more clearly the way forward as a person and as a helping professional. In reflecting on this health crisis, I am grateful for it now that several years have passed. Overall, I learned a lot about myself and even more about how the *Code* can be applied to ethical dilemmas in real life. It also affirmed for me, once again, the value of therapists engaging in their inner work so that they can continue to meet their ethical responsibilities.

Nan's Journey

The helpfulness of inner work practices for facilitating effective therapy became evident for me during my early days of being an art therapist. One of the important take-away messages from the group therapy requirement of the art therapy program I attended was that grief, anger, and sibling rivalry are typically the big unresolved conflicts in people's lives (M. Fischer, personal communication, 1999). I used inner work to focus on these issues during my two-year graduate program, particularly grief, as I outlined in the turning point section of my introduction.

Growing up as *the middle* in a family with five children, I dealt with my share of sibling rivalry. One of the significant realizations of my inner work during my art therapy training was that the sibling rivalry was still relevant and active in my adulthood.

As an art therapy student, I was committed to understanding more about my family of origin. The supervising psychiatrist (the late Dr. Martin Fisher) facilitated intense group retreats and brought to our learning the significance of attachment (or lack of) and its role in one's sense of self and security. It became apparent through my inner work that the lifelong conflict with one of my siblings stemmed from an unconscious and unresolved conflict where the two of us were competing for parental attention and love.

TURNING POINT

I believe that the learning that came out of this early inner work has been extremely valuable in working with siblings and families in my practice. The early work on attachment by John Bowlby (1969), and the more recent work by Neufeld and Mate (2013), have been pivotal in informing my practice for helping clients. Attachment can be formed later in life and can provide a "corrective" experience for those who may not have had the essential bonding they needed earlier in their lives. Within a safe therapeutic relationship, the client can express needs, be vulnerable, and find the acceptance and love they need to feel self-love and self-acceptance. Neufeld and Mate posit that a therapist is a person who can promote the development of trust and create the space for a healthy attachment relationship.

I had the fortunate opportunity to work with a young woman in my private practice who had lived with an eating disorder since her youth. Through the art therapy process, it was uncovered that she did not have an attachment to either of her parents, and we concluded that the eating disorder was related to the lack of attachment which manifested in self-harm. I worked with this young woman for over two years, using art media (painting and clay) as a place to start expressing her needs, her anger, and her unresolved conflicts with her siblings and parents. Without my insight into my sibling rivalry and my own issues with lack of attachment, I may not have been able to be effective with this client. The significance of CATA's (2004) Standard C.3 became very applicable to my experience (See Table 1). I learned on a very personal level that the process of engaging in my own inner work helped to prevent potential conflicts within my practice.

Coming Full Circle: Considerations for Continuing the Call

We believe that there is an increase in interest in *inner work* and its benefits for therapists and their clients. Discussions of inner work have come to prominence in the counselling psychology and art therapy literature, particularly in the past 10 years (e.g., Bamonti et al., 2014; Bernhardt et al., 2019; Hinz, 2011; Salter & Rhodes, 2018). Most professional graduate programs now include discussions of some types of inner work in the practical component of the program (practicum). Indeed, the master's level counselling program where Toupey recently taught emphasizes self-care, self-reflection, and an invitation to consider engaging in one's own counselling throughout the program. We have been encouraged by the increased frequency of discussions about the topics related to inner work at professional conferences in the past several years. During Toupey's master's-level studies in counselling psychology in the mid-1990s, there was little mention of inner work or its relevance to ethical practice. Although Nan's art therapy program required the cohort to engage in mandatory group therapy, the ethical implications of this were not highlighted. We are encouraged to see that most art therapy programs now include mandatory ethics courses, as well as encourage inner work as per CATA's 2015 standards, but not through mandated therapy with one's cohort.

For early-career helping professionals, we recommend continued inner work as part of honouring the ethical principle of Responsible Caring, and specifically to assist with goals of being of benefit to our clients and minimizing harm. We believe recently licensed or newly registered art therapists or psychologists have a responsibility to continue to utilize inner work and its benefits, especially if transference and counter-transference concerns are relevant to their type of practice. This position is supported by Schwing et al. (2011). Their interviews with novice therapists indicated that participants' inner work practices such as reflexive journaling helped them move through their feelings of anxiety about their role with clients, as well as bolstered their willingness to address transference and counter-transference concerns.

As our own experiences have shown us, we think it is very important for newer helping professionals to continue to self-examine and self-regulate. This commitment necessitates some type of continuing development through inner work. In many ways, the stakes are higher compared to being a trainee or student. When a person becomes licensed as a helping professional, that person has a direct personal responsibility to maintain the standards related to competence, as teachers and supervisors are no longer responsible.

We believe in a stronger call to incorporating different types of inner work as a proactive component of training and ongoing development. Part of this could entail faculty and student-led discussions of what inner work is, how it can help students and practising professionals be more effective and ultimately more ethical practitioners; and what some of the limitations and concerns are with respect to engaging in inner work. Perhaps as educators of counsellors or therapists, we could incorporate this topic into our course syllabi more frequently. Supervisors of newer therapists could promote the topic by discussing it in supervision. Of course, we must be mindful of standards (such as the *Code*'s Ethical Standard I.38) associated with privacy and the developmentally—and the culturally defined boundaries of the people who are our clients, students, and supervisees. This means we need to proceed with caution with these types of conversations and respect the needs of those who are most vulnerable in our interactions. We acknowledge this is important for us as educators and supervisors as we have influence and power over trainees and supervisees by virtue of our position. We must keep in mind that we need to broach conversations with our supervisees with caution, continuing to respect their dignity, and ensuring that such conversations are not harmful to the supervisee and that they remain in the realm of supervisory discussions so that the supervisor does not become a therapist to the supervisee.

Future Explorations

Our lived experiences and research for this chapter have made it clear to us that there is a great need to continue the dialogue regarding the ethical implications of inner work and its relationship to practitioners and trainees. We encourage ourselves and those reading to continue considering the following questions throughout one's development as a therapist: What are the ethical implications for supervisors who mentor developing clinicians? How could newer clinicians in the field be encouraged to engage in inner work? What makes certain practices more fraught with ethical difficulty or a lack of safety? Further, as we have highlighted in this chapter, it is worth considering how enacting Responsible Caring might conflict with other *Code* (CPA, 2017) principles, such as Respect for the Dignity of Persons and Peoples. Overall, if we truly want to encourage growth for our clients, we might attend to explicating the link between inner work practice and how it may lead to being a more effective therapist. Although there is a great deal of research on therapists' theoretical orientation and the effectiveness of therapy (Corey, 2017), much less is known about therapists' various inner work experiences, ethical considerations, and client outcomes (Rousmaniere, 2019). We would thus encourage practice-focused research to explore this link. One of the ways this could be accomplished is to have various clients rate their therapists' presence (Siegel, 2010) and helpfulness in sessions. Researchers could examine the link between how helpful and present a therapist is to the various types of inner work they have engaged in. In this way, clients need not know about the therapists' current practices and/or past engagement in inner work. Dan Siegel (D. Siegel, personal communication, October 21, 2018) found that that certain types of inner work practices help therapists achieve empathic, compassionate, and less emotionally reactive states and traits and thus it is important to continue to elucidate this process.

We call on helping professionals at all stages of their development to consider the notion of the *wounded healer* and how inner work might allow us to embody presence for our clients and ourselves (Ratner, 2015; Siegel, 2010). There will be many opportunities for growth that present themselves in our journey as clinicians. We hope that the desire to help others and to remain healthy ourselves will motivate clinicians at all stages to continue to engage in inner work and to continue to reflect on their own development and efficacy with the people whom we are privileged to assist.

Questions for Reflection

1. What is or what would be your preferred way(s) of doing inner work over the course of your career?
2. What has signalled to you in the past that you need advice from a supervisor or consultant regarding your own well-being? What do you think might signal it in the future?
3. What would signal to you that you need mental health services or supports to continue your work activities or schedule?
4. How would you know if you have a need for a partial or full leave from your work activities in order to avoid harm to yourself or others? How would you know when you are ready to return? Would stigma play a role in either decision?

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7

The Role of Deliberate and Reflective Practice in Fostering Responsible Caring in Supervision

Jon Amundson, Marc Ross, Dalal Shaheen

Introduction—Jon

Jean Pettifor and I worked together for over 20 years in a variety of areas. Supervision, the preparation of students, interns, or supervises for entrance into the profession was one such area. To honour Jean, who was always there to open doors for her students, and for a current perspective on supervision and the development of deliberate and reflective practice, I asked two of my former junior colleagues or supervisees to contribute to this project. Marc is in independent practice in Calgary and writes a regular column for *Psymposium*, the official publication of the Psychologists Association of Alberta, on early-career issues for psychologists. Dalal is finishing post-graduate and licensure work in the U.K.

We were asked to select one of the ethical principles in the *Canadian Code of Ethics for Psychologists* of the Canadian Psychological Association (CPA) (CPA, 2017), and to apply it to supervision. We selected Principle II (Responsible Caring) and have connected it to deliberate and reflective practice (Brookfield, 1998), an essential skill related to ethics in general, and to responsible caring in particular. Each of us reflects upon the methods, means, and modes employed in fostering responsible caring through deliberate and reflective practice as an acculturative exercise (Bashe et al., 2007), as the internalization of the ego ideal or inner heroic imagination (Franco et al., 2009), as fostering mindfulness (Campbell et al., 2012), and finally, as the development of contextual know-how (Flax, 1990).

Responsible Caring in Supervision—Jon

At the time of my preparation and entrance into the profession, supervision was initially less than well-structured and defined (Amundson, 2008a). My early supervision was a top-down affair, where the supervisor knew best, and the supervisee was to conform to the supervisor's personal definitions of practice. In my initial work as a supervisor in the 1980s, the experience would be more akin to what I today would call training—almost exclusively, assistance in mastering a model of treatment or assessment. Attention to ethics, generic human relation skills, administrative responsibilities, and socio-cultural considerations were all but absent. Due to salient landmarks in the professionalization of supervision, this is not the case today.

Several articles have addressed the matter of supervision in Alberta (Amundson, 2008a, 2008b, 2009a, 2009c; Van Mastrigt et al., 2008). Into the 21st century, the majority of supervisors had virtually no specific training in supervision nor access to guidance (Amundson, 2008a). As a corrective measure, two actions were taken: (a) the Psychologists Association of Alberta in partnership with the University of Calgary designed an online course (Amundson, 2008b); and (b) two senior psychologists (Dr. Walter Goos and me) were appointed as supervision consultants for the College of Alberta Psychologists. The purpose of the first action was to offer a training opportunity to individuals interested in becoming more competent and confident as supervisors; the second action was to provide consultation to both supervisors and supervisees on supervision issues. Dr. Goos and I referred to these actions as "repairing the ship at sea" because, like most jurisdictions in North America at the time, there were more students, interns, and supervisees than available supervisors (Amundson, 2008a). Hence, to impose a higher standard (i.e., specific preparation or standards for supervisors) too quickly ran the risk of running actual and potential supervisors out of the business.

Supervision also began receiving greater attention in other parts of North America. In 2004, Falender and Shafranske published their first text on competency-based supervision. In 2006, the American Psychological Association began publishing the *Journal of Training and Education in Professional Psychology*, and the competency approach to supervision grew (Fouad et al., 2009; Hatcher & Lassiter, 2007). The competency approach spoke to specific skills, their development, and measurement of their progress during the process of supervision. It was a move away from a top-down and supervisor-dominated approach to one based on mutually identifiable goals and objectives, and it established structure regarding content and evaluation in supervision (Hatcher et al., 2013). The focus on what works and how to measure it in supervision paralleled the movement in professional psychology toward the empirical criterion for clinical practice.

Supervisors began to structure supervision around the concept of functional and foundational principles (Rodolfa et al., 2005).

In my work with both supervisors and supervisees, I emphasize what is referred to as the (basic) competency cube (Rodolfa et al., 2005). For individual psychologists in training, the question is what each of them will be; that is, what functional skills each wishes to acquire. I speak of functional skills, then, as part of professional identity, particular to each psychologist within the broad scope of practice psychologists enjoy. Functional skills include treatment and intervention, assessment and evaluation, consultation, and teaching and training (including skills in supervision, research, and administration). These are concrete aspects of responsible caring. They are elective; that is, specific to whatever supervisees seek to define as their particular scope of practice. However, of equal, and perhaps even greater, importance are foundational skills.

Foundational skills are common and necessary for all psychologists: They are expressive or normative aspects of responsible caring. This is reflected in questions I always ask myself regarding any potential supervisee: "Can this student or supervisee be trusted to be in a position of authority and influence with a potentially vulnerable patient? What is his or her capacity for responsible caring?" Whether working as a therapist or organizational consultant, foundational skills are primary and shared by all. In my work with supervisors, I speak of functional skills as more conceptual in nature (e.g., mastery of manual-based treatment, testing protocols, or particular statistical methods). Of foundational skills, I speak of a more dynamic emphasis, because competency here pertains to human relation skills, self-knowledge and awareness, appreciation of ethics and public policy, and the embracing of empiricism and even skepticism, as well as cultural and larger systemic considerations.

I emphasize the importance of foundational skills such as engagement, appreciation of socio-economic and cultural differences, motivational concerns, and treatment receptivity. It is with foundational skills that clinicians truly approach responsible caring, and where responsible caring emerges in deliberate and reflective practice (DeAngelis, 2018; Rousmaniere, 2016; Rousmaniere et al., 2017). Before discussing responsible caring and its development in supervision, however, it is important to speak to responsible caring on the part of the supervisor. Responsible caring is not a one-way street and, with the statement attributed alternatively to Rumi or Gandhi, I admonish supervisors to "be the change here you want there." This means that the supervisor needs to model responsible caring and be deliberate and reflective in this regard. One method for internalization of ethics is social learning, consisting of modelling and observation, behavioural rehearsal, imitation and, finally, enactment (Bandura, 2017; Bandura & Walters, 1963). Supervisees are watching supervisors to see what they practice and what a psychologist looks like. For this reason, the central place of the supervisee in supervision cannot be overemphasized. Each student, intern, or supervisee is an N of 1—possessing a unique set of instrumental, normative, and expressive skills. Hence, appreciative inquiry by the supervisor is one way to demonstrate responsible caring.

Supervisors often call me and ask, "What is it I ought to do, prioritize, or put in place to make supervision work?" In response, I have found that it is helpful to provide the following four deliberate and reflective perspectives (Amundson, 2008a). First, understand and attend to both the administrative and process aspects of supervision. This involves: having in place a well-thought-out supervision plan and making clear the contractual responsibilities of both the supervisee and supervisor; being attentive to the process as it unfolds and making modifications accordingly; and seeking feedback on the relevance of the supervision to the goals of the supervisee, essentially being aware of what both the supervisor and supervisee are doing and why.

Second, provide feedback progressively (Amundson, 2009b). Nothing should take a supervisee by surprise. Supervisors often speak to me about their concerns regarding a supervisee who is approaching the end of a supervisory relationship with them. I ask how and in what manner they have communicated any of their concerns to the supervisee, and whether they have entered their concerns into the supervision record. Timely and useful feedback, though at times awkward for each party, is important.

Third, be creative in providing opportunities to incorporate not only foundational skills and experience into supervision, but also functional skills (Amundson, 2008b) For example, I often write (as with this chapter) with my younger colleagues and supervisees, so they are exposed to research as a functional skill area. Regarding foundational skill exploration, it is important not to simply wait for opportunities to discuss ethics, or systemic appreciation, or self-care, or cultural issues in supervision; rather, the supervisor needs to create such opportunities.

Finally, as with treatment, it is important to meet supervisees where they are (Prochaska & DiClemente, 2003), and to work in a collaborative, co-operative sense (Amundson, 2008b). Though the supervisor must exercise authority and responsibility, the hierarchy involved ought not be emphasized. The authority of supervisors is best exercised as editors, assisting supervisees to develop their own personal way of being in the profession (Parry & Doan, 1994).

Responsible Caring as Deliberate and Reflective Practice—Marc and Dalal

In our own training, we found that the creation of opportunity in supervision includes not only deliberate effort to develop functional skills but also opportunity regarding the foundational. In what follows, we discuss vehicles for bringing foundational skills to life—fostering more deliberate and reflective practice as a path to responsible caring. People have to walk before they can dance. The goal, however, in deliberate and reflective practice is to move beyond basic pedestrian application of clinical skills to greater and more creative professional judgement and execution.

Supervisees and students, in the process of learning to become professionals, have many opportunities to practice and learn the art of deliberate practice. One of the most important aspects of our growth as psychologists was the time we spent in conversation with supervisors on the theme of what it means to care responsibly. This occurred in various ways and included writing or using other creative ways of expressing insights, curiosities, and struggles.

Ideally, such self-reflection occurs throughout one's career. However, it should be afforded special attention in one's early career, so that one has a solid foundation for reflecting upon foundational skills. For instance, during supervision and consultation, Jon would occasionally provide space for us to share a challenging life event unrelated to the process of learning therapy; that is, our personal struggles related to our exceptional status as disabled or culturally distinct persons. Feedback on these reflections would be done kindly and respectfully, but directly, and would often be accompanied by an explanation of how supervision is different from therapy. This process of reflection was done in such an artful and mindfully non-judgemental way that we learned not just from the practical detail that was shared, but also from the way it was communicated, providing opportunity to see the process from several new vantage points (Paré & Larner, 2014).

To master our craft, however, such reflection also was supported by deliberate practice with each client. Case review is not unlike athletic training, involving a repetition of actions aimed at progressive improvement (Dreyfus & Dreyfus, 1980). We found that this progression goes from the safety of structure, routine, and automatic response to what is called contextual know-how (Flax, 1990). This development in supervision involves thinking, and then thinking about thinking—the ability to understand the minimal skills required for the practice of psychology, and then being able, when required, to think outside the box and execute at a more optimal level.

There are several ways to acquire deliberate and reflective competency, and the responsible caring it sponsors. Below, we present some of these options; namely, seeing supervision as acculturation (Bashe et al., 2007), internalized ideals (Zimbardo, 2007), mindfulness (Campbell & Christopher, 2012) and, finally, the contextual know-how associated with proficiency (Dreyfus & Dreyfus, 1980; Flax, 1990).

Professional Acculturation and Responsible Caring—Jon, Marc, and Dalal

In becoming a professional, there are "some thinks only a psychologist can believe" (Amundson, 2018, p. 1) and must do. These include learning the codes, standards, and guidelines defining conduct, and the habits and behaviours a psychologist must acquire on the way to independent practice. Navigating this process can be thought of as acculturation—the assimilation of a new culture (Handelsman et al., 2005).

When visiting a new culture, people often are exposed to beliefs, behaviours, and practices that are different from their habitual worldview. Sometimes they perceive deviance in those differences. As with any new cultural experience, there are four possible responses (Handelsman et al., 2005, pp. 60-61):

1. Rejection of the psychological ethos and adherence more exclusively to one's own beliefs and experiences: "What I believe is more important than what they believe."
2. Over-assimilation of the culture of psychology such that one's own values, experiences, and beliefs are discounted: "What they believe is more important that what I believe."
3. A third but rare response, where neither personal values nor the values of psychology are significant: "What do I need to believe to rationalize, justify, or defend my actions, situation to situation?"
4. Finally, and the preferable expression of deliberate and reflective process, assimilation of the culture of psychology and its accommodation to one's own experience, beliefs, and values: "How do I balance what they believe with what I believe?"

Marc and Dalal found supervision and consultation to be an intriguing, if not inspiring, exposure to the culture of psychology, and a means of examining their values. Supervision is, as well, exposure to the demands associated with and required for professional identity and practice. *Demands* refer to the ethical and behavioural expectations placed upon the psychologist that are different from those placed on members of society in general. Supervision is not, however, a conversion experience. Supervision is an opportunity for the supervisor to honour what each of us brings as supervisees and to use our inner resources in our development. Parry and Doan (1994) compared this process to editing—supervisors creatively interacting with supervisees to assist them in the realization of their own personal and professional means of expression.

We all agree that it also is helpful to explore personal values and the habits of thought and behaviour associated with professional psychology, discussing the impact of the supervisee's exposure to how the discipline is practiced (Amundson, 2015), with such questions as:

- What have you found in the profession that has surprised you?
- What are things you found in the profession that you did not expect, or expected to find but did not?
- What moral or ethical dilemmas can you recall in your life or in others' lives?
- What has been the most useful, interesting, or unusual learning experience so far in your training?
- If you were speaking to someone who was interested in the psychology profession, what would you want the person to know?
- What life experiences have you had that you think will be useful in the future in your work with other people?
- What sorts of lapses or failures in ethical reasoning or conduct have you seen or experienced? (Fifty percent of supervisees describe negative experiences in supervision as well as observed lapses in ethics in psychologists to whom they are exposed; Amundson, 2008a).

As clinicians, the three of us found that these sorts of questions, when they are explored within a secure supervisor–supervisee or consultant relationship, demonstrate responsible caring by the supervisor who, in seeking such input, may then be prompted to guide or react in greater deliberate and reflective ways (Knapp et al., 2017). For example, in Jon's experience, psychologists-in-training often are surprised that colleagues and older psychologists sometimes fail to practice outside the consulting room what the supervisees observed them practice with patients in the consulting room. Sometimes supervisees find experienced psychologists to be opinionated, abrupt, dogmatic, overbearing, less than supportive, and even condescending with each other; or, as one young psychologist-to-be who wishes to remain anonymous reported, "I thought psychologists would be different." Supervisees' idealized images of psychology as a means of rising above the interpersonal conflicts associated with everyday life become dashed upon the reality of business as usual (Amundson, 1995).

In conclusion, the three of us believe that effective supervision, as reflected in professional acculturation, celebrates what each party brings to the table. Within supervision, professionalization should be viewed as a complex, dynamic, and ongoing accommodation, serving as a means for the development of deliberate and reflective practice.

The Turn Inward: Guidance from the Internalized Hero—Jon, Marc, and Dalal

Zimbardo (2007), in his professional career, sought to understand the contextual nature of good and evil, and purports that ethical concerns often begin and end with situational forces. The *Canadian Code of Ethics for Psychologists* (CPA, 2017) in general, and particularly in Principle II (Responsible Caring), espouses the view that ethics must be more than simply a risk management strategy. The directions, both aspirational and prescriptive, found in the *Code* serve their best purpose when internalized; that is, when they truly serve as habits of thought, leading to and reflected in day-to-day behaviour. The reason such internalization becomes so important is because of the potential external pressure to behave unethically that may be embedded in some situations, and the capacity of internalization to override such pressures and serve psychologists' best judgement (Zimbardo, 2007). In his role as ethics investigator, Jon often finds that, in a lapse of conduct or care, the excuse is that "It is what everyone does," or "Well, the lawyer (or parent, or co-worker) wanted me to do it," or "It was just a business decision." The external forces associated with day-to-day practice related to expediency, finances, the need to maintain a patient referral base, opportunity, personal stress, organizational culture, crisis or emergency, and other demands, can overpower the internal forces associated with ethical consideration and better judgement. However, for Zimbardo, ethics codes and guidelines are not enough to overcome such forces. Franco and Zimbardo (2006), in the Heroic Imagination Project, state that thoughtful attentiveness can override contextual pressures and result in small but significant differences in psychologists' day-to-day experience. They advocate for deliberate and reflective attention to daily circumstances and to the morality associated with virtuous and heroic stances (Franco et al., 2009).

In pursuit of deliberate and reflective thinking, psychologists need to acquire an inner ideal (Cornwell & Higgins, 2015), or "hero," with values that can be linked to an ego ideal (e.g., "What would Dr. Pettifor do?"). These introjects—people who live in our head—can be sources of inspiration that drive a moral intensity that calls forth our better selves and may override contextual pressures. Regardless of whether the virtue being pursued is in the personification of a particular individual, elevating ethics from an external structure for circumstantial regulation to an inner dynamic for self-regulation is a goal in supervision as well as in practice (Handelsman et al., 2009).

In pursuit of an internal antidote to contextual pressures, we learned that the following questions are useful:

- How do we negotiate differences and conflicts in our lives?
- Are we more risk averse or more risk accommodating in our work?
- Who do we admire, not only in our profession but also in history?
- What stories do we have of ethical struggles and choices we made, as clinicians or otherwise?
- What made us proud of ourselves in our lives or in our profession?
- How can we pass on these moments to those we train when it is our turn to train or supervise?

The Turn Toward the East: Mindfulness and Its Role in Fostering Intrapersonal Responsible Caring—Jon, Marc, and Dalal

Through our experiences with supervision, the three of us have found that responsible caring, like Principle III (Integrity in Relationships) in the *Code* (CPA, 2017), is predominantly related to interpersonal issues. These issues encompass primary attention to recipients of professional services and deference to their interests, vulnerabilities, competencies, and right to receive effective psychological service. In the intrapersonal domain, psychologists are reminded not only to continue to remain competent and practice skillfully, but to pursue self-reflective and critical (i.e., deliberate and reflective) thinking regarding their "own values, attitudes, experiences and social context" (CPA, 2017, p. 18). The *Code* encourages self-care as well (Amundson, 2009b). This intrapersonal dimension of responsible caring pertains to one's own well-being, and it is in this light that mindfulness becomes relevant to supervision.

Mindfulness, like the theory of mind in philosophy and mentalization in psychodynamic psychology, is essentially thinking, knowing that one thinks, knowing that others think too, and then thinking about that (Noone et al., 2016). Mindfulness has been associated with benefits to clients when practiced by their mental health practitioners, making it a skill for new psychologists that would be beneficial to responsible caring for others (Campbell & Christopher, 2012; Goldberg et al., 2013; Knowles, 2008). Specific to the context of supervision, Follette and Batten (2000) speak of supervisor and supervisee attunement, and the modelling of a non-judgemental stance. Mindfulness also has been associated with the working alliance in supervision, and with increased self-efficacy in the student (Keil, 2016). Finally, Davis (2014) found that mindfulness led to the cultivation of attitudinal, cognitive, and social skills. His research supports the role of mindfulness in personal and professional development.

Beyond the practical benefits of mindfulness to treatment and training is an argument that mindfulness can sponsor greater ethical commitment and conduct (Purser & Milillo, 2015; Ruedy & Schweitzer, 2010; Shapiro et al., 2012). Mindfulness seems to integrate the foundational skills and to support deliberate and reflective practice, which are active components of responsible caring (Jacobowitz & Rogers, 2014; Shapiro et al., 2012).

Marc and Dalal speak of mindfulness as being threefold: (a) interpersonal, in the sense that it benefits the therapeutic and supervisory relationship; (b) intrapersonal, in the sense of it providing exercise in developing more critical, clinical, and ethical perspectives; and (c) in a more immediate intrapersonal sense, as means of self-regulation. For the most part, mindfulness in clinical practice is associated with management of emotional distress. However, as a self-care skill for the psychologist, it can assist with managing clinical tension. By clinical tension, we think of the demands associated with case formulation, engagement, intervention, and deliberate attention to process and outcome. Cognitive exertion is required and needs to be developed. Responsible caring as self-care can become more than admonitions by supervisors and teachers to eat well, exercise physically, and cultivate a social support system. Responsible caring as self-care can become essential to clinical practice in and of itself.

In a recent article (Amundson & Ross, 2016), Jon and Marc advocate for a distinction between doing (i.e., functional skills) and being (i.e., the refinement of foundational skills). As noted above, much of supervision is dedicated to doing—namely, how to carry out treatments and interventions or assessments and evaluations. We have tried in this chapter, under the banner of responsible caring, to emphasize the aspect of being. “Being” refers to the person a psychologist is, shall be, or aspires to be. Responsible caring as self-care goes beyond care for the patient and reminds the intern, student, supervisee—or any psychologist—to undertake self-care, exercise self-awareness, and be aware of personal well-being. These considerations are all part of our *Code* and our standards and guidelines. Responsible caring for oneself is important because distress, burnout, or brownout (loss of professional enthusiasm) can negatively impact one’s clinical work and well-being on so many levels (APA Practice Organization, 2018). If taken seriously, self-care goes beyond the question of “What kind of psychologist do you want to be?” to “What kind of person do you want to be?”

Responsible Caring as Contextual Know-How—Jon, Marc, and Dalal

The three of us have elected to end this chapter with a discussion of contextual know-how—a term coined by Flax (1990), a feminist clinician. We view contextual know-how as both a means and end to effective supervision, and the best way to talk about responsible caring.

Jon has been involved in Hawaiian culture and canoe racing for many years. In Hawaiian Indigenous wisdom, the Hawaiians speak of *Lokahi*. Lokahi refers to balance, harmony, coherence, and integration of competing, or even contradictory, perspectives (McGregor et al., 2003). Colloquially it means to be the right person, for the right reason(s), for the right people, in the right way, and at the right time. Lokahi, the Hawaiian definition of responsible caring, would be equivalent to the Greek philosophical concept of *phronesis*, or practical wisdom (Dunne & Pendlebury, 2002; Gaete-Silva et al., 2017).

Phronesis is the integration of the technical, the systematic, and the virtuous. It focuses upon the particulars of how to act in specific situations—for psychologists to reflect upon and determine the best purposes and ends consistent with the well-being of our patients. Phronesis emphasizes that there is never only one way to approach a challenge or solve a problem in clinical work, given the realities of integrative complexity (Suedfeld & Bluck, 1988), relational responsibility (Crocket, 2004), critical or reflective practice (Larner, 2001), and not knowing (Anderson, 1997).

When ethics is seen as only a risk management exercise, psychologists limit themselves in their ability to approach the discipline. All three of us have come to understand contextual know-how as the *sine qua non* of responsible caring: The ability to merge ethics and risk management with best clinical practice (Behnke, 2005) leading perhaps to *arete*—the cultivation of virtuous being.

Imagine a swimming pool. The staging of supervision, and supervisee development, requires entry at the shallow end (Žorga, 2003). This means that supervisees are protected from deep water—their feet are touching the bottom, a side of the pool is close by, and a rope is separating the deep end from the shallow end. In the shallow end, there is a greater emphasis upon technique, systemization, and ethics, and the early stages of supervision are often initially seen as risk management: What is expected of me? What do I do, or not do, to not get in trouble? (Barnett et al., 2007). Nonetheless, although many psychologists remain in the relative security of the shallows (Meichenbaum & Lilienfeld, 2018), deliberate and reflective practice invites the psychologist to move beyond the security of shallow water. Schön (1983) has described this movement in his book *The reflective practitioner*:

> When someone reflects in action, he becomes a researcher in the practice context. He is not dependent upon categories of established theory and technique but constructs a new theory of the unique case. His enquiry is not limited to a deliberation about means, which depends upon prior agreement about ends. He does not keep end and means separate but defines them interactively as he frames a problematic situation. . . . Many practitioners, however, locked into a view of themselves as technical experts, find nothing in the world of practice to occasion reflection (pp. 68–69).

Meichenbaum and Lilienfeld (2018) noted that, to be reflective, psychologists ought to embrace skepticism and practice with healthy self-doubt. For clinicians, this means having to swim in deeper waters; to be self-sustaining and refrain from reducing ethics to rules and clinical practice to purely manual-based applications (Amundson & Gill, 2001; Lilienfeld, et al., 2017). Deep water, although a goal for effective supervision, and true responsible caring, is not to be taken for granted (Knapp et al., 2013; Remez, 2016). In his role as consultant for his association regarding ethics and supervision, Jon often is contacted with requests for consults. Frequent in such consultation is a simple request for specific direction: What to do or not to do; a psychologist seeking an answer—“the” answer—to an ethical and practice-related problem. Few such inquiries can be resolved so easily. Instead there is a discussion regarding the often two or more options that exist. In doing this, the goal is to increase reflection on both sides of the dialogue:

- How do the psychologists frame the problem? Do they seem more risk tolerant or risk avoidant? To what extent do they seem interested, capable, or motivated to explore the process?
- How might they frame a response one way or another? What kinds of clinical considerations do they see that they would account for? How many ways might they address the concern, and what contextual matters would require consideration?
- Finally, if they did or did not do one thing or another, how would they responsibly and ethically frame the action or inaction?

Elaborating upon this process of “if you did–if you did not” is beyond the scope of the discussion here (see Amundson, 2016); however, it reflects the contextual know-how of swimming in deeper waters. The consideration here is not simple do’s or don’ts, as one would imagine in the shallow end, but rather how good clinical practice, risk management, and ethical perspective could support decision making one way or another. Again, when responsible caring is equated with pure risk management and rote application of clinical methods, psychologists find themselves in the shallow end of the pool. To manage deeper-end water requires reflection and deliberation, and the associated cognitive exertion, promoting contextual know-how. These are specific habits of thought that support swimming in deeper water.

Initially, psychologists need to see ethics and standards as prosthetics to professional judgement, not as a substitute for such judgement. Codes, standards, and guidelines are not there to end struggle, but to invite struggle (King & Amundson, 1998). This emphasis upon the clinician's reflective learning agility (De Meuse, 2017) opens up opportunity for creativity: not *the* right way, but the right way for patients and psychologists in the clinical moment. As with ethics, learning agility and reflection emphasize that there is probably more than one way to care responsibly (Amundson et al., 1993; Amundson, 1996).

Clinical openness and healthy skepticism are linked. However, skepticism does not imply cynicism. As Meichenbaum and Lilienfeld (2018) have stated, it is

> a propensity to engage in thoughtful self-reflection regarding one's bias and limitations. . . . Practitioners marked by healthy self-doubt are not diffident. To the contrary, they are confident, but not over-confident. Their confidence is properly calibrated to their level of knowledge and skills. (p. 23)

Enhancing confidence, therefore, is a goal in effective supervision. This confidence, however, also might be called *engaged humility.* Dalal and Marc have learned, and Jon perennially seeks, to ground clinical practice less in the pursuit of certainty through a particular theory and method, and more in openness to the potential of the moment (Amundson, 1996; Amundson, et al., 1993). By this we mean being contextually alert and responsive to the patients we serve. What do they bring to the treatment? What has their experience been? What issues related to age, ethnicity, development, gender, socio-economic circumstance, or other contexts may be relevant to the matter? One of Jon and Marc's favourite clinicians, Milton H. Erikson, was once accused of developing a different therapy for each patient. Allegedly he replied, "Of course, or it would be boring otherwise" (as cited in Lankton, 2015, p. 54). Contextual know-how, then, is the capacity not to be bored, to find many ways to responsibly care, and to swim in deeper water throughout one's career.

Conclusion

We have linked Principle II (Responsible Caring) (CPA, 2017) to many aspects of supervision. This included ways to think about effective supervision (i.e., contextual know-how), as well as ways to execute it effectively (i.e., deliberate and reflective practice). There is, however, one additional connection to be made regarding responsible caring, and that is professionalism. In the shallow end of the pool, there is an emphasis upon the technical or systematic. However, as a self-governing health care profession, psychology must offer more than technical knowledge. We concur with Kaslow et al. (2018) that professionalism is the capstone of successful training and supervision. It is “contextually and culturally based and includes accountability, ethical engagement, self-reflection, professional identification as a psychologist, striving for excellence, humanism, civility, collaboration, collegiality, and social responsibility” (Kaslow et al., p. 55).

Responsible caring starts with the supervisor modelling these dynamics in supervision and prioritizing accountability, engagement, reflection, civility, and responsibility in professional practice. Supervision, although heralded as the most important part of professional preparation, has existed as a stepchild in professional practice (Amundson, 2008a). Supervision often has been an add-on activity to a psychologist’s busy schedule in institutions and undertaken in other sectors with naiveté regarding expectations and priority (Barnett et al., 2007; Polychronis & Brown, 2016). Only through increased emphasis on supervision as a type of professional practice will responsible caring be actualized for supervisors, supervisees, and patients.

Questions for Reflection

1. Describe one or two situations in your own experience of being supervised where you felt that your supervisor was responsibly caring. What made you feel that way?
2. Describe one or two situations in your own experience of being supervised where you felt that your supervisor was *not* responsibly caring. What made you feel that way?
3. On a scale of one to ten, with ten being of highest importance and one being of no importance, how would you rate the importance of a supervisor modelling appropriate ethical behaviour and professionalism. Justify your answer.
4. As a supervisee, what role did deliberate and reflective practice play in your development? Would you have wanted more? Less? Why?

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8

Couple and Family Therapy: Steps to Responsible Caring for Practitioners, Supervisors and Educators

Jeff Chang, E. Aiofe Freeman-Cruz

> *Recently, I met an acquaintance, Faith,[1] at a social event. After greeting each other, I asked about her partner, Rob. "We're not doing too well. He's at home, but I think we might split up." I said, "Aw, I'm sorry to hear that. Are you guys seeing anyone?" She responded with the name of an experienced clinical psychologist, whom I sometimes consulted. Expecting to hear how positively the work was going, I replied, "Oh, he's great. Is it going well?" Faith replied, "Not really. He just lets us go on, and sometimes I feel like he is more positive toward Rob than me. I'm not so sure it's going to work.*

Overview

Both authors of this chapter have had the good fortune to have had training in couple and family therapy (CFT).[2] For a long time, we assumed that most psychologists have had such training. While the vignette above is a composite, we have both heard of situations in which psychologists could have benefited from understanding families as systems. This invited us to wonder how psychologists establish competence in CFT, given that a sizable proportion of Canadian counselling and clinical psychologists practice CFT. Falender et al. (2004) define competence as knowledge, skills, values, and meta-knowledge. The College of Alberta Psychologists states that competence is acquired by "education, training and/or experience" (CAP, 2023, p. 13). These statements sharpen the questions we wish to pose in this chapter: How do Canadian psychologists gain the knowledge to conceptualize their treatment of families in a theoretically and empirically sound way? How do they learn the skills to develop a working alliance with multiple clients and effectively deliver family-based clinical interventions? Or, to link these questions with the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association [CPA], 2017), how can psychologists best honour Principle II (Responsible Caring)?

In this chapter, we will discuss pathways to competence in CFT for Canadian psychologists. First, we describe our backgrounds and how we developed an interest in this topic. Next, we examine how much couple and family therapy psychologists actually do. Third, we unpack Principle II (Responsible Caring). Finally, we discuss how psychologists can establish competence, and our personal perspectives on competence in CFT.

About Us

Jeff: I am a counselling psychologist. In the early 1980s, I studied for a master's degree in counselling psychology and worked in children's mental health agencies, where many of my colleagues were interested in CFT, mainly in structural and strategic approaches (Haley & Richeport-Haley, 2003; Lynch & Lynch, 2000). I took a CFT course in my master's program and sought out practica where I could work with families. After moving to Calgary in the mid-1980s, I continued to work in child and youth mental health agencies while completing the requirements to become a registered psychologist in Alberta. My workplace employed two American Association for Marriage and Family Therapy (AAMFT) approved supervisors and provided me with 200 hours of supervision for my family work. In addition, I took additional courses to qualify as a clinical member (as they were then called) of the AAMFT, and later trained as an approved supervisor. I was fortunate to be part of the vibrant CFT community in Calgary in the 1980s and 1990s. In a varied career in child and youth mental health, employee assistance programs, private practice (largely in the area of high-conflict divorce), and academia, family systems thinking has permeated my clinical work, teaching, and publications. In 2011, I started to work part-time as a clinical supervisor at the Calgary Family Therapy Centre. As a full-time counselling professor at Athabasca University, and part-time clinical supervisor, my mission is to support the development of new practitioners. This background, along with the composite anecdote provided above, led me to wonder how psychologists who do CFT acquire their competence to do so.

Aiofe: I am a registered psychologist trained in counselling psychology, and completed my bachelor, master's, and doctoral degrees at the University of Calgary. Through my graduate studies, I developed an interest in working with families with a parent with an acquired brain injury. My master's thesis examined the retrospective accounts of the experiences of adolescents who lived with a parent with an acquired brain injury, which led me to see how these families were underserved in counselling (Freeman, 2012). I further explored family systems theories as part of my doctoral research, which I later applied in my doctoral practicum at the Calgary Family Therapy Centre (CFTC), where Jeff supervised my work. I consider myself fortunate also to have taken a course during my training from Dr. Karl Tomm about his approach to family therapy (Tomm et al., 2014). During my predoctoral internship at the University of Manitoba Student Counselling Centre, I learned couple therapy under Dr. Lori Mac who was trained in the Gottman Method of CFT (Gottman & Gottman, 2015). I have continued to apply systemic therapies in my work with individuals, couples, groups, and families. I assumed that most counselling psychologists were competent to work with couples and families, but later learned that many have not had any CFT training or supervised practice at all. I am grateful for the support I have received to learn CFT but have often wondered how other early-career psychologists develop their CFT competence.

Psychology Practitioners and Family Intervention

It appears that psychologists do a considerable amount of CFT. Hunsley et al. (2013) found 26.6% of Canadian psychology practitioners offer couple or family therapy, and 20.8% of Canadian practitioners report family systems as one of their theoretical approaches. Much earlier, Hunsley and Lefrebvre (1990) surveyed members of the Canadian Register of Health Service Providers in Psychology. Sixty-two of the 88 respondents (70.4%) reported regularly conducting family or couple therapy. Norcross and Karpiak (2012), surveying 588 American Psychological Association (APA) Division 12 (Society for Clinical Psychology) members, found that about half provide couple therapy, while about one-third practice family therapy. Between 30% and 40% of Employee Assistance Program referrals are for couple and family concerns (Azzone et al., 2009), which we think provides a fair representation of the proportion of clients receiving family intervention in community practice. In fact, it might be an underestimate because clients requesting counselling may have needed or benefited from family intervention but did not know to request it.

We believe that even when clients and referral sources do not directly request family intervention, conceptualizing the situation by using family systems theory is helpful. Mastikhina et al. (2013), surveying 1,136 Alberta psychologists, found that 16% of their clientele are children and 16% adolescents. Jeff argues that those who work with children and adolescents should be competent to work with their families (Chang, 2013). Aiofe learned this lesson while working with a blended family that identified their teen as "the problem." As she started to support the teen to have his voice heard in the family, she found that his family thought that the teen sharing his feelings more was just "whining" and/or "pushing back." Their reaction invited more angry outbursts, and then withdrawal, from the young man. This led the parents to question the benefit of family therapy. They saw their teen as more opinionated and "not any better" in terms of the presenting problem of angry outbursts. Focusing primarily on supporting the teen, Aiofe realized that she inadvertently had neglected to engage the parents. As she started to engage the parents and approach the work more systemically, the parents became aware of their contributions to change by responding (mostly) supportively to the teen's newfound voice. They also came to recognize the teen's contributions to the family, creating a context for the teen to "feel like I matter." The therapist-client system recovered from a disruption to the therapeutic relationship that could have contributed to a poor outcome.

We also have found that, in working with individual clients, even adult clients' problems are rarely isolated from personal or family relationships. We take the position that even when "family therapy" is not specifically requested by clients or relational problems are not the focus of therapy, psychologists need to be prepared to treat couple or family concerns in some capacity (directly or indirectly) so they can intervene appropriately. How well prepared are psychologists to do this?

Formal Recognition of Competence in Couple and Family Therapy

We believe that CFT is a distinct professional domain, with a robust body of theory, research, skills, and intervention models, distinct from individual psychotherapy. In contrast to Canada, regulatory and certifying bodies in the United States (US) have long established frameworks for evaluating and recognizing CFT competence, which we describe here. The scarcity of such frameworks in Canada places the onus on individual practitioners to find ways of striving to establish and maintain the levels of competence needed.

American Association for Marriage and Family Therapy (AAMFT)

Most US states' requirements for Licensed Marriage and Family Therapists (MFTs) follow the AAMFT's standards, which incorporate rigorous coursework and supervision requirements. Required are three courses in family studies, three courses in family therapy, three courses on human development, and ethics and research courses. Finally, 1000 hours of direct client contact and 200 hours of supervision are required. In Canada, where MFTs do not have a distinct licence, one can earn the AAMFT designation of "Clinical Fellow" by undertaking equivalent coursework and supervised practice (AAMFT, 2012). More recently, the Canadian Association for Marriage and Family Therapy has begun to award the credential "Registered Marriage and Family Therapist" with similar requirements for education and supervised practice.

In Canada, as of June 2017, there were 693 Clinical Fellows of the AAMFT (AAMFT, 2017). Of the 663 who listed a professional certification/licensure or a degree, only 46 (7%) are licensed as psychologists, while 125 (19%) list social work credentials, and 120 (18%) list theological or pastoral training. The majority (58%) identify as counsellors or psychotherapists (e.g., Registered Clinical Counsellors [British Columbia] or Registered Psychotherapists [Ontario]).[3]

American Board of Professional Psychology (ABPP)

Board certification as an ABPP "Specialist," recognizes "advanced levels of practice including doctoral and post-doctoral preparation" (ABPP, 2015, p. 1). This applies to 15 specializations, including Couple and Family Psychology (CFP). For the Specialist designation in CFP, ABPP requires an APA- or CPA-accredited doctoral degree and internship (or equivalent), graduate course work and/or extensive continuing education in CFP, one year of postdoctoral training in CFP, and an oral exam based on a video work sample. As of September 2022, of the 68 ABPP board certified psychologists in Canada, one was certified in the CFP specialization.

We are not suggesting that only psychologists who possess one of these three designations are competent to provide CFT. However, these designations signify specific competency-based advanced training to the profession and the public. From an ethical perspective, we believe that the legal principle "everything which is not forbidden is allowed" (Slynn et al., 2000, p. 256) is not enough; it falls short of our ethical obligation to ensure that we are competent to the point of benefiting and not harming clients (Ethical Standard II.11).

Furthermore, competence is not binary; there are degrees of competence. For example, Patterson (2009) suggests a "level" system for self-assessing competence. "Level A" practitioners are specialists "equivalent to specialty designation as either an ABPP-or AAMFT-approved supervisor or are certified as a family or couple therapist by state licensing boards" (p. 195). Level B clinicians "regularly see couples or families conjointly, and in addition to graduate coursework in the field obtain at least 12 hours of continuing education courses [annually] and obtain consultation specifically focused in this area . . ." (p. 195). Level C practitioners "occasionally see couples or families conjointly for relatively common problems and short duration, obtain some continuing education . . . [obtain] focused consultation as needed, and have had some graduate-level training in the field" (p. 195).

In the following sections, we describe and operationalize *Responsible Caring* for psychologists practicing CFT and invite readers to reflect on their current level of competence and how to maximize it.

Principle II (Responsible Caring)

Minimally, we must "do no harm" (CPA, 2017, II. Values Statement, para 1). Although all clients are vulnerable, in families some clients are more vulnerable than others. As psychologists we "have a responsibility to responsibly care for all individuals and groups. . . . [with the] greatest responsibility be to individuals and groups in the most vulnerable position" (CPA, 2017, Principle II, Values Statement, para 6). In CFT, seniors and children, who are less articulate and powerful, are typically the more vulnerable. Accordingly, psychologists providing CFT have an added obligation to ensure that the more powerful members of the family do not dominate therapy. One way of doing this is for psychologists to ensure that the more vulnerable member(s) understand the nature and purpose of therapy and are willing to participate, and not to simply be agents of the more articulate family members.

For example, when Jeff receives a referral for child or adolescent therapy in his private practice, it usually starts with a phone call from a parent. At the first appointment (his standard practice is to see the young person and their parents jointly), after some preliminary joining (Lynch & Lynch, 2000), Jeff says to the young person, "OK, I think you know that you are here because your folks are worried about you. Your mom called me to make this appointment and told me a bit about your parents' worries about you. So, I am going to ask her to summarize our phone call. While she is doing that, please listen very carefully to see if there is anything you disagree with. There may also be some things your mom says that you agree with, so once she's done, I am going to ask you to tell me what you think, OK?" At that point, the young person usually answers with "OK" or a nod.

Jeff continues, "One more thing—parents always hate it when I say this—I just need you to know that I am not here to get you to do everything your parents want. Then you would just be a zombie or a robot . . . ." At this point, depending on the age of the child and the emotional climate in the room, Jeff may inject his best robot/zombie impersonation, and say in a droning voice, with his arms outstretched, "'I have no brain. I will do what my parents say.' You don't want to be like that, do you?" And finally, Jeff might say something like, "And one more thing. Everyone here has their own ideas, and I will listen to everybody's ideas. How does that sound?"

Jeff has found that providing an age-appropriate (and hopefully humorous) overview of the CFT process for young people does a number of things. It models transparency by having the parent recap their conversation; it invites the young person to listen carefully to how their parent frames the problems; and it makes clear that the young person might very well disagree. This conveys that Jeff is not accepting only the parents' perspective and permits him to ask about the relational aspects of the problem, which affirms that he is not merely the parents' agent or enforcer, and that he values everyone's ideas. In this way, Jeff hopes to make space for the voice of a more vulnerable family member.

The *Code* further urges psychologists to "take care to discern and balance the potential harms and benefits to the individuals and groups involved, taking into account the degree and moral legitimacy of conflicting interests" (CPA, 2017, Principle II, Values Statement, para 4). Family members often have different interests, with different goals and different ideas about how to reach them. For example, one member of a couple might seek to end the relationship against the wishes of the other. This may be based on different values about the nature of marriage. Although pragmatically the issue is one of developing a shared goal for therapy, the need to consider the "moral legitimacy" of family members' interests is much more difficult. This requires psychologists to reflect on their own values and to ensure that their personal moral positions do not compromise their clinical judgement.

Jeff has seen many couples in which an unfaithful but regretful spouse wishes to preserve the relationship with an angry, hurt, and unforgiving partner. It is difficult to balance the "moral legitimacy" of forgiveness, remorse, the nature (or even sanctity) of marriage, and the partners' mutual contribution to marital troubles before an infidelity. The discovery of infidelity, which many if not most couples consider immoral, is often the catalyst for therapy. Usually, there is a complex interplay of factors that brings the couple to this point.

At the CFTC, Aiofe saw many adolescents with their parents. She could empathize with adolescents who desired more autonomy. Her feelings about these families varied. At times, it seemed obvious to her that parents' behaviour, which she saw as "rigid" or "authoritarian," was overkill for a teen who only wanted to taste a typical amount of freedom. Other times she was alarmed that parents were abdicating their moral duty and legal authority to care for the young person by acting passively in the face of serious, even criminal misbehaviour. Sometimes she found herself aligning more with adolescents, given her belief that parents should know better and take the lead in initiating change. She felt sorry for some parents who seemed to be "saints" in the face of abuse by the teen. And, often, parents simply wanted her to "fix" their child. In all these, Aiofe found that conceptualizing the situation systemically helped her to refrain from aligning unhelpfully with part of the family or helped her to manage her frustration with some family members.

This is not merely a theoretical exercise. In both kinds of situations above, our personal values influence our view of the moral legitimacy of family members' positions, which in turn affects the therapeutic relationship with the family. Individual therapy often includes exploration of the single client's values and reflection on their moral positions. On the other hand, in CFT, contrasting or conflicting values can, and often do, emerge. When clients feel very strongly about their positions, perhaps because of underlying issues or deep feelings of hurt, a pattern of mutual disqualification and defensiveness can emerge, which may include an angry backlash. Psychologists providing CFT must have the skills to deal with patterns of conflict that arise within tense or even volatile therapy sessions. In our view, responsible caring in CFT requires psychologists to have the skills to interrupt volatile patterns of conflict. At minimum we must do no harm; ideally, we should have the skills to use these expressions of conflict therapeutically. We believe that psychologists doing CFT must examine their personal values and moral positions about family life, and refrain from imposing them on clients, while exercising the skills to manage difficult interactions in sessions.

Competencies in Couple and Family Therapy

Is specialized training in CFT necessary? Given our view that CFT is a distinct professional domain, we think so. The Values Statement of Principle II (Responsible Caring) states, that psychologists "engage only in those activities in which they have competence or for which they are receiving supervision" (CPA, 2017, para 5). Ethical Standard II.6 is more specific, urging psychologists to "Offer or carry out (without supervision) only those activities for which they have established their competence"—an affirmative responsibility to *establish* competence.

In a classic article on CFT competence, Tomm and Wright (1979) distinguished *conceptual*, *perceptual*, and *executive* skills in CFT. These skills or competencies are mirrored in the *Code*. For example, to conduct the necessary risk/benefit analysis, psychologists would "Assess the individuals and groups . . . adequately enough to ensure that they will be able to discern what will benefit and not harm them" (CPA, 2017, Ethical Standard II.13), and "be sufficiently sensitive to and knowledgeable about individual and group characteristics, culture, and vulnerabilities to discern what will benefit and not harm [them]" (Ethical Standard II.14). For CFT, this means that psychologists must have adequate theoretical knowledge about family development and family therapy to notice and make sense of clinical dynamics—what Tomm and Wright call *perceptual* and *conceptual* skills. In addition, Ethical Standard II.9 requires psychologists to "keep themselves up to date with a broad range of relevant knowledge, research methods, techniques, and technologies . . . through the reading of relevant literature, peer consultation, and continuing education activities." This reflects the need to possess the skills to work with multiple participants and intervene effectively—*executive* skills.

Within the discipline of psychology, Rodolfa et al. (2005) articulated a "Cube Model" of competency, which distinguished *foundational* competencies (those required of all psychologists) from *functional* competencies (the "knowledge, skills, and values necessary to perform the work of a psychologist" [p. 351] in a particular area of practice). Foundational competencies include reflective practice, research, interpersonal relationships, ethical and legal fluency, cultural competence, and understanding of service delivery systems. Functional competencies are defined as: "(a) assessment–diagnosis–case conceptualization, (b) intervention, (c) consultation, (d) research– evaluation, (e) supervision–teaching, and (f) management–administration" (p. 351). By and large there is agreement that newly registered psychologists will exercise the first four competencies almost universally. Elsewhere (Chang, 2020), Jeff argues that few opportunities exist for psychologists, even graduates from many CPA-accredited programs, to gain competence in clinical supervision (Chang, 2020). Moreover, in our experience, management-administration is practiced only by a minority of new psychologists. As such, we focus below on the first four functional competencies of Rodolfa et al. (2005), operationalizing them for psychologists who wish to develop and maintain competence in CFT.

Assessment–Diagnosis–Case Conceptualization

The first functional competency distinguished by Rodolfa et al., (2005) is *assessment–diagnosis–case conceptualization*. In CFT, the capacity to conceptualize family functioning, provide a coherent diagnosis, and plan treatment rests upon fluency in theory and research on family development and functioning, family-based assessment frameworks, and models of family therapy.

THEORY AND RESEARCH ON FAMILY DEVELOPMENT AND FUNCTIONING

Psychologists practicing CFT should have conceptual understanding of both typical and clinical families. We believe this includes: family systems theory (Smith-Acuña, 2010), the family life cycle (McGoldrick et al., 2015), diverse family structures based on ethnicity (McGoldrick et al., 2016), blended families (Bray & Kelly, 1999), divorcing and post-divorce families (Carter, 2011), immigrant families (Zagelbaum & Carlson, 2010), refugee families (Djuraskovic & Chang, 2012; van der Veer, 1999), families with an LGBTQ2S+ member (Goldberg & Allan, 2012), and families influenced by chronic or life-threatening illness (Leahy & Wright, 1987; Wright & Leahy, 1987). In addition, CFTs need the skills to explore existing theory and research about other family structures or concerns, and the capability to integrate newly acquired knowledge into their practice.

APPROACHES TO FAMILY ASSESSMENT

There are many approaches to family assessment; the scope of this chapter permits only a brief review. Two prominent approaches are worthy of mention here. The Circumplex Model views cohesion and flexibility as key elements in family functioning (Olson, 2000, 2008). Conversely, the *Beavers Systems Model of Family Functioning* (Beavers & Hampson, 2000) focuses on family competence and family style. Family style is assessed along a continuum of centripetal (inwardly focused) and centrifugal (outwardly focused) elements. Proponents of each approach developed a suite of standardized tests that use ratings from parents, children, and trained professional raters who describe behaviours of family members correlated with these theoretical constructs. With these brief descriptors in mind, the reader might correctly imagine that families at the extremes would exhibit problems. For example, problems might occur when families either lack or have an excess of either cohesion or flexibility, or when they are extremely inwardly or outwardly focused.

Jeff has used these instruments in assessments related to child protection issues, alongside measures of individual personality and psychopathology. Although many clients in child protection matters experience significant individual problems, Jeff has found it helpful to present test data about family patterns. Parents often feel less blamed and may be more likely to engage in services when the emphasis is not exclusively on their individual problems.

Among non-standardized approaches to family assessment, we are most familiar with the *IPscope* ("IP" standing for *interpersonal patterns*), developed by Karl Tomm (1991) and his colleagues at the CFTC (Tomm et al., 2014). Interpersonal patterns are coupled behaviours that bring about either problematic or helpful outcomes. Here we describe just three kinds of IPs to give the reader a flavour of the work that is possible from this perspective.

Families usually present for therapy with problems at the foreground of their thinking, so we first identify what Tomm calls *pathologizing interpersonal patterns* (PIPs). In Aoife's example of her work with adolescents and their families, parents' criticizing coupled with a young person's feelings of being misunderstood might exacerbate problems. Similarly, a young person acting aggressively coupled with parents withdrawing passively could be a problem-maintaining pattern. In response, we might have families reflect on what Tomm calls *healing interpersonal patterns* (HIPs), which are possible antidotes to a PIP. For example, parents expressing empathy might be coupled with a young person's feeling of being understood. HIPs fit under the umbrella of what Tomm calls *wellness interpersonal patterns* (WIPs), which are recurrent and healthy.

The IPscope was Aiofe's introduction to family assessment and intervention. As a budding therapist just beginning to feel competent in treating individuals, Aiofe had no clue how to begin to think about families. Practically speaking, her supervision often entailed identifying PIPs and potential HIPs as a basis for intervention. Also, the case note format at CFTC requires identification of PIPs, HIPs, and other IPs, and the recording of their strength as experienced both by the clients and by the therapist. This "forces" trainees to think in terms of what goes on between people to complement psychology's default perspective of what goes on within people. In our view, this is a valuable avenue toward conceptual CFT competence.

MODELS OF FAMILY THERAPY

It is also necessary for psychologists working with families to have a theoretically coherent approach to therapy. Many theoretical models of CFT are adaptations of individually based theories (e.g., Crisp & Knox, 2009; Dattilio, 2010; Gerson, 2009; Scarf, 1987; Zinker, 1998). A psychologist's fluency with individual psychotherapy theories can be extrapolated to CFT.

On the other hand, many theoretical approaches to CFT are based on models of social organization or interpersonal interaction not rooted in individual psychology (e.g., Campbell et al., 1992; Haley & Richeport-Haley, 2003; Lynch & Lynch, 2000; Titelman, 2015). Such approaches focus more on what goes on between people, how interactions shape perceptions, and what we typically refer to as "personality."

In his master's program, Jeff had been trained in pragmatic, present-focused models like behavioural (Thompson & Williams, 1985), cognitive-behavioural (Meichenbaum, 1977), and instructional approaches (Martin & Hiebert, 1985). His first post-master's jobs, working mainly with "acting out" adolescents and their families, required the development of family-based case conceptualizations. He found that CFT approaches like strategic (Haley & Richeport-Haley, 2003) and structural (Lynch & Lynch, 2000) therapy, which are similarly pragmatic and present-focused, gave him concrete guidance—something he craved as a novice counselling psychologist.

Intervention: The Working Alliance in CFT

The second *functional* competency described by Rodolfa et al. (2005) is *intervention*. We just described several theoretical approaches to CFT; within each of these approaches, there is a myriad of intervention techniques. Here, we focus on the development and maintenance of the working alliance in CFT, which is essential irrespective of theoretical orientation.

The most robust research on the working alliance in CFT produced the *System for Observing Family Therapy Alliances* (SOFTA; Friedlander et al., 2006). SOFTA conceptualizes the working alliance in family therapy as having four dimensions: (a) safety within the therapeutic system, (b) shared sense of purpose within the family, (c) engagement in the therapeutic process, and (d) emotional connection with the therapist. Friedlander et al. developed a coding system in which therapists and/or observers rate empirically derived behavioural correlates to evaluate the strength of the therapeutic alliance with the family as a whole. We assume that readers who are trained in individual counselling skills are familiar with (c) and (d), which are important in individual therapy. Accordingly, here we describe the first two dimensions, which are unique to CFT (Friedlander et al., 2006).

Safety within the therapeutic system refers to the extent to which clients feel comfortable participating fully in therapy (Friedlander et al., 2006). In CFT, it is particularly important that family members feel safe enough with both other family members and the therapist to participate in therapy without being attacked, judged, or rejected by them (Higham et al., 2012). This is more complex than in individual therapy where the client only needs to feel safe with the therapist. Clients who report feeling safe in CFT are more likely to take risks and be open to new learning. Otherwise, clients may refuse to disclose or participate, and are more likely to be defensive (Higham et al. 2012).

The extent to which family members see themselves working collaboratively to improve family relationships and achieve common therapeutic goals is called *shared sense of purpose* by Friedlander et al. (2006). Most of the time, CFT begins with family members having different views of the problem, possible solutions, and indicators of progress. Developing mutually agreeable goals that do not simply align with what one family member wants, is essential (Escudero et al., 2008).

In our work at CFTC, we found that clarifying PIPs can be very useful in inviting a shared sense of purpose. Seeing family difficulties as part of a pattern can reduce mutual blame and facilitate participation in therapy. Influenced by narrative therapy (e.g., Madigan, 2019), we have sometimes framed the purpose of therapy as a joint family project with a specific name (e.g., “Helping Wesley Restore His Reputation,” “The Mutual Respect Project,” or “Supporting Kendra to Overcome Fears”).

Aiofe worked with Jasmine (12 years old) and her parents. Her parents only told Jasmine about her first appointment on the same day, as she was picked up from school. Naturally, Jasmine was enraged at having family therapy “forced” on her in a less than transparent way. During the first few sessions, Aiofe tried to negotiate several joint projects to develop a shared sense of purpose, but Jasmine was having none of it. Eventually, as Aiofe worked to develop safety in the therapeutic system, not judging or blaming Jasmine, and balancing her empathy and support for her with that of her parents, Jasmine began to trust Aiofe as *the family’s* therapist. In the fourth session, Jasmine began to warm to the project of developing a better relationship with her parents. Jasmine objected strongly to our first attempt at naming this project “Developing More Co-operation at Home.” She thought it placed the onus on her alone to change. Our revised title

"Developing More Co-operation Between Everyone at Home" was acceptable to both Jasmine and her parents. How we labelled the project was important. This illustrates the fluidity of working alliances as therapy progresses.

Supervising practicum students, predoctoral interns, and registered provisional psychologists, Jeff has observed new CFTs inadvertently emphasizing emotional connection with one member of the family over others. For example, he once observed a session in which a mother castigated her teenaged son, and then expressed a great deal of distress over his criminal behaviour. The supervisee did not moderate the mother's blamefulness of the young man, and then expressed a great deal of empathy for the mother: "It must feel terrible as a mother to see your son violate the values you've tried to instill in your son." The young man seethed as he thought the supervisee was taking his mother's side. In focusing on engagement and emotional connection with the mother, the supervisee inadvertently offended the young man.

Consultation

The third functional competency delineated by Rodolfa et al. (2005) is consultation. Family systems ideas provide useful guidance for psychologists when organizations delivering services became "stuck." Relational issues between the participants—whether these are family members, professionals within systems (e.g., frontline workers and management, physicians, and other professionals)' or different systems themselves (e.g., parents and school personnel, child protection authorities and treatment providers)—can reduce the efficacy of systems.

Family systems ideas have been used to provide consultation to a variety of organizations (Matheny & Zimmerman, 2001), including career development services (Hall, 2003); primary health care (Mayer et al., 1996; McDaniel et al., 2014; Rolland, 2015); family businesses (Lee & Danes, 2012; Pieper et al., 2013); family law/dispute resolution (Chang, 2016; Roberts, 1992); medical education (Botelho et al, 1990); oncology units (Baumann, 2006; Tolley, 1994); organizational consulting (Lee & Danes, 2012); pediatric psychology (Kazak et al., 2002; Piazza-Waggoner et al., 2013); persons with intellectual disabilities (Fennessy et al., 2015; Rhodes, 2003); preschools (Knoche & Witte, 2017; McDowell, 1999,); psychogeriatrics (Purves & Phinney, 2013); social service agencies (Imber-Black, 1988; Woodruff & Engle, 1985); sports teams (Zimmerman, 1994); and veterans with PTSD (Ohye et al., 2015).

For instance, Jeff has found CFT concepts useful when consulting with workplace teams. In one of his first forays into organizational consulting in the 1990s, the CEO of a small oilfield service company asked him to meet with a staff team that he thought was functioning poorly due to interpersonal conflicts. Structural family therapy (Lynch & Lunch, 2000) concepts like hierarchy, executive subsystem functioning, alliances, and coalitions helped him to conceptualize the situation, intervene, and make recommendations to leadership about how to manage some aspects of the situation. He also uses the IPscope (Tomm et al. 2014) when consulting with organizations. Recently, he consulted with the staff of a social agency. Several PIPs that interfered with team functioning were identified, possible HIPs were brainstormed, and WIPs (albeit weak and largely forgotten) were unearthed and appreciated.

Research-Evaluation: Empirical Support for Family Therapy

Research-evaluation is the fourth foundational competency identified by Rodolfa et al. (2005) that is common for early-career psychologists. Given that, after graduation and licensure, psychologists are much more likely to be consumers of research than researchers, we focus here on how psychologists can stay current with the empirical evidence related to CFT.

There are a number of sources that psychologists can consult regarding the current state of CFT research. Major CFT journals and organizations publish periodic updates on the state of the evidence for CFT (e.g., Carr, 2019a, 2019b; Pinsof & Wynne, 1995; Sexton & Alexander, 2002; Sprenkle, 2002, 2012; Stratton, 2016). Many major family therapy texts (e.g., Nichols & Davis, 2017; Sexton & Lebow, 2016) contain sections on empirically supported models of CFT and review the research base of CFT. APA Division 43 (Society for Couple and Family Psychology) publishes the journal *Couple and Family Psychology: Research and Practice.* Finally, Sexton et al. (2011), seeking to encourage greater adoption of evidence-based CFT, provide criteria by which CFT research should be evaluated.

CFT Training in Canadian Psychology

CFT is not emphasized in Canadian psychology education. In preparation for this chapter, Jeff reviewed the course offerings listed on university, departmental, and program websites for the Anglophone CPA-accredited clinical (n=22) and counselling psychology (n=5) programs.[4] Based on web-based information, 13 programs have at least one CFT course listed in their program's course offerings. Eight programs have one course, four programs have two courses, and one program has more than two courses. Only one program, McGill University's counselling psychology program, requires a course in CFT. Fourteen programs do not list any dedicated CFT course.

Among programs without a dedicated CFT course, 10 describe some consideration of family systems ideas and techniques in a child/adolescent therapy course. Three programs describe covering family factors in the context of human development or psychopathology coursework. Seven programs list CFT or family systems approaches as a part or possible part of one or more clinical interventions or clinical practice courses. While it is possible that students in programs without a dedicated CFT course are exposed to some family systems or CFT content, this likely depends on the inclination of faculty and on whether students advocate for such exposure. In contrast, Patterson (2009) indicates that most APA-accredited clinical and counselling psychology programs have at least one CFT course and several programs have a specialized track of four or more courses.

What is not clear from reviewing public web pages and university calendars is whether programs actually deliver the courses listed. For example, one clinical psychology program's webpage lists the frequency of course offerings, but the CFT course in the university calendar is not listed. In another case, a counselling psychology program lists a CFT course in the university calendar, but this course is not listed in the potential electives in the PhD program or in the underlying master's program. We understand that universities often apply budgetary pressure to academic programs to discourage them from offering low enrolment courses, and that such pressure is even more acute for labour-intensive professional practice programs. This means that students must be assertive and persistent in seeking opportunities to develop CFT knowledge—often outside of psychology.

Our experience mirrors the need to go outside psychology for training in CFT. When Jeff was seeking courses in the 1990s to fulfill requirements for AAMFT Clinical Membership, he could not find appropriate graduate psychology courses and ended up taking them in social work and nursing. The situation had not changed in the early- to mid-2000s, when he was doing his PhD. Aiofe was required to take a family therapy course as a condition of a practicum at CFTC. It was cross-listed in social work and medical science, but not as a psychology course, so she could not use it as an elective in her doctoral program. Although the course was excellent, and she had no regrets about taking it, this did not seem equitable given that no CFT course was available within her counselling psychology program.

In summary, CFT courses are not readily available in Canadian clinical and counselling psychology programs. Students can find practica or internship rotations in CFT if they are persistent and assertive. Given the proportion of psychologists who do CFT, and the paucity of coursework and clinical supervision, it is an open question as to how most psychologists establish competence.

Moving Forward to Ensure Competence

Training and Supervision Opportunities

Many psychologists who work with couples and families will continue to do so. Given the significant demand, we believe it is neither desirable nor realistic to limit the work that psychologists do with couples and families. In this chapter, we seek to open a conversation about psychologists' competence in CFT and how it can be enhanced. Although acquiring and maintaining competence is the ethical responsibility of individual practitioners, psychology educators, practice leaders, and professional associations can ease the way for individuals. In addressing the apparent competence gap, we recommend going beyond the existing focus in Canadian surveys on the proportion of psychologists practicing CFT, and "drill down" to how psychologists developed and maintain their CFT competence. The availability of CFT training in predoctoral internship sites also should be examined.

Students interested in developing CFT competence face challenges. As noted above, CFT courses are rare in CPA-accredited programs, and courses from disciplines other than psychology may not be accepted toward licensure or as program electives. Although large organizations might hold internal seminars on CFT, smaller clinical sites may not have the resources to do so. Practicum students and interns might be able to select a site like a family service agency that provides CFT and is staffed by experienced couple and family therapists. It appears that only a small number of psychology internship consortia across the country offer rotations in CFT.

Psychologists who have completed licensure have more flexibility to chart their own course of future professional development. There are many private training programs that provide intensive training and a certification option if the learner engages in clinical supervision. For example, certification programs in Emotionally Focused Therapy (Greenberg & Johnson, 2010) and the Gottman Method (Gottman & Gottman, 2015) are currently available for those with the capacity and interest to embark on the extensive training required. AAMFT's accreditation arm, the Commission on Accreditation of Marriage and Family Therapy Education (COAMFTE), accredits post-degree programs geared toward helping practitioners already licensed in another behavioural health discipline specialize in CFT. However, there are no longer any in Canada. Since May 2018, the Faculty of Social Work at the University of Calgary has offered a graduate-level continuing education certificate program in couple and family therapy, with coursework delivered online and supervised clinical practice. Although these programs contribute to the competence required of psychologists practicing CFT, individual psychologists must take the initiative to develop and enhance their competence by seeking them out.

Personal Perspectives

Aiofe: As a student, I came into CFT with optimism. I had some theoretical background, but not enough to give me a solid foundation. I felt excited at the prospect of learning CFT both in theory and in practice, but I had not anticipated the steep learning curve. Working with real families, I felt unprepared. Although I was learning theory while practicing with families, I became keenly aware that there was more happening in the room than I had originally anticipated. When stepping into the room with families, I was faced with many things to attend to: (a) multiple people with different perspectives of "the problem;" (b) pre-existing relationships and alliances within the family with their own socio-cultural history that often left me playing catch-up; and (c) an expectation that I "fix" their problem. Not only was I practicing my newly learned skills as a CFT, which felt clumsy at best, but I was struggling to incorporate my existing skills into a family context. Concurrently. I was integrating old and new theoretical ideas. I sought solace in CFT books, which I found did not help me in my practice. Speaking with my classmates and supervisor, I found I was not alone. Feeling I had taken a step backward in terms of my skills, Jeff encouraged me to be patient with the process and normalized the feeling that my skills had eroded. He further suggested I stop reading because it was confusing me. I could not incorporate the theory (conceptual skills) quickly enough to help my executive skills, muddying the process. As I continued to learn, one day, it just made sense.

Reflecting on my experience, I have some suggestions for novice CFTs. First, I found the informal and open atmosphere of supervision helped me to open up and be honest about my struggles, questions, and confusion. That said, the most helpful, yet frustrating, part of supervision was Jeff's capacity to not "fix" or resolve the challenges, but to help me manage and normalize the discomfort of the learning process. The steep learning curve I experienced after having been trained as an individual therapist required significant shifts in thinking. This process takes time, and I came to realize that both the supervisor and supervisee need to be prepared to sit in the uncomfortable space of being in-between when one is learning to apply such new skills. Despite my frustration of not having someone "fix it" for me, it was a valuable experience that helped me incorporate other new skills and revise my theoretical orientation accordingly.

Jeff: As a supervisor, I have found it exciting and satisfying to support several doctoral practicum students and predoctoral interns in counselling psychology to learn CFT. Aiofe's experience, feeling she had taken a step back in terms of her skills, is common. Thinking in terms of Tomm and Wright's (1979) conceptual, perceptual, and executive skills, students who have mainly studied individual models of therapy must learn how to think about what happens between people as much as what happens within people. In terms of perceptual skills, I work to support novice CFTs to make sense of what they are seeing. In terms of executive skills, psychology graduate students often have learned to interview using an individual-based microskills approach (e.g., Cormier et al., 2016), which teaches them to be intensively present with one person. As such, new CFTs often end up being chairpersons of sessions, insofar as they engage in serial individual interviews, speaking with one family member, then another. This can lead to family members, other than the one conversing with the therapist, to "tune out." As their executive skills develop, they learn to interview the family as a whole, using circular questions (Fleuridas et al., 1986). This enables novice CFTs to notice interpersonal patterns and invite the family into a more systemic view, which in turn strengthens their perceptual and conceptual skills.

Conclusion

Given that counselling and clinical psychologists spend a significant amount of time intervening with families, they have an ethical responsibility to acquire adequate knowledge and skill. Students and trainees seeking to develop competence in CFT must seek opportunities carefully and advocate with their universities and training sites to provide such opportunities. Community agencies need to continue to develop their capacity to serve families and to pass their knowledge on to trainees and staff. Universities should strive to provide courses within the limits of curriculum requirements and develop affiliations with training sites that serve families and couples. As a profession, psychology needs to survey stakeholders to ascertain the needs of the field. It also needs to ensure that counselling and clinical psychologists have sufficient expertise in CFT to be able to mentor newer practitioners, while socializing them to their professional identity as psychologists. Together, these elements can contribute to ongoing competence in the field of CFT, ensuring ethical practice with couples and families.

Questions for Reflection

1. In couple and family therapy, it is your responsibility to engage each person, balance the airtime each person has, and make each person feel heard. In individual therapy, you need to empathize deeply and develop understanding with a single client. Reflect on the differences between these two experiences and how they relate to your own practice.
2. Identify one or two strongly held values that you hold regarding spousal or family relationships. How might your values influence your work when you see families or couples?
3. Do you think CFT is a distinct professional domain, requiring specific theoretical knowledge and supervised practice? Why or why not?
4. Evaluate your skills and knowledge in CFT against the AAMFT Core Competencies (AAMFT, 2004) (https://www.aamft.org/Documents/COAMFTE/Accreditation%20Resources/MFT%20Core%20Competencies%20(December%202004).pdf). Develop a plan to enhance your competence over the next year.

NOTES

1 Other than the authors, all persons mentioned in this chapter have been given pseudonyms.

2 In this chapter, we use the terms "couple and family therapist" and "couple and family therapy" (both abbreviated as "CFT"). Although the terms "marriage and family therapist" and "marriage and family therapy" (both abbreviated as "MFT") are in common use, we consider "CFT" more inclusive given that not all couples are married. We retain the use of "MFT" when referring to specific organizations or a licensure status.

3 These statistics were based on a directory search for an earlier version of this chapter. It was not possible to obtain more up-to-date statistics because the AAMFT directory was reformatted and would not allow searches by province or territory only.

4 Universities listing more than one program under the "clinical" category (e.g., "clinical" and "clinical developmental") are counted as one program. Two programs are listed in more than one area: The University of Alberta's program in School and Clinical Child Psychology is counted here as a clinical psychology program. The University of Toronto/Ontario Institute for Studies in Education's program in Clinical and Counselling Psychology is counted here as a counselling psychology program.

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PART C

PRINCIPLE III

Integrity in Relationships

9

Intrusions: Third-Party Requests for Psychotherapy Information

Brian Chartier, Linda M. McMullen, Annik Mossière

Locating Ourselves

Each of us has come to be interested in the topic of ethical issues in working with third parties in our own ways.

Brian: My interest in this area arose over a decade ago when I was seeing a client in my private practice for a company that carried the disability insurance for the client. The client was off work due to severe depression. After a period of time, the insurance company requested a progress report, which I supplied noting that the client remained depressed and listing a series of cognitive and behavioural symptoms. I also noted that the client had "improved" and was displaying only a moderate level of depression. About a month later, the client came in and reported that his benefits were being terminated because I had reported that he was "improved." I had felt quite proud that the client had shown progress and was stunned by the consequences of mentioning this improvement in the progress report. Such an experience might be exceptional, but it raised questions for me about my contribution to the problem that arose, and about what should be done to address such experiences with third-party payers.

Linda: Unlike Brian, my interest in the topic of ethical decision making arose from my qualitative research work examining how healthcare professionals (mainly family physicians and pharmacists) construct their decision-making processes with regard to prescribing and dispensing antidepressants; and how service users/clients construct their decision-making processes regarding taking or rejecting antidepressants. Having been trained as a clinical psychologist and having developed expertise in qualitative inquiry, I have had a particular interest in the ways people talk about depression and antidepressants when asked about their decision-making processes. In my conversations with healthcare professionals and service users, I have been struck by the ethical dilemmas that are explicitly raised or implicitly alluded to. Examples include instances in which a client presents to a family physician with a request for an antidepressant and the family physician understands the patient's experience of depression as situationally-based and unlikely to be alleviated with an antidepressant, or whether (and how) prescribers raise the question of the significant placebo response to antidepressants with their clients.

Annik: I have long been interested in ethical decision making. As a clinical graduate student in clinical psychology, this interest was amplified by my first practicum working with clients who had been in a motor vehicle accident (MVA). I found myself questioning some of the insurer's policies, particularly with respect to what personal issues could be treated. For example, a young woman reported symptoms of trauma after an MVA. The symptoms were related to the accident but also embedded in, and exacerbated by, a past sexual assault. I had asked about the possibility of the insurer covering the treatment of this complex trauma; however, it was denied since aspects of the person's reaction were not a direct result of the accident (i.e., more historical). Since then, my work in forensic psychology allowed me to further develop awareness about other types of ethical challenges in third-party situations such as the ethical intricacies of power imbalances, issues of confidentiality, and the impact of diagnoses.

Overview

The primary focus of this chapter is on how Principle III of the *Canadian Code of Ethics for Psychologists* (Integrity in Relationships) applies to dealing with third parties. Although psychologists are expected to demonstrate the highest integrity in all their relationships (e.g., Canadian Psychological Association [CPA], 2017, Principle III, Values Statement), the principle of Integrity in Relationships generally should be given the third highest weight (CPA, 2017, Preamble) among the *Code's* four principles. That is, some aspects of Principle III might need to be subordinated to the values contained in principles related to respecting the dignity of persons and peoples (e.g., respecting their moral rights), and responsible caring (e.g., protection from harm). From our perspective, a psychologist's responsibility to the person being assessed or receiving a service is greater than the responsibility to those indirectly involved (e.g., third-party payer). The goal of this chapter is to consider when, and under what conditions, a psychologist should or should not release psychotherapy information to a third-party insurer and the role of Principle III in making such decisions.

Concerns in Working with Third Parties

Although there are ethical codes and practice standards that guide our work as psychologists, the application of these codes and standards can be complicated when third parties are involved. For this chapter, the term *third party* includes such entities as insurance companies, employee assistance programs, workers' compensation boards (WCB), and government agencies (auto insurance in some provinces). Barnett and Johnson (2008) highlighted the fact that the best interests of a client can sometimes be in conflict with the interests of third-party organizations. The "best interests" of a client, by definition in the *Code*, are those interests that support the dignity and well-being of individuals and groups and are morally justifiable. When third parties are involved, we have a responsibility as psychologists to balance the requirement for truthful and accurate reporting to the third parties with maintaining the moral rights of our clients to privacy and informed consent. Moral rights are defined in the *Code* as "the fundamental and inalienable rights of persons and peoples," are "grounded in moral reasoning," and may be "protected by international, regional, and national declarations, constitutions, laws, and statutes." As such, several ethical considerations arise when dealing with third parties. These considerations include the psychologists' specific roles and responsibilities to the parties involved, the psychotherapy client's moral rights and best interests, the legitimate interests and "need-to-know" of the third party, and how best to balance what is owed by the psychologist to each of the parties involved (e.g., the injured worker and the insurance company).

In looking at third-party payers, the *Canadian Code of Ethics for Psychologists* (CPA, 2017) makes distinctions among a "primary client," a "contract examinee," and a "retaining party,"[1] as well as distinguishing whether individuals or groups are "independent, partially dependent, or fully dependent" in their decision making. Individuals receiving psychotherapy are deemed to be "primary clients" (i.e., "receiving services that are intended to help with the individual's . . . own issues, responsibilities, questions, or problems" [CPA, 2017, Definition of Terms]). In situations in which third parties are involved, a primary client may be independent, partially dependent, or fully dependent, depending on the level of choice they have about whether to receive psychotherapy, and under what conditions or limitations. We have found that, in the third-party context, most psychotherapy clients are either partially or fully dependent on the third party, particularly with regard to the funding of treatment. We also have found that the distinctions between types of clients and the level of dependence/independence are helpful in defining roles for all parties involved in a psychological service to a primary client, as well as in demarcating the parameters of informed consent. In our (Annik and Brian) experience, most clients are not aware of these distinctions. It is, however, our role, as treating psychologists, to be aware of these distinctions in the context of consent and integrity in relationships. For example, consent must be handled differently for an independent, partially dependent, or fully dependent client in terms of such matters as information sharing, treatment planning, and payment of services.

A second important related issue noted in the *Code* is vulnerability. Vulnerability arises whenever the dignity, well-being, and best interests of any individuals or groups are more easily violated. The *Code* notes four circumstances in which there is such heightened vulnerability: (a) when particular characteristics such as a low level of cognitive and emotional functioning or a history of oppression are present; (b) when there is a reduced capacity to consent voluntarily; (c) when an individual such as a claimant has to contend with a more powerful individual or group such as an insurance company; and (d) when there is a high risk of harm (CPA, 2017, p. 9). These instances of heightened vulnerability readily apply in the context of third-party involvement in psychotherapy.

In sum, the *Canadian Code of Ethics for Psychologists* (CPA, 2017) addresses some important aspects of the ethical issues and processes in working with third parties. However, we have found that balancing the legitimate interests and requests of third parties with the moral rights and best interests of clients is not easy. Thus, in the following three scenarios, we show how such ethical balancing might proceed. Although this analysis is primarily done through the lens of Principle III (Integrity in Relationships), the other principles in the *Code* also are considered.

Scenario #1

> **Client A:** You receive a request from an insurance company for psychotherapy information about a client whose psychotherapy is being paid for by the company. The client was physically injured in a serious fall at work and remains off work due to the physical injury. The insurer includes a generic release of information that is dated over 12 months ago. The client conveys to you that, at the time he signed the release, he was told that he either signed it or his benefits would be terminated. Some of the current issues being addressed in psychotherapy revolve around his experiences of having been abused as a child.

The following discussion of this case will explain the problems and issues related to (a) signing a generic or omnibus release of information, (b) signing an enduring release of information, when changing conditions may require revision to the form and the extent of consent, and (c) when a client referred for one condition may reasonably result in treatment of other conditions.

The Moral Right to Confidentiality and its Relationship to Integrity in Relationships

This scenario highlights the conflicts that can arise among the ethical principles in the *Code*. The psychological services are being provided to a primary client who at best is partially dependent upon the insurance company that is paying for the psychological services. In addition, the therapy client is vulnerable. And further, when seeking help from a mental health professional, individuals are often, and rightly so, concerned about confidentiality. The expectation of confidentiality has long been an important component in maintaining a positive therapeutic relationship between client and psychologist (Jagim et al., 1978). As such, protecting confidentiality has always been an important obligation of psychologists (e.g., American Psychological Association, 2017; CPA, 2017). Typically, ethical standards require information disclosed to a psychologist to be held in confidence and not released without the client's consent except under certain specific conditions (e.g., when there is the potential for harm to the client or someone else, or when a child or other vulnerable person is being abused or neglected). Although these limits are standard in the discipline, additional limits concerning confidentiality become imposed on the client-psychologist relationship when a third party is involved.

A key position of the *Code* is that a psychologist's greatest responsibility for protection of moral rights, well-being and best interests is to those clients who are most vulnerable in a situation (typically the psychologist's primary client or contract examinee). Although the responsibilities of psychologists to third parties need to be honoured, our responsibility as a psychologist to third-party payers is normally secondary to the responsibilities regarding the moral rights (e.g., privacy and confidentiality) of vulnerable clients. While this ordering seems straightforward, some legal statutes and organizational policies involving third parties may require the release of information with or without the clients' fully informed or fully voluntary consent (Truscott et al., 2013). For example, we have found that if a client initially seeks services from a psychologist and then submits a claim for benefits/coverage to an insurance company, the client may have to agree to the insurance company having access to information from the psychologist[2] (e.g., access to diagnosis and services/treatments provided). Hence, in spite of the existence of a previously signed consent form, and even a client's subsequent statement that they would like the information disclosed to the insurance company, it is a matter of integrity for the psychologist to inform a client, whose psychotherapy information is being requested, of the possible consequences of the disclosure and of any reservations the psychologist may have. (cf. Ethical Standard III.13 which instructs psychologists to inform clients of any limitations "imposed by third-party payers"). Moreover, Ethical Standard I.26, under Principle I (Respect for the Dignity of Persons and Peoples), of the *Code* indicates that psychologists should clarify the nature of multiple relationships to all concerned parties when obtaining consent. In addition, Ethical Standard III.13 also reminds psychologists that they need to be "clear and straightforward" about their explanations, especially those related to consent. (For example, Brian found it quite helpful to explain to clients what information a third party may and can request and to note the precautions that should be considered such as when a retaining party requests a copy of all the therapy notes.) This kind of explanation is consistent with Ethical Standard III.14. Even after such explanations, dependent or partially dependent primary clients might not understand the comprehensive implications of consenting to disclose particular information and might not fully realize that they could be permitting third parties to use and share their information in any way that the third party sees fit (Koocher et al., 2008, p. 212). This issue is further exacerbated when consent forms are signed far before treatment issues arise. As such, we find that a significant responsibility falls on the psychologist (Ethical Standard III.14) to ensure all reasonable steps are taken to communicate as clearly as possible in protecting clients' moral rights to privacy, confidentiality, and informed consent.

We have found it helpful to follow several steps of action recommended in the literature (e.g., Fisher, 2008; Smith, 2003; Vanderpool, 2013) that are consistent with Principle III. These include preparation, transparency, open and straightforward discussion with the client, adequate documentation, and discretion. First, we need to be prepared as psychologists. Clients need to understand their moral rights and psychologists need to own their ethical responsibilities and be familiar with relevant local and federal laws, ethical obligations, clinical guidelines related to third-party treatment, and the legitimate interests and need-to-know of the third party. Second, we have a duty to be transparent and tell clients the truth about the limits to confidentiality up front and at the outset. Doing so requires time, honesty, clarity, and repetition on the part of the psychologist. We need to inform clients of any roles or potential conflicts of interest that might affect confidentiality. Psychologists need to discuss with clients the rights they might forgo when receiving services paid by a third party (e.g., discuss that WCBs legislatively have the right to access personal and health information regarding a client, and that the client needs to decide about the acceptability of these limits). As informed consent is an ongoing process, we also need to reopen the conversation if/when the client's circumstances (or the psychologist's intentions) change. Third, although not strictly required under Principle I, a practice that can enhance the openness and transparency expected under Principle III is having the client sign, prior to beginning services and when circumstances change, a written consent form that outlines many of the points presented above. Ongoing documentation (e.g., dates of service and fees; diagnostic impressions, treatment plans, client contact) also helps to ensure transparency and openness. Finally, we should exercise discretion in responding ethically to requests for personal health information. With respect to Scenario #1, for example, when being seen by a psychologist for pain related to an insurance-covered injury, a client might disclose a history of sexual abuse that is affecting her/his current well-being. Although this disclosure is relevant to treatment, it is unrelated to the insurance injury. Should the client choose to retain confidentiality regarding such history, this decision needs to be respected. Specifically, psychologists have a responsibility to release only the minimum amount of information necessary. They should disclose information only agreed upon in the written authorization signed by the client, and release only the information that is relevant to the purpose of the service and to the purpose of the request for information (Fisher, 2008; Smith, 2003; Vanderpool, 2013).

The practice of releasing only the relevant information needed for a specific purpose is reinforced by various practice guidelines and jurisdictional advisories. For example, the Saskatchewan College of Psychologists' *Practice advisory on release of psychology records* (2013) states that psychologists dealing with third parties "must limit access to client records to preserve confidentiality" (p. 3). Further their *Practice advisory on final checklist for consent* (2013) states, "When a request for release of information is received . . . [t]hat request is for specific information for a specific purpose. . . . [a] letter from an insurance company with an omnibus general release for all information does not meet practice expectations or legislative requirements for protecting private information" (p. 4).

Overall, then, the issues we have discussed above highlight the importance of the moral right to be *informed* about confidentiality and its limits, and the risk to this moral right not being respected when third parties are involved. Further, it also falls to the psychologist to inform third parties or "retaining parties" of restrictions on disclosure due to the right to confidentiality, even in a third-party scenario.

The Moral Right of Informed Consent to Services, and its Relationship to Integrity in Relationships

Another highly relevant issue with respect to this first scenario is the issue of informed consent to services. If communication with third parties is involved, the primary client has the right to be informed in the consent process about the purpose(s) of the service and the involvement of third parties, as well as a right to be given the opportunity to ask questions (Barnett et al., 2008). It also involves the right and ability of the informed client to then decide to *provide or refuse consent* to the services offered within these limits.

The potential for refusal highlights that the process of informed consent is viewed as voluntary. Truscott and Crook (2021) stated that "The ethical foundation for consent is derived from the principle of autonomy whereby each person's right to be free from controlling influence by others is respected" (p. 84). It could be argued, however, that clients who participate in treatment through third parties cannot provide fully informed consent because such services inherently lack the element of full voluntariness and remove some of the clients' autonomy and freedom (Bemister et al., 2011; Melton et al., 2007; Vanderpool, 2013). In terms of the *Code*, such individuals are considered partially dependent. Specifically, if treatment is mandated by employers in order to get compensation, the client is not able to refuse without serious consequence. Even if clients are fully involved in the informed consent procedure, and it is done with full disclosure, the client is constrained by needing to abide by the terms and conditions of the services if s/he wants to receive treatment. In this type of scenario, we have found that clients often perceive that they are required to undergo an examination or treatment to access monetary benefits or as a condition of their employment, and if they do not abide by the terms of the service providers, they will not receive the services (Vanderpool, 2013). For example, in a WCB insurance setting, the client who does not agree to the terms of mandated treatment might not get the rehabilitation needed or obtain salary compensation. In addition, psychologists need to recognize that clients often trust and depend on them to guide client decisions. These features of the client-psychologist relationship can lead unaware therapists to influence decision making in ways that violate Ethical Standard III.28, which encourages therapists to not take advantage of the trust and dependency of clients. Thus, in the context of obtaining informed consent, we have found that possible decisions regarding the acceptance of terms of service need to be discussed with the client to determine what consequences are and are not acceptable to the client.

In addition, clients often blindly sign consent forms and related documents because they view their signature more as a requirement to obtain the desired coverage or required services than a personal choice (Bemister et al., 2011). However, while clients can experience the pressure to sign as involuntary, they do in fact have a choice as to whether to undergo a treatment plan. It is up to the psychologist to explore clients' expectations about what signing a consent form means. Specifically, psychologists need to be certain that clients understand that they do indeed have a choice, albeit between less-than-ideal options, such as forgoing a disability claim or voluntarily relinquishing employment (Vanderpool, 2013).

Because of the serious consequences described above, we believe it is the psychologist's responsibility to explore what is in the best interests of the client, while managing the multiple relationships inherent to third-party work. In particular, the psychologist might want to consider involving the retaining party in a consent process at the time of agreeing to a contract (See Ethical Standard III.31).

This involvement might lead to a better understanding by a third-party payer of the importance of privacy to the treatment process, as well as an understanding of the problem of "blank-check" consent forms. It also might lead to agreement from the third-party payer that they will accept limits on the type of confidential information they seek (cf. Ethical Standard IV.14).

Summary

In Scenario #1, the client is informed that he must sign or face serious consequences. The client might feel coerced into treatment and coerced into agreeing that unlimited confidential information will be disclosed. The issues being addressed at the time of the request of the third party for psychotherapy information include significant past traumatic experiences, which, from clinical experience, are known to affect a client's capacity to deal with pain and develop greater resilience (Mancini et al., 2006). Protecting the client's privacy about such matters while assisting the third party to make its own legitimate decisions is complicated by problems in the consent process, particularly given that the consent was obtained over 12 months ago and was not framed as a request for specific information for a specific purpose.[3] In Brian's experience, many of the clients who are seen in a rehabilitation setting are dealing with residual effects of previous trauma, which complicates and may prolong the treatment process. The dilemma is his desire to communicate to the insurer the severity of the issues the client is dealing with, but without disclosing the details that are protected via confidentiality. In cases of this nature, Brian often spoke directly with the insurer to indicate that the client had disclosed other psychosocial issues that are affecting the treatment plan. When pressed by the insurer to disclose the details, he indicated that he had not been given permission to do so. He found this approach to be generally effective.

In conclusion, we believe that such a dilemma requires effective and detailed communication between the psychologist and the third party about limits to disclosure. Such an approach, while requiring more time and effort, is consistent with Ethical Standard III.32, which requires the psychologist to inform all parties "of the need to resolve the situation in a manner that is consistent with Respect for the Dignity of Persons and Peoples (Principle I) and Responsible Caring (Principle II), and take all reasonable steps to resolve the issue" consistent with the best interests of the partially dependent and vulnerable client.

Scenario #2

> **Client B:** You receive a request from a third-party insurer asking you to provide your therapy notes and a DSM-5 diagnosis regarding

> an individual involved in an MVA. You have provided a report, but not your notes or a diagnosis. Shortly thereafter, you receive a phone call from an employee of the insurer questioning your report. In the discussion, you become suspicious that the third-party insurer is using unqualified personnel to review psychological reports and provide disposition recommendations. When you contact a manager at the insurance company, the manager refuses to disclose how or by whom files are reviewed.

Privacy Protections

When providing therapy for individuals who have been in a work accident (WCB) or a motor vehicle collision (MVC), information is shared with insurance companies, who use this information to assess the amount of money they are willing to put toward the rehabilitation needed for the individual involved. This practice can impact psychologists' work and clients' healing process, possibly undermining the therapeutic work and the therapeutic relationship, among other consequences (Borkosky & Smith, 2015, Cohen et al., 2006). There can be two types of problems that arise when sharing information: selective editing by third parties and over-disclosure by the psychologist.

The Problem of Selective Editing

Schatman and Thoman (2014) highlight that third-party involvement can become problematic when claims managers engage in "cherry picking" (p. 191) or "selective editing" of records and reports. They provide the example of an individual who was physically injured on the job, resulting in psychological sequelae (specifically, he experienced neck pain and headache as well as problems with concentration, memory, and anxiety), and who had participated in an assessment about this by a psychiatrist. When this individual was sent for an independent medical exam (IME) to assess the claimant's physical and psychological status, the psychiatric assessment from the individual's psychiatrist was not forwarded to the psychiatrist doing the IME, consequently not informing the IME psychiatrist about the connection between the physical injury and the psychological sequelae. Although Schatman and Thoman discuss this issue in the context of what records insurance claims managers selectively provide to psychologists who perform independent examinations of psychological status, the practice also applies to psychotherapists whose records are the ones being selectively held back. When such cherry picking or selective editing occurs, only some of the information is known or focused on. Consequently, third-party decisions are based on incomplete information and can result in unwarranted and harmful termination of appropriate treatment (Schatman et al., 2014).

Adversarial perspectives suggest that third parties cherry pick facts that support the interests of the insurance company (i.e., saving them money by rejecting a claim), and fail to include other notes/facts that would refute their decision (Gholizadeh et al., 2016; Schatman et al., 2014). This type of selective editing reflects a misinterpretation, and importantly a misrepresentation, of what the psychologist reported. In addition, this practice puts a client at risk for harmful psychological and physical repercussions. Given the occurrence of the practice, Schatman and Thoman advocated that psychologists be aware of the potential for selective editing of their reports (e.g., by claims managers). To offset this, Schatman and Thoman advise psychologists to ensure to the best of their ability the reporting of concise and accurate information that is unlikely to be misunderstood or misused. In other words, consistent with Ethical Standard III.1, we need to be prepared to confront any "dishonesty, fraud, misappropriation, or misrepresentation" of client information by a third party.

Based on interviews with psychologists, Cohen and colleagues (2006) found that psychologists find themselves in a position whereby they try to describe a client's condition with sufficient urgency and severity that coverage for treatment will be approved; all the while, being concerned about privacy and being reluctant to put damaging information into a record for fear of misuse. The question is whether this kind of presentation is itself intentionally misleading (e.g., selective editing, as discussed above). On the other hand, this kind of presentation could be viewed as necessary because many third-party assessors/adjudicators who review the client's claims do not have a background in psychology and might therefore be unfamiliar with the context/topics discussed in such reports. Indeed, Ethical Standard II.32 of the *Code* states that psychologists should "be acutely aware of the need for discretion in the recording and communication of information, in order that the information not be misinterpreted or misused to the detriment of others." Whatever the case, report writing and sharing of information is something that needs to be handled with care by psychologists working with third parties (Cohen et al., 2006).

Psychologists can struggle to find ways to protect clients' privacy while meeting the third-party demands for detailed information in progress notes (Cohen et al., 2006). Examination of this issue includes consideration of the *Code,* but Brian and Annik have found that it also can be helped by a review of Canada's federal law (the *Personal Information Protection and Electronic Documents Act*—PIPEDA), the *Health Information Portability and Accountability Act* (HIPAA—see examples in the following section) in the United States, as well as professional practice guidelines and local jurisdiction advisories.

The Problem of Requests for Session Notes

The sharing of unedited notes can be fraught with problems. PIPEDA is the Canadian law relating to privacy, which governs how organizations collect, use, and disclose personal information. The Act requires organizations to obtain consent when they collect, use, or disclose their personal information and to have personal information policies that are clear, understandable, and readily available. It appears that "Quebec, British Columbia and Alberta have adopted private sector legislation deemed substantially similar to the federal law. As well, Ontario, New Brunswick, Nova Scotia, and Newfoundland and Labrador have adopted substantially similar legislation with respect to personal health information" (Office of the Privacy Commissioner of Canada, 2018).

PIPEDA is comparable in many ways to the HIPAA in the United States, except that PIPEDA does not address the specific issue of session notes. However, the Ontario *Personal Health Information Protection Act*, 2004, Section 37 (1) states, "A health information custodian may use personal health information about an individual, . . . (i) for the purpose of obtaining payment or processing, monitoring, verifying or reimbursing claims for payment for the provision of health care or related goods and service." However, as noted previously, many national and local psychology bodies have issued guidelines and advisories that recommend caution in releasing entire records, indicating that any release of information should be limited to *specific content* that meets *specific purposes*.

In US jurisdictions where progress notes are accessible by third parties with appropriate consent forms, the privacy rule compliance specified under HIPAA allows for some flexibility when needing to challenge or comply with third-party requests for this information (Holloway, 2003). Under HIPAA, disclosure of psychotherapy notes requires more than just general consent; it requires specific permission by the client to release this sensitive information (cf. example below regarding guidelines in Saskatchewan). It is worth highlighting that HIPAA's definition of psychotherapy notes explicitly states that these notes are kept separate from the rest of a client's file. Although this practice might differ from the way some psychologists are instructed by their employing organizations to store client information, it does offer greater protections for client notes. For instance, the US Department of Health and Human Services suggests that these notes be kept separate from clients' official records, in order to prevent this information being available to third parties (Holloway, 2003).

In Canada, the release of therapy notes is often guided by provincial professional practice guidelines. For example, the College of Alberta Psychologists states in its practice guidelines *Disclosure of Personal or Confidential Information*, "To the best of their ability, in any circumstance where disclosure is contemplated, psychologists should endeavour to clarify to all stakeholders (i.e., clients, funding agencies, third-party participants, third-party collaterals, etc.) the risks and benefits associated with disclosure." The Saskatchewan *Professional Practice Guidelines (3rd Version)* goes further and states, "Members will inform all clients of the standard limits to confidentiality at the outset of their professional contact as part of an informed consent for treatment process. This will include informing clients that information about them will not be released to any outside source without their permission, except in situations in which there is: (a) potential, imminent harm to the client or others; or (b) suspected neglect or harm to a child, including the witnessing of violence; or (c) a court order to release client information; or (d) where required by legislation." Thus, psychologists are being guided to limit access to client records to preserve confidentiality. These guidelines, as well as many other provincial guidelines, imply that when a request for release of information is received, such requests should be for specific information for a specific purpose. Thus, a letter from an insurance company with an omnibus general release for all information likely does not meet practice expectations or legislative requirements for protecting private information. However, it is important to review local guidelines on an ongoing basis, as such advisories are updated rather regularly in most jurisdictions. Similarly, each province has Acts regarding the protection of health information, as well as professional practice guidelines and advisories/policies. Each provincial legislation/Act specifies the responsibilities of health information custodians. These provincial Acts, guidelines, and policies generally specify that explicit consent must be obtained to release any information, but also may specify when implied consent is present and when information could possibly be shared without explicit consent (See, for example, Steinecke, 2020).[4] It is our belief that being ethical regarding third-party requests for psychotherapy information includes psychologists being familiar with their jurisdiction's relevant Acts, professional guidelines, and policies regarding release of private information.

In Brian's practice, he on occasion sent a letter to the insurer explicitly stating that he would not share his therapy notes, citing the relevant legislation and practice guidelines. If an insurer pressed him further on this disclosure, he followed up with a telephone call to seek their understanding. He usually found this strategy to result in collaborative and co-operative communication. In his experience, third-party assessors/adjudicators with more knowledge about mental health allowed more collaborative interaction regarding the information needed to make their decisions regarding a claim.

However, if an assessor/adjudicator's approach or decision seems to clash with that of the psychologist, the psychologist can consider going above that assessor, and discussing the matter of coverage flexibility with a supervisor or manager. If a third-party assessor/adjudicator misused information obtained from a psychologist, Brian sometimes decided to no longer share information, or to encourage the client to go through the insurers' appeal process to challenge the request for information and its possible (mis)use. While he has found this strategy to be effective in about half of the cases, it is a great deal of work (e.g., assisting the client in writing documentation for the appeal). These considerations speak to the need for psychologists to take on an advocacy role, which is the focus of the next section.

Advocacy

Although the issues of consent, confidentiality, and privacy are not unique to third-party mental health care, it can be argued that disclosure of mental health information is more significant than disclosure of general health information because of the greater risk of stigmatization (Boyle et al., 1995). As a result, higher levels of care and advocacy might be required on the part of psychologists to ensure the promotion and protection of their clients' well-being. This view is consistent with the position stated in the Preamble to the *Code* that its use is intended to be both proactive and reactive. It also is consistent with the values of Principle IV (Responsibility to Society) regarding psychologists advocating for change when societal structures or social policies ignore or oppose the principles in the *Code*.

WCB and MVA insurance cases are prime examples of the types of structure and policy complexities psychologists face in collaborating with third parties. For occupational injury or MVC insurers, the primary purpose and key objective of providing coverage for intervention is based on promoting the client's return to healthy functioning and resumption of occupational or everyday lifestyle activities (Sullivan et al., 2007). Many clients of workers' compensation or motor vehicle insurers present with symptoms of pain and disability; however, sometimes there may be no objectively identifiable disorder or disease (Sullivan et al.). In these cases, the authenticity of the client's condition might be questioned, and a lack of a diagnosis might be deemed insufficient by third-party payers to provide coverage for psychotherapy. As such, a psychologist might find him/herself in an advocacy role working to protect the client in conflict with an insurer (righting the "unfairness" of clients' situations). For example, on one occasion, Annik found herself unsuccessfully advocating with an insurer for extended coverage for a woman who was not only in an MVA but had a history of sexual assault that complicated coping with her accident. She ended up centring sessions on the client's current coping and how the MVC contributed. Annik touched on the client's sexual assault in terms of enhancing her insight regarding its impact on her overall difficulty coping but did not make it the focus of treatment. Instead, she provided the client with information for other resources/services if she was interested in seeking additional psychological support. Through her experience working with this client and the insurer, Annik learned that third parties may limit the scope of our treatment as clinicians. While this may be frustrating, we can at the very least do our due diligence by making an appropriate referral.

We have found that advocating can come in many different forms—whether it be encouraging a client to appeal a decision, or challenging, or not complying with a third-party request. In these cases, a psychologist needs both to ensure that the client is informed and in agreement with the action and to have weighed the potential harms/benefits of her/his behaviour on the client. Adversarial approaches can increase the likelihood of a third party refusing the client's coverage and could even result in cancellation of all future coverage for the client. Appeals or challenges also can result in legal ramifications and increase stress for the client. Although well intentioned, challenging or appealing the decisions of third parties does not always lead to positive outcomes and paradoxically can result in deterioration of the client's health and well-being.

Given the potential negative side-effects that can come with advocacy, how then should a psychologist proceed? Cohen et al. (2006) found the following strategies useful in helping us to live up to our professional and ethical responsibilities in third-party payer situations. First, psychologists can emphasize the negative aspects of the client's condition, not in the sense of making up fraudulent information, but rather in terms of sharing accurate information in a timely or strategic manner that works to help the client (e.g., summarizing only the relevant information in the form of letter to the insurer). Another strategy is for psychologists to adopt the language of the third party and to learn to reframe clients' problems and progress using this language; in other words, "[give] them what they want to hear the way they want to hear it . . . know what the buzzwords are" (Cohen et al., p. 257)—for example, using the precise medical term for a form of cancer rather than the generic word "cancer." Another strategy that Brian has used is to see clients pro bono on a short-term basis when third-party payers have denied urgent care.

Summary

In Scenario #2, where the third party is requesting information that will be assessed by unqualified personnel, the dilemma is whether or not to provide the requested information, given the potential of inappropriate review and decision-making by the third party. The first part of the dilemma can be addressed by informing the client of the request, discussing possible consequences and, if the client agrees, then obtaining consent. The latter part of the dilemma likely requires advocacy by the psychologist, such as requesting to speak to a supervisor or manager within the third-party organization, but only with the client's consent. Advocacy also might be needed when the client chooses to share only a portion of the information requested.

Scenario #3

> **Client C**: You have been seeing a man following the death of his spouse six months previously. There was no prior history of depression, but your client continues to actively grieve the death of his spouse. The costs for psychotherapy have been covered by private insurance. However, the insurer is questioning the ongoing therapy and states that unless a DSM diagnosis is provided, the client will receive no further coverage for therapy.

Diagnoses

The policies of many third-party funders limit the number of mental health care services (i.e., therapy sessions) they will cover, or apply a total fixed dollar amount for such services. Often, the number of sessions covered/reimbursed will vary depending on the perceived severity of the presenting problem (e.g., ten sessions for addiction, six sessions for depression, three sessions for interpersonal problems). There are some serious ethical considerations to keep in mind when working with third parties who require a diagnosis of mental illness and base their coverage of services on the diagnosis (Pope et al., 2016). In particular, we strongly believe that psychologists working with third parties have a responsibility to consider the risks and benefits of providing a diagnosis (See Ethical Standards II.13 and II.14).

Support for our concern about psychiatric diagnoses is found in the research literature. Danzinger and Welfel (2001) conducted a study surveying 108 mental health professionals about their experience and the perceived impact of working for managed-care companies and found that when client diagnoses do not fall within the reimbursement guidelines of insurance companies or managed-care organizations, psychologists can feel pressure to choose between an accurate diagnosis (which may result in denial of third-party coverage) and an alternative and possibly inaccurate diagnosis in order to gain reimbursement (Braun et al., 2005; Danzinger et al., 2001; Murphy et al., 1998). If a client's needs exceed the fixed allotment for a specific diagnosis, then those services are not covered by the insurance companies. Further, clients can be motivated to exaggerate their symptoms (Mittenberg et al., 2002), and psychologists can find themselves endorsing this exaggeration or providing a questionable diagnosis to extend coverage. In Danzinger and Welfel's study, a total of 60% of mental health professionals said they would change treatment plans based on third-party limitations, and 44% admitted that they would change a client's diagnosis to receive additional reimbursement/coverage from the third party. Although we see altering diagnoses and changing treatment plans as likely discreditable and unethical, its reported frequency reflects a common conflict between the responsibility not to provide fraudulent information (or less-than-accurate information), and the responsibility to do no harm and to act in the best interests of the most vulnerable person (i.e., usually the primary client or contract examinee) (CPA, 2017).

Although a benefit to providing a diagnosis might lead to coverage for services, providing a diagnosis also can put the client at risk for harmful consequences (e.g., the stigma of mental illness, Boyle et al., 1995). Moreover, a diagnosis of a mental disorder might endanger a client's chances of gaining future insurance coverage or exclude her/him from certain services (Cohen, et al., 2006, Murphy et al., 1998). In a workers' compensation context, clients with diagnoses might be discriminated against for employment, work promotions, and salary increases (Braun et al., 2005). As such, reflections on balancing the risks, benefits and role of advocacy need to be considered (CPA, 2017).

Summary

In Scenario #3, it should be noted that DSM-5 has dropped the bereavement exclusion that existed in the previous edition. That is, DSM-5 allows for a diagnosis of major depression in the context of bereavement. There is, however, a very instructive discussion in the DSM-5 manual on this issue (American Psychiatric Association, 2013, p. 161). Thus, in this scenario, a diagnosis might be quite legitimate. The question arises, however, as to whether supplying this diagnosis to the insurance company is in the client's best interests, and whether it is stretching diagnostic criteria to meet an insurer's need. The former question revolves around informed consent (See Ethical Standard I.26) and being clear about the needs of the insuring party (see Ethical Standard III.13—clarifying relationships and boundaries among affected parties—which in this case are the client, the insurer, and the therapist—as well as any limitations imposed by the third party); the latter question revolves around confidently providing a clinically accurate diagnosis as required by Ethical Standard III.1. Finally, as Ethical Standard III.35 advises, seeking consultation regarding these issues is advisable.

Conclusion

We have found that maintaining integrity in relationships with third parties and clients is a complicated area, influenced by several client factors and third-party contexts. The scenario discussions above might make psychologists wonder if they can make sensible decisions about participating in services through third parties. For us, one of the most important conclusions is that psychologists should not feel constrained or controlled by their third-party involvement. Yes, we have a duty to make ourselves aware of existing laws and regulations; however, we are ultimately bound by our professional ethics to do no harm and to protect the moral rights of dependent or partially dependent primary clients and contract examinees as much as possible. As such, we strongly encourage psychologists to be proactive in their approaches, both in terms of their communication with clients and with third parties, and to challenge the power of third parties when necessary/appropriate.

We present a set of recommendations in Table 1, some of which we have found helpful when working with third-party insurers (see Recommendations 1 to 3), and some of which are aspirational (see Recommendations 4 and 5).[5] We believe that psychologists should be informing their clients of these recommendations and how they address potential problems that can arise in working with third-party payers. We believe that the recommendations are consistent with the *Code*, particularly Ethical Standard IV.14, and with the privacy legislation that has emerged in Canada, both federally and provincially. The principles in such privacy legislation include accountability; identifying purposes; informed consent; limiting the use, disclosure, and retention of information to the purposes for which the information was collected; and safeguarding the information (LeGault, 2003). However, we recognize that there are problems with the proposed recommendations insofar as they are likely to challenge the business practices of some third-party insurers in Canada. For example, some third-party insurers have reacted negatively to such practices, citing prior consents having been given when clients signed up for insured services. Indeed, provincial legislation governing workers' compensation often broadly permits access to private information.[6] Regardless, these recommendations attempt to balance the privacy rights of individuals with the need for information by third-party insurers who are required to plan and adjudicate.

As psychologists, we have several choices with regard to engagement with third parties: (a) work with them; and/or (b) challenge them; or (c) avoid them. In this chapter, we have touched on a few questions and dilemmas that we (and others) have encountered in working with and challenging third parties. However, it is important to acknowledge that, even when a psychologist decides to avoid working with specific third parties (e.g., WCB or auto insurance), several issues need to be considered. For example, organizations' need of psychological expertise to make the decisions they need to make. Also, it could be doing a disservice to clients not to have access to mental health care arranged and paid for by these organizations (Harris & Zehr, 2014). Even considering the inherent constraints of these third-party arrangements, clients can derive some degree of therapeutic benefit (Haas et al., 1991; Harris & Zehr 2014) and, therefore, perhaps more harm is done by not providing even constrained services. These are the types of risk/benefit analyses (see Ethical Standard II.13) that psychologists need to consider at a systems level. Psychologists have a responsibility to give careful consideration to the features of the insurance plans they join (see Ethical Standard IV.14), the potential impact of the third-party limitations on the therapist-client relationship (such as requirements for disclosure or providing a psychiatric diagnosis), and the appropriateness of various client conditions for time-limited treatment (Haas et al., 1991). The ideal would be to find a way to work collaboratively with all parties.

Questions for Reflection

1. How do you think you would feel if a client withdrew consent for disclosure of an assessment report when payment to you depends on the report being shared with a third party? What do you think you should do? What do you think you would do?
2. In such a situation, do you think there is an inherent conflict of interest that needs to be managed? If so, how would you manage it?
3. In responding to the above situation, how do you think you might honour the Principle III (Integrity in Relationships) value of *Openness and straightforwardness*, while also honouring the Principle I (Respect for the Dignity of Persons and Peoples) value of *Informed consent*, and the Principle II (Responsible Caring) values of *General caring* and *Minimizing harm*?
4. Do you think there might be ways of avoiding this type of dilemma in future? If so, how?

Table 9.1: Recommendations Regarding the Disclosure of Psychotherapy Information to a Third Party

1. Notify third-party insurers with which you work or plan to work (e.g., WCBs, insurance companies) that general requests for information, such as the release of complete files, will not be responded to, as such requests reflect an intrusion into the moral right to privacy. Rather, ask the third party to pose specific questions relevant to the third party's interests regarding progress, prognosis, or any other relevant matter.
2. When a third-party insurer requests a copy of a complete therapy file, decline to do so. If the insurer is persistent, consider using an independent qualified psychologist to mediate the transfer of only specific information from the client file to the third party. The mediating psychologist's role would be to review contents of the file, under trust conditions not to release the file, extracting only the information that addresses specific questions posed by the third-party insurer.
3. When psychologists have had prior therapeutic relationships with a client who is now receiving services from the psychologist paid for by a third-party insurer, notify the third-party insurer that the insurer cannot have access to prior client information as that information is private and was obtained for a different purpose.
4. When psychotherapy information is being used by a third-party insurer to adjudicate eligibility for or continuation of coverage, psychologists should decline to release the information unless the professional qualifications of reviewers (and/or experts used by the third party) are disclosed to the psychologist, and their qualifications are commensurate with their level of duties.
5. Consider working only with third-party insurers that subscribe to an institutional code of ethics and employ professionals with qualifications that are commensurate with their level of duties.

NOTES

1 "Retaining Party" means the *individual* or *group* that has retained a *psychologist* to assess a *contract examinee* for the purpose of helping an external decision-maker (e.g., court, insurance company, or employer) to make a decision (CPA, 2017).

2 Such agreements are often contained in third-party consent forms. However, clients in our experience often do not read consent forms carefully.

3 It is important to understand that we believe that consent is a *process*, not simply the signing of a form. That is, consent should evolve as circumstances change. Although there are no specific practice or ethical guidelines on time limits for consent forms, practically speaking, a 12-month period is a time frame in which circumstances could reasonably change. Therefore, best practice might be that a consent form could be reasonably considered still in effect for 12 months if the client can recall the process of informed consent, the risks and benefits have not changed, and the client has not rescinded that consent at any time in the 12 months. However, we believe this needs to be decided on a case-by-case basis, and that the voluntariness and client's understanding of what they signed always needs to be considered.

4 It is important to note that this discussion is in the context of dealing with individuals who are deemed to have the capacity to provide consent. The issues regarding individuals who are deemed not to have this capacity is a separate topic.

5 These recommendations can be seen as a potential outline or template for a contract with a third-party insurer.

6 For example, the *Manitoba Workers Compensation Act* (2016) states, "Health-care providers must also provide reports to the WCB of injuries that are covered by the WCA (section 20). Reports are for the WCB's use and purposes, and the worker's consent is not necessary (p. 34)."

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10

Stormy “Whethers”: Ethical Challenges of a Clinician in Academia[1]

Donald W. Stewart

I never expected my career would become so complicated. My first professional job seemed straightforward enough—I was hired to provide clinical services to students at a university counselling centre. As an added attraction, the position came with a tenure-track academic appointment at the assistant professor rank. However, in working with my clients, I quickly learned that I needed to pay attention to more than their clinical needs. I also needed to understand the complex university system in which they were studying—and in which I was employed. If I were to be successful in my pursuits, I needed to broaden my focus to acknowledge the unique culture of academia in an effort to understand how it influenced all aspects of my clients’ lives and, by extension, my work.

Thus began my developmental journey into the complex web of interrelationships, moving targets, and multiple stakeholders that has characterized all stages of my career to date. In the sections that follow, I will discuss various aspects of these challenges from an ethical standpoint, focusing mainly on issues related to Principle III (Integrity in Relationships), from the *Canadian Code of Ethics for Psychologists* (Canadian Psychologist Association [CPA], 2017), as this best reflects the character of most of the dilemmas I have encountered in my overlapping roles as a clinician, supervisor, administrator, and regulator. In particular, I will focus on challenges related to establishing and maintaining professional integrity, managing multiple relationships, and avoiding bias in interactions with supervisees and colleagues. I also will touch on challenges in identifying priorities when ethical principles conflict. At the end of the chapter, I include a few questions for reflection intended to help you apply some of the themes in this chapter to your own work in hope that this will deepen your understanding of issues related to maintaining integrity in relationships.

A Chilly Reception: Early-Career Challenges in Maintaining Professional Integrity

When I began my career as a newly-minted Ph.D. in clinical psychology, I was greeted by the senior counselling staff with a healthy dose of skepticism—which I countered with youthful enthusiasm and confusion about how they could see things so differently from me. I knew that most of the counselling staff had studied psychology, even if they were not psychologists, but their humanistic and developmental perspective seemed to frequently conflict with what they considered my "medical model" approach. Rather than being warmly welcomed as a unique resource, I instead felt that I was being pushed to the margins of the department. Adding insult to injury, my department did not support conventional research—which was most unfortunate for a conventional researcher like me (see Stewart & Sheckter, 2001). How was I ever going to secure tenure under these circumstances?

Looking back now, I am sure that I held many unrealistic expectations about what my professional life should be like—and equally certain that these coloured my perceptions of both my colleagues and the culture of my work environment. I think the following depiction of life as a new academic captures much of what I recall about my own expectations during that period:

> During my first year as a new faculty member I expected that I would be able to publish several manuscripts, present at multiple conferences, apply for at least one grant, develop working agreements with a number of practicum sites for our new graduate program, direct four to five thesis projects, and excel in all of my other job responsibilities (i.e., teaching, research, service) while still having time to spend with my family and enjoy my hobbies (Zayak, 2013, p. 65).

Not surprisingly, I did not achieve all that I expected during the early days of my career—and, in retrospect, I probably externalized the blame for this to an undue extent. As a new psychologist, it was disappointing to feel I did not have a strong peer group to support my efforts. However, instead of continuing to blame my colleagues for marginalizing me and subverting my work, I eventually began to search for ways in which I could connect with those whose background and perspective aligned more closely with my own. Such efforts went beyond mere attempts at personal validation. Frankly, I was afraid that if I did not take steps to maintain my identity as a psychologist, my professional integrity would begin to suffer as I drifted away from my reference group. I thus began to actively cultivate relationships with other psychologists on campus and in the community, forming productive working relationships, research partnerships, and even friendships with a number of colleagues with whom I had no evaluative connection. Along with this, I also worked hard to clarify my intentions, values, and clinical perspective through dialogue with my counselling centre colleagues, just as I tried equally hard to understand where they were coming from in their professional activities.

Taking responsibility for my own unrealistic expectations was necessary in order for me to begin fulfilling my ethical obligations with respect to maintaining integrity in relationships—even if it was a little tough to see these expectations as "unrealistic" at the outset. In fact, with the benefit of experience, I can see now how there were elements of departmental politics, interdisciplinary rivalries, and perceived encroachment that made difficulties such as those I experienced all but inevitable (cf. Zayak, 2013). But, that notwithstanding, as noted in the *Code*'s Values Statement for Principle III, psychologists "are expected to understand how their own experiences, attitudes, culture, beliefs, values, individual differences, specific training, external pressures, personal needs, and historical, economic, and political context interact with their activities, to be open and honest about the influence of such factors, and to be as objective and unbiased as possible under the circumstances" (CPA, 2017, para 3).

Reflecting further on this, I can see how my efforts to identify like-minded psychologists in the community helped to provide insight into my own motivations and assumptions, particularly when these contrasted with those of my counselling centre colleagues. I also recall how discussions with some of my outside contacts and mentors were helpful in disentangling what was a real problem from one that I had created by being either unrealistic or impatient. Zayak (2013) similarly outlines the benefits of informal and formal networking as an antidote to some of the stress and isolation young faculty members can feel. It is good advice, and well worth the effort—even (or perhaps especially) for introverts.

Besides building a professional support network, I also recall reading a very helpful article that described 10 principles of success for new psychologists in clinical practice-oriented careers (Plante, 1996). I recall being particularly struck by Principle #10, "Remember, you are a psychologist: You can still be proud of it" (Plante, p. 307). Bolstered by this sage advice, I essentially adopted this as my personal mission statement. This further strengthened my identity as a psychologist, which helped to reduce my defensiveness around my non-psychologist colleagues and increased my openness to their ideas. As a result, I was gradually able to find comfort in my department, develop strong relationships with some colleagues, and continue to do good work clinically. Truth be told, it probably also helped that additional psychologists came on board during the years since I had initially been hired into the department. Whatever the reasons, I eventually was rewarded with the assignment of new duties and responsibilities, which is often how the academy shows that it appreciates you (and, yes, I did secure tenure).

Getting Warmed Up: Initial Encounters in Managing Multiple Roles

Having endured a somewhat cool reception at the outset of my career, once I found my place—and pace—I also began to acquire new responsibilities and, of course, new challenges. One of the first such challenges was my role as a supervisor of practicum students and interns. At that time, there was little training for supervisors, and it was assumed that consuming supervision over a number of years somehow imbued one with the ability to supervise others. As a colleague and I stated some years ago:

> The basic deficiency in current efforts to prepare psychologists-in-training for the supervisor role parallels a similar deficiency in the way academics have traditionally been prepared to instruct students. The time-honoured belief that attending university for many years automatically makes one competent to teach is now less commonly accepted, and faculty development initiatives to train new professors in teaching are becoming increasingly prevalent on campuses (Johnson & Stewart, 2000, p. 129).

Although the situation has certainly improved over the years, particularly with respect to availability of coursework in supervision (e.g., Hadjistavropolous et al., 2010), there is still considerable room to grow in terms of providing supervised training in supervision to psychologists (Stewart & Johnson, 2023).

For my part, I did not have any coursework in supervision, but was fortunate in having my early forays into supervision supervised by a senior psychologist. Grateful as I was to have this supervisory oversight, in retrospect I realize that I did not take full advantage of this opportunity. In particular, I recall that the main focus was on whether I was helping my supervisees make progress with their clients. This is obviously a critical aspect of supervision, and I was quite pleased to go along with my supervisor in focusing on the development of my basic supervisory skills. However, the supervision experience could have been substantially enriched if I had been more forthcoming with my supervisor about some of the issues I was facing as a supervisor myself—and also been sufficiently aware of their importance to bring those issues forward for discussion. In fact, as outlined in the *Ethical Guidelines for Supervision in Psychology* Guideline I.3 (CPA, 2009, 2017), as a supervisee I shared the responsibility for defining the goals and expectations for the supervisory relationship. Acknowledging this lapse in retrospect, what I ought to have discussed with my supervisor were some of the personal issues that my new role as a supervisor was raising for me.

One salient matter that I could have discussed with my supervisor was the obvious fact that most of my early supervisees were also my age contemporaries. Setting aside—for the moment—my insecurities about whether I had the necessary expertise to effectively supervise my peers, our age parity also created the potential for dual relationships given our possible similarities in interests and activities outside of the supervisory relationship. For example, when interns expressed interest in some of the cultural and community activities in which I was also interested, I had the dilemma of whether I should share all of my local knowledge with them, given that this would likely result in their participating in the same events or accessing the same venues that I favoured and thereby increasing the likelihood of a social encounter that I was not yet confident I would know how to manage successfully. However, if I did not share this information, I would feel petty and selfish for putting my interests above theirs. After all, shouldn't I be doing all that I could to help my supervisees feel at home in their new city?

A helpful way to manage social relationships during internship was developed by Burian and Slimp (2000), who devised a model for evaluating the potential risks associated with such dual relationships. Although they advocate a very formal process that I have yet to follow explicitly, I still find their article helpful as a way of alerting interns to these concerns. I figure that if my supervisees are aware of these issues, it will get them thinking along lines similar to mine. That way, any subsequent discussions about these risks will be anchored in a shared perspective and more clearly oriented toward maintaining integrity in our supervisory relationship. I also believe that Burian and Slimp's article may serve a prophylactic effect insofar as I do not recall having any social relationship challenges with interns during the 20 years or so in which I have been sharing the article—just as I am sure that our increasing age disparity has had no effect whatsoever on the likelihood that we happen to share similar social interests . . .

There were certainly other things that I could have discussed with my supervisor as well, including my initial fears about not being competent to supervise my supervisees. Harvey and Katz (1985) identified this as the *impostor phenomenon*, which they describe as a common affliction among young professionals. However, I am comforted by the reassurance that this feeling is most likely to arise within supervisees "when their level of actual competence exceeds that of their felt competence" (Bernard & Goodyear, 2014, p. 97). In any event, as advocated in the *Ethical Guidelines for Supervision* (CPA, 2009, 2017), I think the take-away message is that I could have and arguably should have done more to share my personal concerns with my supervisor—and that my failure to do so probably led me to struggle more than necessary during a critical developmental period.

This once again highlights the wisdom of the *Code* and its companion documents, which advocate both proactive and reactive ethics (see "Uses of the *Code*" from the *Code's* Preamble), thereby orienting us toward practices that provide a framework for positive professional behaviour in addition to minimizing the risk of misbehaviour. This is why it never hurts to pull out these documents from time to time to refresh ourselves with them—we should not let them languish simply because we have passed our licensing exams and no longer need to recite them by heart before a panel of our peers.

Feeling the Heat: Muddling Through Mid-Career Multiple Relationships

In addition to the challenges related to my earliest supervisory responsibilities, another substantial challenge occurred a few years later when I took on the role of director of clinical training (DCT) for our then quite recently accredited psychology internship program. As noted by others, entry into this role is initially characterized by excitement and apprehension (Lamb et al., 1986). The excitement stems from the potential contributions to be made to the program, while the apprehension resides in concerns about one's competence to meet the daunting expectations of this role. Anybody who has served as a DCT can attest to the complexities of this unique leadership position—not the least of which involve creative efforts to fulfill the DCT responsibilities without having any real authority over the program staff, as this usually resides in the office of the department head. In addition, with the exception of very large programs, most DCTs also have direct supervisory responsibilities for interns. In fact, now that I think about it, agreeing to become a DCT can be seen as a choice to enter into multiple role relationships that are entirely avoidable should one decline to become a DCT. As articulated by Sinclair and Pettifor (2017), a role such as this holds many "loss-of-integrity traps" (p. 113) about which one needs to be vigilant.

Fortunately for our profession, we nevertheless are able to find people who can credibly and ethically serve as DCTs despite how fraught with potential difficulties such a role may be. In my own case, one of the most frequently recurring difficulties was dealing equitably with conflicts between supervisors and supervisees. As a beginning DCT, I very quickly became aware of the cognitive biases associated with primacy effects (e.g., Kruglanski & Freund, 1982). In other words, I tried to be cognizant of the temptation to believe the first person who came forward with their version of the conflict, which if not checked would subsequently bias me against the other person's version of events. In addition to being careful not to violate the standard of objectivity as stated in Ethical Standard III.10, I also needed to be aware of the power imbalance in any dispute involving an intern and a supervisor. As noted in the *Ethical Guidelines for Supervision* (CPA, 2009, 2017), "the power differential adds to the complexity of the supervisory relationship" (p. 5). Given this, DCTs ought to be mindful that it is always riskier for an intern to bring forward a complaint than it is for a supervisor and, as such, should be sure to acknowledge and validate the supervisee's courage in bringing forward a complaint whenever possible.

Another source of complication in managing conflict arose from the fact that I knew my colleagues better than I knew my interns. Generally speaking, since I had an enduring relationship with my colleagues, I could very easily be biased in favour of them due to increased exposure and a shared history. However, depending on who the colleague was, and the source and nature of the complaint, this historical knowledge could equally bias me against that person. For example, some supervisors were known to be easily slighted and prone to complain that they were being treated disrespectfully if their supervisory input was not enthusiastically embraced and immediately applied by an intern. This was certainly something that I needed to bear in mind when addressing concerns, most of which were cloudy enough that it was difficult to parse fact from fiction in the competing and equally compelling scenarios each party presented.

I would like to say that I had nothing but success in achieving equitable outcomes for all such dilemmas, but that would not be the case. I struggled through most of these situations and probably made some unwise decisions over the years. However, by following a repeatable step-by-step process in arriving at the decisions, as advised in the *Code*, I could at least articulate my problem-solving process in tackling these situations. In line with the *Code*, I also would consult with informed others as necessary to ensure that the process I was following was fair and reasonable, even if I knew that ultimately somebody would be unhappy with the decision I made.

Developing confidence in the problem-solving approach outlined in the *Code* certainly stood me in good stead as I shimmied further up the administrative ladder and found myself as the head of my department. It seemed that all of the conflicts and dilemmas that I had encountered as a DCT were still there, along with a host of other ones that I was blissfully ignorant about until they landed on my new desk. As we have previously pointed out (Pettifor et al., 2011), ethical supervision as an administrator requires a tricky balancing act among roles and responsibilities, including such things as organizational planning, developing policies and procedures, facilitating case management, conducting program evaluations, monitoring recordkeeping practices, and meeting institutional accountability standards (Borders et al., 1991).

As you might gather from this description, a department head basically has responsibility for *everything* that goes on in his or her unit, and the potential for multiple relationships increases exponentially when those responsibilities include supervising interns and postdoctoral candidates, as well as managing support staff and providing leadership to the clinical team, including the DCT. As if this weren't enough, administrators also must take responsibility for the leadership aspects of their position by modelling and maintaining appropriate standards and values in all activities, as well as relying on our discipline's rules and regulations in carrying out their daily functions. In short, administrators must "scrupulously avoid exploitation, manipulation, or harm, either by themselves or any member of their organization, and take necessary steps to redress any such situations when identified" (Pettifor et al., 2011, p. 204). In so doing, risks related to subjectivity, conflict of interest, and bias will be minimized.

All of this may seem like a tall order, but it really boils down to the simple fact that leaders must set a good example and expect everybody in their purview to do likewise. This expectation is noted in Ethical Standards III.36-37, as part of our "extended responsibility." Fortunately, there are some helpful sources of advice available in the literature about how to live up to this responsibility. In addition to the article by Pettifor et al. (2011) mentioned above, CPA's *Ethical Guidelines for Supervision* (CPA, 2009, 2017) provides some helpful information to guide one's practices in administration, as does the accompanying *Resource Guide for Psychologists* (CPA, 2011), which contains practice ethical dilemmas for administrators. Better to spend some time wrestling with these issues in practice dilemmas than to confront them for the first time in your own administrative practice!

Keeping Things Cool: Maintaining Integrity in More Complicated Relationships

So far, I have focused mostly on my developmental trajectory and career milestones, outlining how our ethical guidelines and related materials have been helpful in negotiating a host of challenges primarily related to maintaining integrity in relationships. An important aspect that I have not yet mentioned relates to some of the parallel activities I have been engaged in throughout my career, most notably my role with the professional regulatory body for psychology in my province, which brought with it its own particular set of challenges.

First, a little bit more backstory. While struggling with my early professional identity crisis, I also was working actively toward registration as a psychologist in my province. Through a series of coincidences, on the day I received news that my registration had been approved, I was invited to let my name stand as a nominee for an open position on the council for our provincial regulatory body. As is often the case, there was not a lot of competition for this voluntary position, and I was soon acclaimed as a council member and immersed in regulatory issues about which I knew absolutely nothing.

Undaunted by this, I also volunteered to be the editor of the official publication of our regulatory body, which (fortuitously) proved to be extremely helpful as a way of learning about regulatory issues. As the editor, I received copies of similar publications from jurisdictions across North America, and this allowed me to identify common issues, emerging trends, and various perils and pitfalls that our members could possibly encounter. On this latter point, I always found the practice updates in these publications to be of particular interest and value—and sought where possible to share my excitement about these with the readership. If you have a similar publication in your neck of the woods, you should be sure to check it out; and if you do not have access to something in your own jurisdiction, you can certainly search out similar publications online by exploring websites for the provincial Colleges of Psychologists or their equivalents.

Along with my editorial duties, I attended our bi-weekly council meetings where, among many other topics, we were informed about the status of complaints against our members. This was a real eye-opener for me. I certainly had heard and read about the kinds of things that lead to complaints against psychologists, but (fortunately, I suppose) had no direct experience with such matters. So, to be confronted with news that these incidents were occurring locally—along with the identities of those involved—moved me quickly up a very steep learning curve. In fact, I learned not just about the disciplinary process but also how easy it was for a psychologist to end up on the receiving end of a complaint—even if the complaint was without merit and subsequently dismissed without proceeding to a disciplinary hearing. Since we have a fairly small psychological community, almost all of the psychologists ultimately involved in disciplinary proceedings were known to me either directly or by reputation. To the best of my knowledge, none of these people were evil or stupid. To the contrary, most of them were competent, dedicated, and earnest professionals who made a mistake, went too far, or failed to think through the consequences of their actions. In some cases I actually ended up being pretty impressed with the psychologists subject to sanctioning, especially those who acknowledged the misdeed and accepted responsibility for their actions at an early stage in the proceedings, consistent with Ethical Standard II.3 from the *Code*.

From this background information, you already might have begun to imagine the sorts of ethical issues that I was now encountering. People whom I knew as colleagues in a range of contexts were now coming onto my radar for professional misconduct of one form or another—and I had to continue interacting with them in our "regular" capacity outside of my "regulatory" one. What about the colleagues who put their self-interest above that of their clients? What about those who practice outside their area of competence? What about the colleagues whose judgement is impaired? Given what I now knew about them, how could I look these people in the eye . . . or make referrals to them? Although the

Code's, Ethical Standards II.43-45 provide some guidance for how to deal with concerns involving colleagues, it focuses mostly on issues related to identifying and addressing concerns as opposed to how one subsequently transacts business with these people.

Turning to the more experienced council members for support was very helpful. They not only helped me overcome the disappointment I felt toward some of my colleagues—they also served as exemplary role models in balancing the dual relationships that emerged from the regulatory role. In observing them, I saw that they had developed a clearer sense of where their roles as council members and disciplinary authorities began and ended with respect to interactions with colleagues and, over time, I was able to develop similar boundaries myself. It was very helpful to understand how some degree of compartmentalization was necessary in order to serve a regulatory role without interfering with one's ability to function in other professional capacities. Although such a strategy did not obviate all difficulties, such as awkwardness at incidental encounters, it certainly increased my comfort in interacting with colleagues subject to discipline when we had business to transact that was unrelated to the disciplinary process.

Along with this, my fellow council members also helped me to appreciate the importance of avoiding the fundamental attribution error (e.g., Ross, 1977)—that is, being careful that I did not assume infractions were the result of a colleague's shortcomings without considering relevant situational factors, as well as my own biases (see Ethical Standards III.9-10), when trying to understand another's actions. Unsurprisingly, things were usually more complicated than they seemed, and the benefits of hindsight were plainly evident during the hearing process, when an opportunity was provided to reconstruct and review events with a fully articulated set of details, timelines, etc. In addition to providing the information necessary to understand the respondent's actions relevant to the complaint, this exploration of context allowed for evaluation of the extent to which the member relied on the *Code* as a guide to their practice. In particular, it allowed for an examination of the process the respondent followed in addressing the situation, including such things as acknowledging the conflict and parties affected, consulting with colleagues, and documenting the process invoked to address the dilemma. Although following these steps does not mean that complaints will never arise, such a process will almost certainly play a mitigating role in the eventual outcome of the complaint process.

As stated previously, the *Code* is a valuable resource that should be consulted frequently in the course of our daily professional activities. Although there is no guarantee that assiduous compliance will prevent complaints, adherence to the *Code* will reduce the risk of ethical transgressions; and, in cases where it does not prevent the act, it will certainly slow the slide down the slippery slope—allowing for more opportunity to resolve or correct the situation before one finds oneself at the bottom.

Made in the Shade: Striking a Sustainable Balance

At this point in my career, I am identified by my institution primarily as an administrator, but in my heart I remain a clinician. As such, I continue to do clinical work on campus (while also supervising interns and practicum students). The reason I keep my hand in these activities is because it helps to maintain my somewhat hard-won professional skills and, more selfishly, because these activities feel deeply rewarding in ways that many administrative tasks do not (probably something to do with immediate versus delayed gratification, I suspect). Having said that, I do spend a lot of time in administrative activities and continuously encounter new situations in which ethical concerns arise. I certainly recognize that psychologists do not have a monopoly on ethical behaviour, but it is during such administrative challenges that I am heartened by my professional socialization and familiarity with identifying and addressing ethical dilemmas—even as this leads me to worry a bit about those administrators from other disciplines who do not have the benefit of such a solid ethical foundation for their own decision making.

Although my institution classifies me as an academic administrator, our senior administration is definitely pleased to take advantage of my ability to bring a clinical sensibility to the table. One example of this arises in situations where there are concerns expressed about the behaviour of a student or staff member who may pose a safety threat to themselves or others. In many such cases, these concerns are brought to the table for discussion by our institutional threat assessment team, which consists of a diverse group of professionals committed to promoting a safe and respectful work and learning environment for the campus community. As a founding member of our institutional threat assessment team, I am joined by colleagues from a number of other disciplines and backgrounds, including law, human resources, and law enforcement, in deciding how best to respond to such situations. These meetings are rarely dull.

One of the most frequently-occurring issues in these meetings involves balancing the rights of the individual with institutional responsibilities to protect other community members. Savvy readers will immediately see this as an example of weighing aspects of Principle I (Respect for the Dignity of Persons and Peoples) from the *Code* (e.g., preserving confidentiality, obtaining free and informed consent) against Principle II (*Responsible Caring*) (e.g., Ethical Standard II.42, which includes the duty to protect or warn others about potential harm).

Because the threat assessment team is interdisciplinary in nature, there are sometimes differences of opinion about priorities at our meetings. To overgeneralize, somewhat unfairly, security personnel tend to focus more on public safety aspects, administrators tend to focus on institutional reputation, and legal counsel tries to ensure that we are acting in accord with all relevant policies to mitigate liability. As a psychologist, I am primarily interested in the mental health and wellness of the people we discuss, including how these aspects both influence and are influenced by the issues that brought these staff members or students to the attention of our team. Although we generally find our priorities aligning, we sometimes have to work through disagreements over competing concerns. When such disagreements arise, I find it helpful to recall the importance of maintaining public trust in our discipline (as noted in Ethical Standards III.10-12) by being accurate, honest, and unbiased in my comments. I also try to communicate respect for the limits of my professional knowledge and honour the competencies of my colleagues in their respective areas of expertise, in line with the Values Statement for Principle IV (Responsibility to Society), which emphasizes the need to work in partnership with others and be open to their suggestions and criticisms. I have found such an approach to be very helpful in maintaining the civil and productive tone that generally characterizes our meetings, even if we do find ourselves disagreeing at times.

In addition to managing occasional differences of opinion among team members because of my many roles on campus, it sometimes occurs that threat assessment discussions involve clients seen by my supervisees or about whom I have been consulted by clinicians in my reporting units. When this happens, I have to be very careful about my role and what I can and cannot say, as this information arose within a confidential context and generally cannot be shared without permission except to prevent harm. I also need to be very clear about who my "client" is in such situations—is it the person of concern, my supervisee or staff member, or the institution itself? The *Code* again offers some helpful guidance in addressing these complicated matters.

In the most extreme cases, where there is a threat of imminent harm to an identifiable party, the decision to share information without consent is usually made without difficulty. After all, as noted in Ethical Standard II.42, we are obliged to keep people safe by doing "everything reasonably possible to stop or offset the consequences of actions by others when these actions are likely to cause imminent serious bodily harm." However, only the minimum amount of information necessary to ensure safety should be shared, and then only with those who have a definite need to know. This will help to ensure that confidentiality is preserved to the greatest extent possible, consistent with Ethical Standards I.43 and I.45. So, in the case of a student threatening his roommate with violence for perceived transgressions, providing information about his prior history of mental health problems seems reasonable as a way to activate an optimally supportive response for both the student of concern and his roommate.

Most cases are not so clear, however, and so the decision about whether to share confidential information requires more deliberation. For example, perhaps the mental health of the student above has not deteriorated to the point where he is threatening violence, but instead he stops eating because he believes his roommate is poisoning the food in their fridge. When the threat assessment team discusses this case, ought I to share the information I have about his mental health history? Given that this situation involves a much lower degree of risk (after all, the student can still eat elsewhere), there appears to be no need for immediate action or to break confidentiality. This allows for development of a different sort of response plan, probably involving efforts to get the student to voluntarily access mental health services. In such a case, I would not need to share the information I have regarding his prior mental health history and would simply respond to whatever information was brought forward by others at the meeting. This approach would preserve confidentiality and also facilitate the development of a reasonable response plan. However, as cases like this involve some degree of clinical judgement, it is never a bad idea to consult with colleagues (as the *Code* advises) to ensure that you have considered all of the relevant factors and are following a defensible course of action.

As you may have gathered from the discussion above, I generally have adopted the default position that my greatest responsibility in these situations is protecting the person of concern—even if I have no clinical relationship with that person myself or through one of my supervisees. I have chosen this most conservative approach as it generally ensures the highest level of protection for the people who are most vulnerable during the threat assessment process, which seems consistent with Principle I (Respect for the Dignity of Persons and Peoples) from the *Code*, and also does not prevent taking any further steps that may be necessary should an elevated level of risk be identified. To my mind, this seems much more prudent than seeing the institution as my primary responsibility, which would increase the risk of unjustifiable breaches of confidentiality for more routine cases.

Besides having the courage of my convictions (backed up by Ethical Standard III.35), I am also fortunate in having enlightened colleagues who are aware of my position on confidentiality and respect my professional boundaries and priorities, as I do theirs. Like any good team, I suppose, much of our strength comes from our differences. Funny how I can say something like that now, recalling how much I struggled with such professional differences in the early days of my career!

After the Storm: Concluding Comments

When teaching about ethics, I sometimes identify myself as "an ethics geek" to acknowledge that I am more enthusiastic than many about this foundational aspect of our profession and its role as a guide to virtually all aspects of our professional activities. Although I harbour no illusions about successfully recruiting new members for the ranks of ethics geeks, I hope that by sharing my professional journey I have shown you how the *Code* is flexible and generalizable enough to be widely applied to a host of different types of relationship challenges across a progressively more diverse and demanding set of professional roles and responsibilities.

I further hope that I have helped to persuade you to adopt the *Code* as a lifelong companion throughout your own professional journey. For my part, I have always appreciated the integral role that the *Code* has played throughout the various stages of my career. Whether acting as a clinician, supervisor, administrator, or regulator, I have no doubt that the *Code* will continue to serve me well in the next stage of my career—whatever that might involve—and trust that it will serve you equally well in yours.

Note to readers: As psychologists, we are expected to demonstrate values such as honesty, openness, and objectivity—and to avoid bias and conflicts of interest—in all our professional activities. In so doing, we are more likely to maintain a standard of integrity in our relationships as required by the Code. However, despite their importance, we often do not explicitly think about how these underlying values guide our everyday interactions, be they personal or professional. As such, the Reflection Questions that follow are intended to help you consider your values in more depth and to identify the important (yet often unarticulated) role they play in guiding interactions and influencing the integrity of our relationships.

Questions for Reflection

1. How do you define trust? What makes somebody trustworthy? Is trust a categorical or continuous variable? How do you re-establish trust after it has been damaged?
2. What role did your own biases, assumptions, and self-interest contribute to a disagreement you had with somebody important in your life? Would things have unfolded differently if you had reflected more fully on your own perspective before engaging in the conversation that led to the disagreement? How did you repair the relationship?

3. Is it ever acceptable to misrepresent or "strategically present" information? If so, under what circumstances? Are the "rules" around this different in your personal versus your professional life? Why or why not?
4. To what extent are values absolute versus relative? Think of examples where societal values have changed over time. Identify how your own values have changed. What was the impetus for change? Are your personal and professional values optimally aligned?

NOTE

1 In addition to the obvious parallels between stormy weather and ethical dilemmas, I thought this title was also an apt way to reinforce the notion that ethical practice involves choices about "whether" to pursue one course of action over another. Beyond the title, for the sake of continuity, I have used weather and temperature-related metaphors to identify each section in this chapter as well.

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11

Indigenous Wellness and Healing: My Role as a Helper

Randi L. Sager

My Journey

Hello! hau![1] tans'i![2] My name is Randi Lee Sager; I am Dakota/Saulteaux/Nêhiýaw/Métis. They call me Owl Woman or Hawk Woman, depending on which Elder[3] you speak to. I was born in Calgary but raised in Okotoks south of Calgary. I belong to the Muscowpetung Salteaux Nation Reserve in Fort Qu'Appelle, Saskatchewan in Treaty 4 and have lived and worked as an appreciative visitor on the traditional territory Treaty 7, of the Blackfoot Confederacy.

My father is Dakota/Saulteaux/Nêhiýaw/Métis and German; his father was German, and his mother was Dakota/Saulteaux/Nêhiýaw/Métis who was born in Devils Lake North Dakota. As for my mother, she is Scottish and Dutch. Her father was Scottish, and her mother was Dutch. To say the least, I have a unique cultural background. I also want to state that what I talk about in this chapter is based on what I have learned and experienced. I do not speak on behalf of the Indigenous community.

Although I identify as a Dakota/Saulteaux/Nêhiýaw/Métis woman, I have not always done so. My father's mother, kôkom[4], and her siblings went to residential school. My great grandmother did everything she could to prevent from this happening. It took the priest, the Indian agent, and the RCMP to take my kokum and her siblings. However, my great grandmother did not let her children go without a fight; in fact, she was arrested for assaulting one of the RCMP officers. From what my father has told me, my kôkom never spoke about what she endured, but her actions spoke louder than her words. My father once told me that his mother chastised him and his siblings for being out in the sun too long, concerned that they would become too dark and look Native. One could assume that my kôkom's experiences in residential school created shame. I believe that shame was passed down to me by my father unknowingly. My father was attracted to my mother because of her fair skin and as a result I have light skin, but with dark hair. In my younger years, my father encouraged me to lighten my hair and he would also "joke" about me never dating an Indigenous man, telling me in a joking manner they do not have jobs. As I reflect on this, one could assume it was an attempt to conceal my Indigenous identity and to protect me from what he had experienced.

My journey as a Dakota/Saulteaux/Nêhiýaw/Métis woman began in 2010 when I received my status as a Native. Receiving status did not fulfill the emptiness within me; my cultural identity did not come forward until I was in the darkest despair of my eating disorder in 2014. In the next few paragraphs, I will take you on my journey—how I moved from an Indigenous student/researcher to someone who is now on her path to becoming an Indigenous psychologist/helper.

Throughout my childhood, I endured physical, sexual and psychological abuse. During that time, I did the only thing I could. I hid within myself, kept quiet and bottled my emotions. At the age of 14, the way I learned to cope was to control what I ate and purging (self-induced vomiting). By doing this, ED (my eating disorder) came into my life. ED created a false sense of temporary happiness or relief for me, but not without damaging consequences (Ekern, 2012). For several years, I was underweight and malnourished, my immune system was weakened, my teeth were in terrible shape (tooth decay), and my heart was at risk. All this did not matter to me, because purging gave me relief. Unfortunately, my continuous purging created dependency habits. I depended on ED to make me feel better. ED provided a false solution through emotional relief, comfort, and stability (Ekern, 2012).

I went on this way for 20 years and did not think I had a problem. I believed I could stop whenever I wanted to. There were times I did stop, but the moment things became stressful or a significant event occurred (e.g., a death in the family), I resorted to purging, the only way I knew how to cope. In 2014, I finally admitted to myself that I indeed did have an eating disorder. I became aware that I needed to change my story if I wanted to live. I knew I could not overcome my eating disorder on my own and so I went to my Western doctor and he referred me to an Eating Disorder Clinic. During my time at the clinic, I was having difficulties with the treatment, more specifically with group therapy. There was a discrepancy between the facilitators and myself on what the actual problem was in my situation. For example, from my perspective, they were telling me that ED was my enemy, he was the problem, and I should hate him. I had difficulty believing and accepting this and attempted to express my beliefs. However, one of the group facilitators felt I was resisting the treatment and dismissed my point of view. On one occasion, I was instructed to write an "I hate you" letter to ED, to tell him what I hated about him. In actuality, I did not hate him, I appreciated what he did for me. So, I wrote a thank-you letter instead. Perhaps that is why the facilitators believed I was resistant.

During this time, I felt a pull to my culture, and started to attend ceremonies. These consisted of various things, including Healing Circles, Full Moon Ceremonies, and Cree Grandmother Tea Ceremonies. I also began to speak with an Elder frequently. Soon, after engaging in my Indigenous culture, my eating disorder behaviours ceased. The Western doctors were fascinated with my progress and soon recognized, along with me, that my culture aided in my growth. Shortly after this realization, I became aware of why I had engaged in an eating disorder for so long. ED was not my enemy; instead, he was a friend that protected me from the trauma I had endured. He was my coping mechanism. Once I could recognize this, with the assistance of my Elder organized a conversation between myself (Me) and ED. It went something like this:

> Me: "ED, I need to talk to you."
>
> ED: "Okay, what's up?"
>
> Me: "You and I have been friends for a long time, right?"
>
> ED: "Yep! You and I have been best buds! Like two peas in a pod! I have been there when no one else was. I helped you when you were in your darkest. I took the pain away for you and gave you control. I did good right?!"
>
> Me: "Yes, you did, I appreciate everything that you did for me. I mean it. Without you, I don't think I would have survived."
>
> ED: "Awe shucks, I was only being a good friend, you would have done the same thing for me."
>
> Me: "Well, that's what I want to talk to you about. You see, you've gotten a little out of control lately; well, to be completely honest, it's not a little, it's a lot."
>
> ED: "Oh? I thought you liked it when I helped."
>
> Me: "I do! I mean I did. What I mean is that I don't need your help anymore. It's actually causing more problems than relief. It's interfering with my life."
>
> ED: "I see."

> Me: “As I said, I am very thankful for what you have done for me, but I’m much better now, and you can go to sleep now.”
>
> ED: “Well now that you mention it, I am pretty tired. It’s been a long journey with you, and I could use the sleep. But what about us? Do you want me gone? Out of your life forever?”
>
> Me: “I’m not asking you to leave. I don’t think you could ever leave me. I’m just asking that you go to sleep and let me live my life. You have done enough for me. It’s time for me to take actual control of my life.”
>
> ED: “I can do that. You know, I’m proud of you. You have done well, and I wish you the best.” [*Ed gives a big yawn.*] “I’m going to sleep now, ’kay?”
>
> Me: “Thanks, ED. Thank you for being understanding. Good night.”
>
> ED: “Goodnight Small Fry” (Sager, 2018, p 52).

I could not have this conversation with ED until I understood why he entered into my life and understood our relationship. ED saved me, literally. I could not have survived nor coped for that matter without ED. I had a relationship with him, whether they (facilitators) liked it or not. It was not a healthy relationship, but it served its purpose: it allowed me to survive the trauma I had endured. The facilitators could not see past my “resistance.” More importantly, they did not respect our relationship. I had a 20-year relationship with ED and only a couple of months with the facilitators. At that moment, I trusted ED more than them.

In my opinion, it was unethical of them to believe they knew what was best for me and not respect my perspective. It appeared they only viewed ED as a disorder and nothing more. From my experience, to assist someone, one must understand the relationship between the individual and whatever disorder it may be. If the relationship is not understood, nor respected, change and growth may not occur. My Elder understood the relationship that I had with ED. However, rather than educating me on how bad ED was for me, she showed me, through our culture, (e.g., storytelling), why ED was so important to me. I learned that ED was there for me when no one else was. He kept me safe. I could not control what was going on in my life during those 20 years, but ED provided that sense of control for me. He kept me alive, and that mattered. I was in survival mode for those 20 years, but the problem came when I no longer was in survivor mode. Our relationship did not work; it was actually harming me. When I had the conversation with ED, we came to an agreement, and by honouring our relationship, I was able to move forward in my life without ED taking over. Our relationship is still current, but he is asleep. He will from time to time wake up and ask if I need him, but I tell him I'm good, and he goes back to sleep.

I have learned that it is not my job to tell a person the moral of my story; rather it is up to the person what they take away from the story. What I took away from my own story was that I needed to respect and honour my relationship with my eating disorder in order for me to move forward in my healing journey. I have also applied this teaching (learning) to my anxiety, which I call Henry. Professionals may call this externalizing, but I view it as acknowledging my relationship with Henry. I used to hate Henry, I felt he was useless, frustrating—well, to be honest, a pain in the ass. Henry always made a mess of things in my life, questioning my decisions, constantly worried about insignificant things (e.g., how I greeted someone). My grades were also affected by him in having severe test anxiety. It is disheartening to be told that you have a high IQ, but the assessment results do not reflect this due to anxiety being so present.

I have experienced severe anxiety as long as I can remember and have been diagnosed with General Anxiety Disorder. There was a point in time when I could not leave the house without my medication. However, it has been a couple of years since I have had to refill my anti-anxiety medication. What has changed for me was understanding my relationship with Henry in the same way I did with ED. I explored our relationship and once again, became aware that Henry came into my life to protect me. It became apparent to me that Henry was important and that his role was not to intentionally screw me over; he just was doing what he thought was best for me. As with ED, I had a conversation with Henry, telling him that he was no longer in the driver's seat. I said to him that he could be in the car with me, but he was not in charge anymore. I had wanted Henry out of my life for so long, wishing that he did not exist. But once I acknowledged our relationship and understood it, I realized Henry would never be out of my life. Some would call this a form of Acceptance and Commitment therapy; but to me, it is thought of as honouring the relationship that I had with Henry. I spent a lot of time and energy hating Henry, wishing him gone. I had never taken the time to get to know Henry, to understand what he did for me in those early years.

Becoming aware of my relationships with my "disorders" has given me a deeper understanding when working with clients who are battling addictions. I respect and honour their relationships with their addiction/disorders. I do not view them as an "addict" or see addiction as their "disorder"; instead, it is part of them. Similar to my story, their addictions had come into their lives for a reason—a way to cope with whatever they had or were experiencing. When we honour or acknowledge the relationship that they have with their disorder or addiction, it allows them to move forward in their healing journey. It is easier for some clients than others, but that is because they are at different points in their journey.

In my culture, as a helper, it is customary to share your story. It is a way of demonstrating that healing is possible; but, more importantly, it creates trusting and long-lasting relationship. I told my story within this chapter because, if appropriate, I disclose my story to my clients. I cannot expect them to embark on their healing journey if I do not tell my story. How else could I ask clients to tell their stories if I did not tell mine?

My Role as a Helper (Indigenous Mental Health Therapist)

When I was asked to participate in this book, I first felt great trepidation. I did not think that I could contribute anything of value since I have been working with Indigenous clients only since 2017. Truth be told, I did not feel I had a voice as an author yet. I view myself as someone who has just begun her journey as a helper (Indigenous Mental Health Therapist) and is still learning. As I mentioned earlier, Western medicine/therapy did not work for me; rather, my culture saved my life. When I came to the realization that culture could be used as a form of treatment and be successful, I was astonished. I asked my Elder, "Why is this not an option for Indigenous people? It is so simple, but yet so powerful!" She had this knowing look in her eyes telling me she felt the same way.

Through storytelling, my Elder showed me the relationship that I had with ED and Henry. She also taught me that for me to work on my mind, emotions, and body, I must begin with spirit. What she meant by this is that, when I reconnected with my spirit, it allowed me to connect with my mind, body, and emotions, resulting in harmony and balance within myself, which would then promote wellness and healing. The teachings I received from my Elder were not just for my benefit; she was actually teaching me so I could help others find their path to their healing journey.

In 2017, I started my practicum at a shelter for those experiencing homelessness. Before starting, the selection process for choosing a practicum placement was quite stressful for some. For myself, it was not, because I had known before I applied where I would be going, where I would be needed. I knew that I would be working with those experiencing homelessness and so I trusted my spirit and applied to the agency. During the interview, I identified as being a Dakota/Saulteaux/Nêhiýaw/Métis woman. When asked why I wanted to work with the vulnerable population, I replied that I am not here on this earth to fix people, but instead to be a travel companion on their healing journey—to shed light on their path. I know what it is like to be in the dark and feel utterly alone. I meant every word, and still do to this day.

Gratefully, I was offered a placement, and even though I knew the placement was where I was to be, I was still scared out of my mind about being a "counsellor." During my first shelter shift, I was rather nervous. However, instead of letting Henry into the driver's seat, I asked myself, "What do I like to do when Henry is getting to be too much"? Colour. I love to colour. What I discovered through colouring is that it kept Henry entertained and allowed me to focus on the task at hand. So, on my first night, I brought crayons and colouring books and sat in the dining hall unsure of what it would bring. I was worried; well, Henry was worried. He was concerned. What if no one talks to us? What if we end up sitting there the entire night colouring alone? I told myself and Henry there was only one way to find out—just go and do it. I walked into the dining hall looked around and found an empty table. I sat down, took a deep breath and opened my favourite colouring book, *My little pony*, and began to colour. After less than five minutes of sitting there, an Indigenous man from the table across from me asked me what I was doing. I looked up and said with a straight face, "I'm colouring in *My little pony* book." He proceeded to get up and sit across from me, picked up another colouring book, and began to colour with me. We talked for three hours while colouring. Our conversation was more than rapport building, I was building trust with this man. I did not ask him questions; however, he asked me questions that I answered. I knew that if I was to create trust and a relationship with this person that I also had to share about myself. I knew that he and I were equal at that moment, we were both getting to know each other. Because of our conversation in the dining hall, and several additional colouring interactions over a couple of months, this gentleman asked if we could speak privately in the counselling office. Some would think that after a few months some actual counselling finally was beginning. However, counselling had started in our first conversation. As a helper, I created a relationship and built trust with him, and when he felt safe and ready, he asked to talk privately. In that dining hall, I was in his environment, his home essentially, and I was respectful of his situation. I did not present myself as the "counsellor" but rather just as a person with whom he could have a conversation.

This client provided invaluable teaching that I continue to carry with me. There is no hierarchy in my role, the only difference between us is that I am at a different point in my healing journey. When I sit with clients in the dining hall, I am removing that hierarchy. Often, I have been mistaken for a client because I dressed in clothing that allows me to blend in. I sit with clients while they eat dinner; I will bring my dinner and share what I have brought. They, in kind, do the same. We are not only eating together but creating a trusting relationship. How can a person trust someone right away if they do not know who they are? Where they come from? If we know the same people?

Although there is a sizable Indigenous population in Canada, it is still a small community. More often than not, I will know the same people as clients do. In one instance, it gave a potential client great relief to know that I knew the same people as he did. He felt great trepidation speaking to a counsellor, but once we started to talk about where we came from and found out we knew some of the same people, he became visibly relaxed around me.

During my practicum, other Indigenous clients began to reach out to me. It was not only because I was Indigenous, but also because I was seen in their environment (e.g., dining hall), speaking to other Indigenous clients. What they saw was that others trusted me. It allowed them to trust me. This continues to happen today. I was fortunate for my practicum placement to hire me.

It is crucial for me to be visible and identified in the Indigenous community (Ross, 2014; Shouldice, 2015). As mentioned above, I achieved this by sitting with clients, but also by attending ceremonies and Indigenous events. Whenever there is a ceremony or event, I invite the clients to them. By being visible in the dining hall, or at events/ceremonies, I am seen by clients and community members as a presence. While I am interacting (e.g., partaking in a ceremony) with the community, it allows clients to observe me with other people and with Elders (Shouldice, 2015). By doing this, it allows trust to be built before counselling begins. In the Indigenous culture, the relationships with people who are considered as an authority (e.g., Elders, leaders, knowledge holders) are different than they are in most Western cultures. They live together in the community; they are interconnected with one another (Ross, 2014; Shouldice, 2015).

I enjoy my work immensely because it is not only about being a helper but, even more so, about creating a sense of community to allow growth and healing to occur. When I returned as an employee, I sat with one group of Indigenous clients for three months before any formal “counselling” began (e.g., speaking privately). Some of them have pulled me to the side and asked to speak with me privately. However, with most of them, our conversations occur at the table, with others around in an informal way. It is not your typical counselling setting according to the Western ways, but what I have learned is that sitting with others and telling your story is healing within itself. That table is a community within the shelter. They look after one another, know each other’s stories; but most of all, they trust each other. I took it as a great honour when they each started telling me their stories. I knew that our informal conversations were just as important as formal private conversations were. I also knew they were testing me to see what I would do with their stories. I listened and asked questions, but also shared my story. In a sense, we held informal sharing circles, but I would call it the sharing table. Story sharing is so powerful and is a traditional way of transmitting healing messages (Mushquash, 2014).

In the Indigenous culture, most healing involves working with groups of people together, not individuals. Indigenous clients feel safer sitting with a group of others who have had similar experiences than sitting in front of a single person who may have nothing in common with them (Ross, 2014). For this reason, I held weekly dreamcatcher-making circles for clients who wish to partake. Sharing/healing circles are held to heal physical, emotional, and spiritual injuries. Healing circles signify the cycle of life; all beings are interdependent (Stevenson, 1999). Storytelling circles encourage people within the group to explore their feelings, battles, hopes, worries, joys, and strategies for healing. What I have witnessed is, as feelings are discussed, traumas and fears are explored and expressed, leading to the more profound compassion about how each person has experienced the world (KiiskeeNtum, 1998; McDowell, 2009; Sager, 2018).

Talking does not mean healing. A client can partake in a healing circle and not be expected to talk. Everyone heals differently, and just being part of the healing circle is good medicine. Good medicine is whatever helps you in your healing journey (Portman & Garrett, 2006; Sager, 2018). The central point within a healing circle is that everyone is there to heal in their personal way, and to find comfort knowing that they are not alone as they hear the stories about them.

I have met several people who are comforted just to know that I am available. In other words, they may not seek my assistance right away, but they are comforted to know that I will be there for them when they are ready. I also have learned through the relationships with my clients that me being available to them is crucial. What I mean by this is that regular appointments do not necessarily always work for Indigenous clients. I have learned to have walk-in appointments available to them within my schedule. Allowing them just to show up and speak with me is crucial. This is not a boundary problem; rather, it is respecting our ways of being. We do not make appointments with our Medicine Man, Healers or Elders, we go to them when we need to. I do not view myself as any of these, but rather just as a helper who makes herself available when clients are ready or need to talk that day.

My role as a helper means that there is no specific number of sessions a client may receive. Healing is continuous, and our journey with one another may occur for years. Simply put, there is no end date for our sessions. Healing goes on throughout our life and so why should I limit how many times clients are allowed to have? For some, I may see them a few times, and it will be months or years before I see them again. I do not forget them, I remember them and their story, which solidifies our relationship even more. Others I may see weekly, and it may be only for ten minutes, but those ten minutes are just as significant. I have had clients who no longer see me regularly contact me to update me on their lives and some to ask me to smudge and pray for them. I respect and honour their requests.

The relationship between the client and a helper is interdependent. Our therapeutic relationship is viewed as an essential factor for establishing, maintaining, and promoting mental health and healing in an Indigenous context. There is a level of intimacy and emotional involvement that is needed and helpful to produce a positive response (Sager, 2018; Stewart 2008). My purpose in the relationship is to be as an instrument that plays on the physical, emotional, mental and spiritual dimensions. I do not "give advice," nor try to change the client. Instead, a story may be told to the client, and in that story, the client attempts to figure out what the message is to them (Ross, 2014; Sager, 2018). Simply put, it is up to the client to understand on their own rather than have me telling them what the message is. Finally, my role as a helper is to be compassionate, empathic, and open-minded towards the client. I listen in a non-judgemental way; but more importantly, I am friendly, people oriented, and familiar with my cultural identity.

wiwiwacis[5]

In this section, I talk about the medicine bag that I carry and use in my role as a helper. During my last year of graduate school, I began my research journey as an Indigenous researcher. I was unsure what my experience would entail; but if nothing else, my research journey was more than an educational one. The year I completed my thesis was one of my most challenging years, but yet it was the most rewarding. I learned so much about myself, especially my spirituality and what is important to me. My thesis research was not only a means to the end of finishing school; rather, the co-researchers (participants) provided me gifts/teachings that I incorporate in my work today as a helper.

My research topic was Indigenous wellness and healing through cultural engagement (Sager, 2018). The research focused on capturing Indigenous people's experiences with healing and wellness through cultural engagement, with the intent of providing insight about the importance of incorporating cultural engagement into counselling for Indigenous people. It was found that one can encounter wellness and healing through cultural engagement (Sager, 2018). Five individuals who self-identified as belonging to one or more Indigenous groups of North America engaged in a conversation with me concerning their experience with wellness and healing through cultural engagement. Each person gave me a gift or teaching: community, spiritual gifts, spirituality, empowerment, and cultural identity. I now carry these teachings in my medicine bag for well-being and healing, not just for myself but for my clients.

Community

The first teaching that I implement is community. From my research and experience in working with Indigenous clients, I learned that there is a strong desire for community; in other words, a strong desire to belong. I see this at the shelter where Indigenous clients sit together, eat together, and heal together. I have facilitated several events—beading, drumming, ribbon skirt making—all of which have created a sense of community. It is a beautiful thing to witness the healing that occurs in these moments. Words cannot describe what I witness when people come together, helping each other heal in whatever way that they can. We are a collective culture that lives in an individualist society; it is essential that we heal as a community. It allows individuals to feel that they are not alone; that there are others who have had similar experiences. More importantly, community establishes and maintains mental health and healing along with increasing social support for the individual (Kirmayer & Valaskakis, 2009; McCormik, 2009; Renfrey, 1992; Sager, 2018; Stewart, 2008). Simply put, healing together as a community is powerful medicine.

Spiritual Gifts

The next teaching I received was honouring individuals' spiritual gifts. Spiritual gifts can be described as: "One is vision, the ability to see into the future. Other gifts are given to people to be healers, providers, orators, leaders, teachers, or entertainers. Everyone has a gift to be shared with others" (Stonechild & Starblanket, 2016, p. 85). Unfortunately, in Western society, from my experience, spiritual gifts sometimes are mistaken as mental disorders. I have been surprised to meet so many Indigenous clients who have been diagnosed with schizophrenia. For the most part, I would not have thought that they would have been considered to have this mental disorder if they had not disclosed it to me.

Spirituality

The third item in my medicine bag is spirituality. Indigenous spirituality presents a variety of prescribed, positive values and behaviours. It is the moral basis of a culturally derived and holistic concept of individuality, including the nature of relationships to others and the natural world (Grieves, 2008; Sager, 2018). I learned from my Elder that when we connect with another's spirit, we are then able to work on their mind, body, and emotions. The question then becomes, where does one start with spirituality? We simply start with a smudge. With clients who view their culture as essential, we will smudge before we begin our session. Not only does this allow the client to connect with their spirit, but it also allows the client to embark on their healing journey (Hill, 2017; McCabe, 2017; McCormick, 2000; Sager, 2018). Smudging also allows us to set intentions. Think of smudging as if we are wiping our feet before we enter a house. We are cleansing ourselves. I find before I begin a session, when we begin with a smudge, emotions are not as intense; there are fewer angry outbursts for some and, most importantly, we have created a safe place for someone to let their walls down.

Spirituality is powerful medicine, and what is so beautiful about spirituality is that it is expressed through ceremonies and teachings (McCabe, 2017; Ross, 2014; Sager. 2018). Ceremonies are an instrumental part of our culture, and each and every ceremony is closely connected to spirituality. How I incorporate ceremonies into my practice is to invite clients to ceremonies that I attend. Not only does this strengthen their spirituality, but it also assists clients to increase their sense of belonging (community), cultural identity, empowerment, and resiliency (Hill, 2017; McCabe, 2017; McCormick, 2000; Sager, 2018). Spirituality has taught me that not only does it give a person strength in difficult times, but it also gives us faith—Creator has a plan and to trust and surrender to him.

Empowerment

The next teaching that I incorporate into my work is empowerment, since my role as a helper is not to "heal" someone or "fix" them, but instead is to empower them. I empower my clients by assisting them to engage in their culture and connect to the community. As a result, I have witnessed some of my clients feeling/becoming empowered to face the challenges that come their way rather than giving up. They do not view the challenge before them as a barrier; instead, it is Creator testing them to see if they are committed to embarking on their healing journey. From my experience as a researcher and clinician, it is imperative, if appropriate, incorporating culture into counselling, not only to empower them, but also to support and strengthen their spirituality, cultural identity, and sense of community (Fellner, 2016; LaFromboise et al., 1990; Poonwassie & Charter, 2001; Sager, 2018).

Cultural Identity

The last teaching in my medicine bag is cultural identity. Unfortunately, I have come across several Indigenous clients who have never experienced their culture. One reason for this is attendance at residential/day schools, whether it is the clients themselves or their family members who attended. Many Indigenous clients were raised to be ashamed of who they are. Their experiences and upbringing taught them that being Indigenous was wrong and that engaging their culture was forbidden. Others, who were part of the Sixties Scoop,[6] shared with me that they were raised in non-Indigenous families and they have no idea who they are as an Indigenous person. They have no knowledge of their Indigenous family, or worse, their tribe and community.

For those who were raised outside of their culture, one of the biggest challenges I have witnessed is not having any sort of cultural identity, or any perceived identity for that matter. All they know is they look Indigenous, but they do not know where they belong or what it is like to be Indigenous. My role as a helper is to provide some guidance on their journey. Several have confided that they are scared to attend ceremony because they fear they do not belong and will not be accepted by the community. I am that bridge for them. I connect them to their culture by guiding them and showing them that by participating in ceremony myself that they are welcome. By doing so, clients are able to explore their roots and engage in their culture, resulting in them experiencing good medicine; experiencing a sense of belonging. But more importantly, embracing their Indigenous identity.

When working with Indigenous clients, it is important to consider cultural identity within the counselling session, as it may be a key component to their overall well-being. Engaging in ceremony or traditional practices permits people to have a way of identity, a way of purpose, and an understanding of what it is like to be an Indigenous person. This leads to the fortification of one's overall well-being (Durie, 1998; Durie, Milroy, & Hunter, 2009; Ross, 2014; Sager, 2018; Stewart, 2008). Knowing who you are is powerful medicine and can be the key to your journey.

Integrity in Relationships

In 2018, a Canadian Psychological task force prepared a report, *Psychology's response to the Truth and Reconciliation Commission of Canada's report* (Canadian Psychological Association, 2018). "The task force created a statement of accountability and responsibility to Indigenous Peoples on behalf of the profession of psychology in Canada and developed guiding principles for psychological practice with Indigenous Peoples in Canada" (CPA, 2018, p. 6). According to the report, there have been many violations of the ethical principles and values of the *Canadian Code of Ethics for Psychologists* (CPA, 2017) in the profession's dealings with Indigenous peoples. Integrity in Relationships is identified as a particularly serious problem in the task force report, as follows:

> Psychologists have not, as a profession, engaged in the essential cultural safety and cultural competence training required to reflect on cultural values, implicit biases, and ethnocentrism that dominates the field, in order to engage in these relationships with true integrity" (CPA, 2018, p.9).

As a helper, I have participated in cultural safety and cultural competence training. However, there is limited training available to professional psychology while working with the Indigenous peoples of Canada. While attending ceremony, I was feeling distressed over the lack of training available. However, as I listened to the Elder speak, it dawned on me that I am in training—ceremony is training. I consulted with the Elder afterward about this revelation. As I spoke, he nodded his head in agreement with what I believed to be accurate. Attending ceremony is not only for personal healing, but it is also training for me as a helper. Not only do I engage in ceremony, but I also engage in ongoing consultation and conversations with Elders, Knowledge Holders, and community members. This allows me to continue to evaluate my experiences (professional and personal), attitudes, culture, beliefs, values, external pressures, and individual needs (CPA, 2017, Preamble, Ethical Decision Making; II.10; III.9).

Within the task force report, several recommendations are made. Many of these, I carry out as a helper, including "Recognize the value and importance of Indigenous epistemologies, and the roles of culture and tradition in the conceptualization of problems and healings" (CPA, 2018, p. 10). I do this by providing culture as a treatment option in the counselling setting. I also "Recognize the importance of the connection to the land within Indigenous concepts of self and healing, and the relevance of the natural environment to healing and treatment" (CPA, 2018, p. 10). Several of my clients report connection to Mother Earth is an essential factor to aid them on their healing journey. Another recommendation that I have been working towards since I became a helper is assisting my clients to achieve "the good life" (Mino-pimatisiwin) (CPA, p. 10; Hart, ND). Lastly, I am aware of how vital the role of culture is in health and wellness through empowering clients to reclaim their identity, culture, and ceremony (CPA, 2018).

As I mentioned before, the integrity of relationships within the Indigenous culture is to tell our story. I narrate my story as a mean of demonstrating that healing is possible. Trust is such an essential piece of the therapeutic encounter within the Indigenous culture; I established it in part by detailing my struggles and providing a model for disclosure (Ross, 2014; Sager, 2018; Waldrum et al., 2008). There is no hierarchy in my role as a helper but rather humility. Personal disclosure is a cultural norm. Our relationships are based on mutual respect from shared experiences in life (Ross, 2014). Essentially, my role is to be where the client is and guide them and shine light where they cannot see. If we have not created the relationship, they cannot trust me to guide them through the dark.

Concluding Thoughts

Throughout this chapter, I have taken you on the journey of my story—how I embarked on my own healing journey and embraced my identity as a Dakota/Saulteaux/Nêhiýaw/Métis woman. I also talked about my role as a helper and what that entails and shared the teachings that I carry in my medicine bag and use daily with my clients. Lastly, I spoke about integrity of relationships and what that entails from a helper's perspective. I can only speak on what I have experienced and do not speak on behalf of the Indigenous community. This chapter came from my spirit. What I mean by this is that I worked with my spirit in the writing of this chapter. I also asked my spirits and ancestors to be part of this chapter. After all, they are the ones who govern me daily on this journey as a helper.

I would like to thank you for taking the time to read my story and experiences. Whatever you remember from this story is meant as teaching for you. I do not expect you to retain everything I wrote. Whatever you take away from the chapter is intended for you. pidamayaye.[7]

Questions for Reflection

1. How could you as a clinician be an ally for the Indigenous peoples of Canada?
2. What protocols would you have to consider when working with an Indigenous client?
3. What do you believe mental health services need to change to better serve the Indigenous peoples of Canada?
4. As a clinician, how would you protect and honour the integrity of the relationship when working with a client?

NOTES

1 Dakota for "Hello."

2 Plains (y) Cree greeting meaning "How are you?"

3 "An Elder is any person recognized by an Aboriginal community as having knowledge and understanding of the traditional culture of the community including the physical manifestations of the culture of the people and their spiritual and social traditions" (Couture, 2000, p.38).

4 Plains (y) Cree for Grandma.

5 Plains (y) Cree for medicine bag.

6 "The "Sixties Scoop" refers to the large-scale removal or "scooping" of Indigenous children from their homes, communities, and families of birth through the 1960s, and their subsequent adoptions into predominantly non-Indigenous, middle-class families across the United States and Canada" (Sinclair & Dainard, 2016, para. 1).

7 Dakota for thank you.

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12

Synergy and Challenges of Ethical Rural Interprofessional Collaborative Practice

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Rural practice is a rewarding area of health care filled with clinical complexities that often are best approached from an interprofessional collaborative practice (ICP) perspective. However, rural ICP has the potential to create ethical challenges that require much attention and diligence. Our purpose in writing this chapter is to explore the ethical challenges encountered in rural ICP, as well as to examine how such a setting can be utilized to mitigate such challenges. Although ICP is a health care trend in Canada, and one with particular relevance for rural practice settings, there is a dearth of literature in the area. As such, we explore ethical best practices for ICP in rural settings based on our collective experiences. These are underscored with case examples and reflective queries. As will be illuminated, one can best practice with competence and integrity in the marginalized context of rural ICP practice when one establishes a solid grasp of the ethical obligations of one's own profession, as well as an awareness of the ethical obligations of one's ICP colleagues.

We, the authors, bring varied professional backgrounds to this shared examination. We have worked, lived, and thrived in rural settings across Canada, and have close to 100 years of collective experience in rural practice settings. We have known each other to varying degrees over a span of almost two decades. It has been a productive, yet informal and organic collaboration (Goodwin & Doucet, 2015, 2016; Goodwin et al., 2016). As a group, we have experience in clinical service, academia, and research. Like many rural practitioners, our backgrounds are rich and varied. Shelley is a doctoral-level psychologist who has a general independent practice involving participation in several ICP teams. She teaches at the graduate and undergraduate level in departments of education and psychology and is retired from law enforcement. Barry, also a doctoral-level psychologist, has a lengthy career as a psychologist in hospital-based mental health settings in direct service, management, and team leader roles, and has a special interest in ICP in behavioural health settings. Lisa is a masters-level registered nurse who has a background in home-health nursing, teaches at the undergraduate level in nursing, and is active in interprofessional education. Jaqi, a masters-level clinical social worker, has focused her career in mental health in both hospital and community settings, with particular attention to issues of relevance to the LGBTQ community. Judi is a doctoral-level psychologist with a 20-year rural generalist practice that includes academic and practical expertise in rural professional ethics and is currently a professional practice leader in a provincial association. As we all share a committed enthusiasm for living and practicing in rural Canada and have experienced the challenges and rewards of working collaboratively in such settings, we have chosen to write this chapter together.

Overview

Our group has frequently puzzled over perceptions of professional ethics as absolutes—black and white, and something to be dreaded. We have found that when discussions on ethical standards focus on consequences for misconduct, punishment for illegal acts, and sanctions for practice misdemeanours, practitioners tend to forget the positive aspirations, virtues, values, and principles that underpin ethics. In this chapter, we wish to shine a light on the stimulating and, dare we say, inspiring side of professional ethics from a rural perspective. We will provide an overview of ethical issues and guidelines in a rural and ICP context, particularly from the perspective of Principle III (Integrity in Relationships) of the fourth edition of the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association [CPA], 2017). We then will present four scenarios, suggesting practical and rural-friendly approaches for ethical decision making.

Rural ICP Practice and Integrity in Relationships

All relationships are built on trust and mutual expectations of integrity or, in other words, on *Integrity in relationships* (CPA, 2017, Principle III, Values Statement). This is magnified significantly in a rural environment where one's decisions and actions can quite literally become everyone else's business. Therefore, it is not only important for the psychologist to abide by the profession's ethical principles, but it is also important for collaborating partners to perceive the psychologist as abiding by these principles. How well one is perceived as manoeuvring through ethical challenges is of critical importance with other professionals in the community, as well as with the community at large.

Peer-reviewed literature on ethical issues and dilemmas in small communities (e.g., in areas such as policing, military, rural, feminist, and cultural-ethnic communities) gained prominence in the psychology literature in the 1980s and 1990s. In particular, there was considerable focus on what was at first called "dual" relationships and then later "multiple" or "overlapping" relationships, which are inherent in small rural communities (Bagarozzi, 1982; Biaggio & Greene, 1995; Borys & Pope, 1989; Schank, 1989; Schank & Skovholt, 1997). The practice guidelines and codes of ethics at that time directed practitioners to avoid dual and multiple relationships. This created significant dilemmas for psychologists in rural settings, where such relationships were very hard, if not impossible, to avoid, insofar as such avoidance would result in a lack of engagement in their communities and, when not avoided, be very difficult to manage to the level implied as ethically needed by the guidelines and codes of the day. Simply stated, in the 1980s and 1990s, ethical codes, practice guidelines, and standards did not reflect the reality of rural practice. One respondent in a national study on rural ethical practices suggested that unless you were willing to live like a hermit, multiple relationships in small communities are a fact of life (Helbok et al., 2006).

The third edition of the *Canadian Code of Ethics for Psychologists* (CPA, 2000) softened this hard-line approach and suggested that although practitioners should avoid multiple or overlapping relationships, there were exceptions which must be carefully considered, managed, and ethically resolved. Although this was a positive transition for rural practitioners, it still could be (and often was) interpreted to mean that multiple relationships were exceptions, rather than the common practice context, of so many rural practitioners. In the 2000s, the literature began to differentiate between boundary crossings and boundary violations, highlighting the notion that relationships which overlap are not always harmful (Ebert, 1997; Zur, 2000a; 2000b; 2006). For instance, Truscott and Crook (2013) wrote:

> The concept of dual relationships is generally considered to be outdated because avoiding having more than one relationship with a client is almost impossible, particularly in settings such as rural communities. It has now been superseded by the idea of harmful dual relationships. That is, we are not expected to avoid all dual relationships, only those that are harmful to our clients (p. 132).

The more recently released fourth edition of the *Canadian Code of Ethics for Psychologists* (CPA, 2017) offers a greater acknowledgement that small communities of practice require psychologists to be active community participants, stating that dual or multiple relationships may be "inevitable or culturally expected (e.g., rural, Indigenous, or immigrant communities) or could enhance the benefit of an activity" (CPA, Principle III, Values Statement, para 6). From our experience, we agree that in rural and small communities of practice the existence of multiple and overlapping relationships is the norm, not the exception.

In addition to the ethical value of *Avoidance of conflicts of interest*, under which the *Canadian Code of Ethics for Psychologists* addresses multiple relationships, Principle III (Integrity in Relationships) also addresses broader integrity issues of relevance to rural practitioners. The familial, generational, and/or lifelong loyalties and connections in rural settings includes both benefits and potential risks to integrity. Also included in Principle III are the ethical values of *Accuracy/honesty, Objectivity/lack of bias, Straightforwardness/openness, Avoidance of incomplete disclosure and deception, Reliance on the discipline, and Extended responsibility.* Even a cursory examination of the titles of these values suggests how easily ethical challenges might arise in an environment where overlapping, intertwined relationships prevail. The latest edition of the *Canadian Code of Ethics for Psychologists* provides a relevant guide to deal with these challenges to practicing ethically in a rural environment, acknowledging the geographical and cultural variations of practice necessary to thrive professionally and personally, as well as ethically, in the rural communities we serve.

History of ICP

As early as 1950, Macfarlane (1950) recognized the importance of professionals in the field of psychology engaging with other healthcare disciplines. Since the establishment of the *Canadian Medical Care Act* in the 1960's and the subsequent *Canada Health Act* in 1984, the principles of universality and accessibility of publicly funded healthcare services to all Canadians have been fundamental. However, over the decades in Canada, offering equitable health care services within the constraints of an inequitable distribution of resources, particularly to those who are disadvantaged and living in remote settings such as rural communities, has proved challenging (Engel & Prentice, 2013). The Royal Commission on the Future of Health Care in Canada (Romanow, 2002), also known as the Romanow Report, continues to be an influential document. It highlights key issues and recommendations on how health care could streamline both human resources and infrastructure to secure an affordable health care system in Canada. One recommendation was to advance ICP in healthcare delivery—where health professionals from varied backgrounds, along with patients, families and/or communities, collaboratively deliver quality care to achieve health goals. Within this recommendation, developing and maintaining effective working ICP relationships is recognized as an important direction for health care.

ICP also is recognized globally as a necessity in providing effective, sustainable health care in complex environments. The World Health Organization

(2010) endorses ICP as a core framework for healthcare services. According to the Canadian Interprofessional Health Collaborative (2010), the required competencies include: (a) knowing the roles of other professions; (b) understanding the commonalities and differences between different professions; and (c) sharing common goals. ICP is seen as a key driver for facilitating healthcare equity to rural Canadians, as it has the potential to improve access for individuals living in these regions (Donato, 2015; Goodwin et al., 2016). Today, ICP practices in Canada are embedded in our fiscally constrained health care system through sharing of professional expertise, ensuring person-centred practices, and maximizing scarce resources. Rural communities can greatly benefit from these practices as oftentimes they lack a full complement of professional healthcare teams, have limited resources, and/or experience geographical isolation. As such, ICP is an ideal practice for rural health services.

Introduction to Scenarios

Ethical issues in ICP can be ubiquitous, and we invite readers to transfer the experiences described in the following scenarios to their own actual or potential experiences in rural or small communities of practice. All the scenarios are a compilation of real-life situations drawn from the authors' collective experiences and are modified and disguised for confidentiality. We believe the narratives that such scenarios provide can connect difficult or complex concepts in transferable ways. As explained above, we present our four scenarios primarily from the perspective of Principle III (Integrity in Relationships) of the *Canadian Code of Ethics for Psychologists* (CPA, 2017), while acknowledging that the three other ethical principles of the *Code* also may apply. In addition to relying on the *Code*, we also reflect on relevant ethical statements from some of the other professions we represent.

The *Code* is strongly aspirational in nature and emphasizes striving to meet the highest ideals of human awareness, intention, reasoning, and behaviour. Yet, this level of perfection is rarely, if ever, seen in real life, even when we strive and aspire to it (CPA, 2017; Truscott & Crook, 2013). In the spirit of striving towards these ideals, we invite the reader to ponder how these case examples may relate to and be addressed within their own current and/or future areas of practice.

Scenario #1

Our first scenario presents a common ethical challenge that confronts many rural and remote practitioners working on an ICP team. The primary ethical value highlighted is *Reliance on the discipline* (Ethical Standards III.33–III.35).

Marie is a psychologist practicing in a small town 300 kilometres from any other psychologist. She works in an ICP primary care setting with a physician, registered nurse, paramedic, nurse practitioner, occupational therapist, and a non-regulated counsellor from the local non-profit Women's Centre. It is a close-knit ICP team where many members socialize with each other outside of the office. Some have children of a similar age. At dinner one evening, Marie learns that her 14-year-old daughter continues to be bullied at school by an ICP colleague's child, despite Marie having addressed the issue with the school. The 15-year-old adolescent, who is the aggressor, experiences learning difficulties and impulsivity challenges. This adolescent had been referred to Marie by the school but instead, Marie recommended telepsychology with a professional outside the community due to Marie's dual relationship with the child's mother. However, the child refused to participate in any form of counselling. Marie now feels isolated. She is worried about her daughter, and worried about talking with her ICP colleague about the situation. If it goes poorly, the emotional fallout may impact their working relationship and, in turn, the team.

Marie remembers a graduate professor once saying to her, "You don't need to know it all, you just need to know how to reach out and find it," which she thought was very wise advice. Although Marie would prefer to obtain advice about her situation through face-to-face contact, she does not feel comfortable speaking with any other team member about the situation, as she believes this would put them in a very awkward position. However, finding a face-to-face alternative is not always possible in rural areas.

Marie reminds herself that she needs to remain isolated for advice only as far as the nearest phone or internet connection, and that she could contact her former registration supervisor, a past colleague, or her provincial association where, in her province, a list is maintained of psychologists willing to consult with fellow psychologists on ethical matters (III.35). In preparation, she familiarizes herself with her province's consent and child protection legislation (III.33) and psychology's standards of practice for telehealth services (III.34). She also reviews relevant sections in the *Criminal Code of Canada* related to bullying and social media harassment. Once prepared, she chooses to consult with her former registration supervisor who has good knowledge of her practice environment, with whom she had a positive supervisory relationship, and who she thinks could probably provide her with very workable suggestions. She follows through and is very happy with the advice she receives.

DISCUSSION

The primary ethical value of the *Canadian Code of Ethics for Psychologists* (CPA, 2017) highlighted in this scenario is *Reliance on the discipline*. A number of professional codes of ethics promote or require their members to actively seek consultation within their discipline (e.g., nursing, social work, physicians, and psychology). This was true of most of the members of Marie's ICP team. In rural

ICP, however, non-regulated colleagues who are not governed by a code of ethics also might be team members. Although not part of Marie's dilemma, psychologists on ICP teams sometimes can take on the added responsibility of educating and encouraging others to adhere to high ethical standards both in practice and in research, as appropriate (Ethical Standards III.36 and III.37).

Marie remembered that, similar to other regulated professionals (e.g., Canadian Nurses Association, 2017; Canadian Association of Occupational Therapists, 2007; Paramedic Association of Canada, 2016), psychologists are required to be familiar with their code of ethics, practice standards, and relevant provincial and federal statutes/acts. This was helpful to her in preparing to proceed with consultation. Considering that consultation between urban and rural colleagues can be beneficial (Malone & Stanley, 2011), she did not need to rule out an urban colleague for consideration. Furthermore, considering that consultation may usually be profession specific, but does not have to be province specific, Marie also could have considered calling a friend from graduate school living in another province, or a colleague on a national committee that she knows. Reflecting on the *Canadian Code of Ethics for Psychologists* and the *Universal Declaration of Ethical Principles for Psychologists* (International Union of Psychological Science, 2008), she even could have considered the relevance of stepping outside her own country for consultation.

QUERIES FOR CONSIDERATION

1. If the bullying situation did not exist, could Marie have started a therapeutic relationship with this client in this ICP/rural setting? If so, under what conditions?
2. Exercise: From your profession's scope of practice, write out what you think your potential role could be in an ICP team with respect to a child of one of the team members in this scenario.
3. Exercise: Now imagine yourself to be a member of another discipline on an ICP team. Write out what you think your role might be. What are the similarities and/or differences to your role within your own profession's scope of practice?

Scenario #2

This second scenario takes us into the complexities of balancing service provision with financial and administrative responsibilities in a rural private practice. The primary ethical values highlighted are *Straightforwardness and openness* (Ethical Standards III.13-III.22) and *Extended responsibility* (Ethical Standards III.36–III.37).

John is the only private practice psychologist in his rural area. Aki is the owner/practitioner of the only rehabilitation clinic in town, the Painfree Clinic. The nearest clinic like this is 400 kilometres away. Aki has invited John to join her clinic's ICP insurance-related injury team. In addition to psychology, the clinic's ICP team includes chiropractic medicine, general medicine, massage therapy, occupational therapy, physiotherapy, and social work. During negotiations, John is encouraged to streamline his assessment process, and feels pressured to allow other professionals (whose hourly rate is less expensive) to administer psychological inventories, and to lower his hourly rate (the provincially recommended rate) to match the insurance company's allowable billing rate. John is excited by the opportunity to join the clinic as the opportunity to collaborate with other professionals in this way does not always happen when practicing in a small town. He also is aware that it will increase his revenue, which is a good thing, as he is still developing his business. One area of concern for John, however, that makes him apprehensive is that the collaboration would require him to work with professionals from whom he had personally received medical care, albeit six years ago. After contemplating the pros and cons and consulting with fellow psychologists, John decides to pursue this collaboration. Further details of his thinking appear in the discussion below.

DISCUSSION

Money is often a difficult topic for people to address. In this case, a third party (the insurance company) is mandating an hourly rate that is below psychology's provincially recommended rate. In many settings this is not unusual; some psychologists do not adhere to the provincially recommended rate, some charge more and some charge less. Discerning what he needs to charge to complete the assessment and what the Painfree Clinic can afford requires a respect for openness, a level of directness, and a degree of co-operation from all parties. Through open and respectful dialogue, these issues may be resolved while maintaining both integrity and harmony in the ICP relationship.

The *Canadian Physiotherapy Association Code of Ethics* (2016) emphasizes the importance of physiotherapists practicing to their full scope of practice. This opens the question of who can administer psychological tests. Although other professions can administer level A and B inventories, the standards followed by psychologists require that the more complex level C tests be used only by those with specific competencies and credentials (American Educational Research Association et al., 2014; Simner, 1994). Those companies that sell psychological tests and inventories, however, set their own criteria for who can administer them. Understanding this may help lessen the need for psychologists to defend the right to administer and interpret inventories by instead allowing the sellers of psychological assessment tools to confirm the user's qualifications. In an

ICP team, John needs to be aware of his colleagues' abilities and scopes of practice, thus allowing him to promote a harmonious working relationship (Ethical Standard III.10). John reviews the test publisher requirements to determine if it may be appropriate for the ICP team member to administer the inventories. With this information, John decides to engage his ICP teammates to have their input, and then have the team evaluate what is best for the clients being served.

When John reviews confidentiality with his regular private practice clients, he informs them of the usual exceptions to confidentiality, namely: harm to self; harm to others; vulnerable persons in need of protection; and a judge ordering the information to be shared. John realizes that, when working with an ICP client for their insurance-related injury assessment, he also will have to advise each client that some information will be shared among team members (Ethical Standard III.13). However, not all client information should be shared with ICP team members if it is not relevant to the injury assessment. This will require sound judgement on John's part and could impact the level of openness and engagement of the relationship of other ICP team members. Maintaining confidentiality also includes not sharing client information between his private practice office and the Painfree Clinic by email unless password protected, and most preferably by fax or personal delivery (Ethical Standard III.14). John knows that the other health professionals on the ICP team are bound to confidentiality through their own professional codes of ethics, but these may not be to the same ethical standard as John believes is required by his own code. The *Canadian Code of Ethics for Psychologists* (CPA, 2017) encourages John to engage in conversation with his team members to promote confidentiality to the same ethical standard, which reflects the value of *Extended responsibility* (Ethical Standard III.36). John is aware of this and engages Aki in a conversation about how to navigate these requirements.

As already noted, a number of scholarly publications exist that highlight the challenges of overlapping roles in rural community practice (Malone & Dyck, 2011; Schank, 1989; Schank et al., 2010; Schank & Skovholt, 1997, 2006; Truscott & Crook, 2013; Zur, 2006). John knows that he must also consider the issue of dual roles with the ICP team during negotiations. In the *Canadian Association of Social Work Code of Ethics* (2005), Principle 4 recommends the avoidance of multiple roles, and promotes the values of openness and transparency. However, John realizes there are ICP team members for whom overlapping relationships are not discussed in their code of ethics. This allows John an opportunity to inform and discuss with colleagues psychology's *Code* and the issues that it raises with respect to overlapping relationships (Ethical Standard III.36).

Some psychology practitioners may read this and revert to the absolutist thinking mentioned in the introduction, and see overlapping roles as forbidden, to be avoided at all costs, or as inherently dangerous. Fortunately, John is aware of recent advances in the literature and changes in the fourth edition of the *Canadian Code of Ethics for Psychologists* (CPA, 2017) that counteract such interpretations of overlapping relationships. For instance, in the *Code*, under the ethical value *Avoidance of conflict of interest* (discussed in more detail later), Ethical Standard III.30 states that practitioners should "avoid dual or multiple relationships . . . that are not justified by the nature of the activity, by cultural or geographic factors, or where there is a lack of reasonably accessible alternatives" (CPA, 2017, Principle III). The wording of this standard supports the view that a linear way of thinking about overlapping relationships is too restrictive, particularly in rural settings. Having this knowledge allows John to open a dialogue while negotiating his role on the ICP team.

Aki, as a physiotherapist, will be guided by her own professional body's *Code of Ethics* to "communicate effectively and respectfully, and practice cooperatively with colleagues, other health professionals and agencies for the benefit of patients/clients" (Canadian Physiotherapy Association, 2016, p. 3). Having read Aki's code for his own knowledge, John takes comfort in this information as it allows him to engage in an open, straightforward dialogue on the best approach. Although John is mindful that this new ICP opportunity has ethical considerations, he does not feel that they are insurmountable; rather, he believes he can navigate them with openness and clarity. With this understanding, John and his ICP colleagues sign a contract (Ethical Standard III.13); in doing so, he is protecting his clients, himself, and his partners.

QUERIES FOR CONSIDERATION

1. John completes an insurance-related injury assessment and advises the client and his ICP team that there are no psychological barriers for the physically injured client to return to work. He does not reschedule with the client and advises the team there is no further reason for him to see the client. Two weeks later he receives an update on the client's progress by fax. Does receiving a progress report when he has terminated his service to the client pose an ethical concern? Why or why not?

2. John is a distance runner and experiences an injury. What are the ethical implications if he receives services from the Painfree Clinic while he is in an ICP partnership with them?

3. A client advises you that he wishes to have his injury treated with Indigenous methods of care. How do you respond? How does this fit within the ICP model of care and within your code of ethics?

Scenario #3

This scenario underscores the opportunities for ICP research, while acknowledging the rewards of rural community engagement and the need to manage multiple roles in a rural setting. The primary ethical values highlighted are *Avoidance of incomplete disclosure and deception* (Ethical Standards III.23-III.27), and *Avoidance of conflict of interest* (Ethical Standards III.28-III.32).

Ben is a psychologist and equine enthusiast who lives in a small remote community. He is aware that he has gotten to know people in many ways through his work, family life, shared hobbies, and passions. He is also aware this is the way of small communities, where people get to know each other in many ways and on many levels. Included in such knowledge is who might contribute professionally to a project and who might volunteer their time when doing so. They know this through word of mouth, social media, community involvement, past work experience, or just because they are part of a local interest group. So, when he is asked to be the primary investigator leading a team conducting program evaluation in equine therapy, he appreciates the fit between his personal and professional life and is excited by the opportunity to engage in the project, albeit somewhat leery of the potential for role conflict and interprofessional challenges. He also sees the opportunity to use the data collected from the program evaluation for publication and wants to make sure that he obtains ethical approval for this data collection as he hopes to present and possibly publish the findings.

Ben learns about the project from Allison, who describes how a local rural-based parent support group, of which Allison is a member, has received a grant for a summer recreation day camp for children with a developmental disorder. The project would run on Saturdays over the summer at a local equestrian centre. Grant money would cover the project's operational costs but not staff salaries or program evaluation/research expenses. The parent support group, however, hopes that the effectiveness of the program can still be evaluated, especially with respect to the effectiveness of the new type of equine therapy that will be part of the program. Allison and other parents approach acquaintances and professionals known to them through the support group, but also through community and shared social circles, about volunteering to participate. Ben sees and appreciates how the ICP participants are respectful of colleagues' parenting obligations, work, and personal demands; for example, by being flexible in scheduling and being mindful of childcare constraints during summer vacation. With small-town community spirit, two teams are formed—a service provision team to run the program, and a program evaluation/research team to conduct a mixed method study on the effects of the program. The service provision team consists of three recreation therapists, an artist, nursing students, community volunteers, and a certified equine therapist. The program evaluation/research team consists of two psychologists, a registered nurse, a registered social worker, and a nursing student. One of Ben's roles is to build team capacity by providing basic research education for inexperienced team members.

Having lived in this small community for many years, Ben is very aware how roles can become unintentionally and unavoidably blurred in a rural collaborative relationship compared to those in an urban setting where roles are better defined and easier to maintain. He is aware that ethical values and standards may not be applied easily. So, before accepting the opportunity, Ben wisely reflects on possible relationships that might come to bear on this new opportunity. These include his having taught some of the students in the past and the possible teaching of some in the future, riding horses with several of the volunteers and the pediatrician, and taking riding lessons from the certified equine therapist. As with many things rural, this ICP team was realized because of "who knew whom," and he feels honoured to have been asked to work with his colleagues in this way.

Ben advises the teams that to ensure a more objective research approach, members of the ICP research team were not to be directly involved in the project's service provision. Not only did this allow for research objectivity, it also allowed Ben to avoid overlapping roles, particularly where he had had a therapeutic relationship with some participants. Other members would be responsible for data collection, tabulation, and responding to research questions that arise. Some professions' codes of ethics do not address research expectations or standards as clearly as psychology (e.g., recreation therapists). Aware of this, Ben asks his professional partners to follow the *Code*'s ethical values and standards for research (consistent with Ethical Standards III.36 and III.37 regarding the value of *Extended responsibility*). Ben is able to assume overall responsibility for the research activities of his collaborating partners (III.37) and, in doing so, he is mindful of the ethical standards for research laid out in the CASW *Code of Ethics,* Value 6.5 (CASW, 2005) and the Canadian Nurses Association *Code of Ethics*, Value C.1-4 (CNA, 2017).

In keeping with the *Canadian Code of Ethics for Psychologists*' values and ethical standards regarding research, and the Canadian Medical Association's (CMA) *Code of Ethics* (2004), Ben ensures that ethical approval of the research is obtained through the ethics board of the hospital with which he is affiliated. In addition, reflecting CPA's Ethical Standard III.29, he also makes sure that rewards are not offered to motivate individuals or parents to participate in the recreation program or the research portion of the program. Furthermore, because of the financial limitations of the grant, remuneration and/or financial rewards are not offered to ICP research team members for their participation. They are asked to participate on a completely voluntary basis. Nina, the social worker, affectionately argues that her arm had been gently "twisted" to compile and tabulate the data, but she states that she is pleased to contribute as she recognizes the potential non-financial gains. As is common in rural settings, where a handshake and a person's word are the way of doing business, no written contracts are signed as team members are pulled together for this project. Ben is surprised when one of the team members, Jordan, unexpectedly, after two planning meetings, submits a written request for payment of his proposed hours. Ben acknowledges Jordan's valuable contribution as well as apologizes for the apparent lack of clarity in the initial verbal agreement. He then respectfully advises Jordan privately that there is inadequate grant money to pay the fee requested (Ethical Standards III.16 and III.19). Ben leaves it open for Jordan to remain as a volunteer or leave the project. All ICP members' professional codes of ethics advise handling this type of situation with straightforwardness and respect, which reflects the Canadian Therapeutic Recreation Association's (CTRA, n.d.) *Code of Ethics* Principle 4 of "Professionals practice mutual respect and work cooperatively for the benefit of those they serve," while also adhering to the *Canadian Code of Ethics for Psychologists'* Ethical Standards III.5 and III.13, CASW code's Principles 1 and 4, and CNA's code Values A and B.

Ben, recognizing the value for students to participate in an ICP activity, arranges for separate groups of undergraduate students to participate either in the research or in the service provision. Given the nature of the work, this was appropriate, yet required clarification of boundaries with the students both during and after the project concluded, particularly when all returned to the classroom in the fall. One student used this experience to present at a national conference, which was supported fully. Collaborating on an interesting local research project, while building research skills, provided an exciting professional growth opportunity. For this student and other ICP partners, these benefits help offset the time commitment and lack of compensation.

DISCUSSION

Putting youth and families first, while also paying attention to collaborating partners' well-being, allows ICP team members to feel respected and appreciated for their contributions. ICP involves developing and maintaining effective working relationships with professionals, paraprofessionals, mental health consumers and their families, students, and communities to ensure optimal health outcomes (Canadian Interprofessional Health Collaborative [CIHC], 2010). This scenario is an example of ICP at its best, weaving all the threads of an effective collaboration into a beautiful fabric where the threads of comradery within the team make it strong. CIHC states that effective collaboration can only occur when individual professionals move their approach from a traditional mindset of "I/we know best" to a holistic approach that allows all team members to feel welcome and respected (Canadian Collaborative Mental Health Initiative [CCMHI], 2006; Coffey & Anyinam, 2015). We believe this scenario highlights how it is possible for the grey areas of overlapping relationships to be managed ethically and with integrity. Notice we did not say it was easy, just that it is possible.

QUERIES FOR CONSIDERATION

1. If, because of interpersonal conflicts, not all of the current team members want to work together, but still want to work on Ben's new equine therapy research project, how might Ben select his team members? How can Ben maintain the relevant ethical values of Principle III?
2. Xavier, a social worker, has been an enthusiastic part of the organizing committee from the start. Two weeks before the project starts, Xavier's extended family unexpectedly decides to take a family vacation during week four to six of the eight-week project. They invite Xavier and his family to come. Xavier advises the team he would like to go with his family. He is not a lead on the project but is an important part of the project. Relevant to Principle III, how might Ben navigate this dilemma?

Scenario #4

For our final scenario, we introduce you to a more complex ethical dilemma which has ramifications for the psychologist not only professionally, but also on a personal and family basis. The primary values highlighted under Principle III are *Accuracy/honesty* (Ethical Standards III.1–III.8), and *Objectivity/lack of bias* (Ethical Standards III.9–III.12).

Pat is the administrative supervisor for both Jacob, an occupational therapist, and Emma, a psychologist. Emma witnessed Pat sexually assaulting Jacob and has just heard that the police are now investigating. They want a witness statement from Emma regarding what she observed on that day. Emma is torn between being truthful and supporting her colleague versus risking potential consequences from both her family and supervisor if she gives an accurate and complete factual statement. To complicate the dilemma even more, being in a small rural environment with its web of interconnecting and overlapping relationships, Pat is a relative of Emma. Emma is worried that possible subsequent court testimony for this case would be big news in her small town. Such news coverage or small-town gossip regarding her testimony could influence her current and future interprofessional collaborative relationships in her community, as well as her family relationships.

Several of Emma's confidants have suggested to her that no one would blame her for having one or two passing thoughts of refusing to provide a statement, or perhaps giving a vague statement. Emma reflects on the difficult spot she finds herself in. She realizes that the idea of a vague statement, although it might preserve the stability and comfort of her ongoing family relationships and career path, would sacrifice the truth of what she witnessed as well as the trust of her ICP colleague, Jacob. Emma realizes providing an inaccurate or incomplete statement is not something she could do in good conscience, and she begins to seek guidance and answers. Her first resource is the set of ethical standards under Integrity in Relationships of the *Canadian Code of Ethics for Psychologists*.

The initial ethical standard under Principle III is particularly relevant to Emma's deliberations, as it calls for psychologists to "not knowingly participate in, condone, or be associated with dishonesty, fraud, misappropriation, or misrepresentation." How to handle this situation from an ethical standpoint seems straightforward in that Emma just needs to tell the truth, even though the personal costs of doing so could be quite high.

The Principle III value, *Objectivity/lack of bias*, encourages being "as objective and unbiased as possible," and to "take care to communicate as completely and objectively as possible." Furthermore, the Canadian Association of Occupational Therapists' (CAOT) *Code of Ethics* encourages use of professional communication with colleagues, valuing and respecting those they work with, and working collaboratively through interdisciplinary collaboration (CAOT, 2007; Dick & Brockett, 2006). The CPA ethical value *Straightforwardness/openness* further clarifies how to approach this dilemma. Emma appreciates these guidelines as she develops a framework for not giving in to work and family pressures on her to provide a dishonest or biased statement. She also explores whether she would benefit from an awareness of other statutes and policies including the *Criminal Code of Canada* sections (e.g., obstruction of justice), provincial statutes forbidding harassment in the workplace (e.g., Department of Labour), and knowledge of a workplace anti-bullying/harassment policy.

Emma would be adhering to the ethical values and standards of Principle III if she is complete and truthful in her witness statement and in any subsequent subpoenaed court testimony. She finds that Principle III provides support and direction for her amongst the whirl of competing thoughts, pressures, and feelings. She also realizes that she can rely on colleagues for support during this time, including consulting another psychologist.

DISCUSSION

Professional relationships in rural environments are built on trust and respect, or in other words, on Integrity in Relationships. Emma's situation illustrates the importance of having a professional code of ethics to guide her through a difficult situation that could impact her career, family, and work relationships. Standards and other legal statutes can provide important external guidance to help her ethically manoeuvre through the competing pressures of the situation. This scenario illustrates that it is not only important for the psychologist to abide by the ethical principles, but it is also important for present and future collaborating partners to perceive the psychologist as abiding by these principles. Thus, how well one is perceived in manoeuvring through ethical challenges is of critical importance in the community at large, as well as with other professionals in the community. As noted earlier in this chapter, this is significantly magnified in a rural environment where one's decisions and actions, quite literally, can become everyone else's business.

QUERY FOR CONSIDERATION

1. Keeping in mind the importance of Integrity in Relationships, what situations might you if your friendship and/or loyalty to a colleague conflicts with the values of Principle III? Such a situation could extend anywhere from the colleague who likes to take home office supplies to the friend who admits to you that they biased their instructions to some of their research subjects in hopes of getting "better" results for their honours research project. What are your professional and ethical obligations? What steps might you take?

Summary and Future Directions

We are fully aware of the challenges and embrace the opportunities of ethical rural ICP (Goodwin et al., 2016; Malone & Stanley, 2013). We recognize the importance of helping our peers and peers-in-training to be better prepared for this type of vibrant practice. To this end, there are now greater opportunities for rural practice, internship placements, and increased ICP interaction/training in the classroom and graduate programs. We hope that by having shared some of the ethical challenges we have faced in our own endeavours that our current and future colleagues can be more aware, better prepared, and more enthused by this approach. In rural collaborative practice, our daily interactions are entwined with those around us. It is not just on our professional lives that collaboration will have an impact, but on our daily personal lives as well. We can best influence the fabric of our rural cultural experience by ethically weaving the collaborative threads of our schools, hospitals, non-governmental organizations, communities, and skilled individuals of all disciplines.

As noted at the beginning, our intent in writing this chapter is to raise awareness and interest for this area of practice and its amazing possibilities for: personal, professional and collegial growth; enhanced service to clients; and a richer and more rewarding engagement in one's community. We hope we have demonstrated that ethical ICP rural psychological practice and research can be dynamic, rewarding, and energizing. We have found that, when we collaborate ethically, we benefit from the richness that we invite into our professional and personal lives, and we strengthen our communities. Becoming comfortable with engagement in ICP in our communities can spread to collaboration provincially, territorially, nationally, and even on a global scale. This synergy creates exciting opportunities to practice locally with global influence (McDaniel, 2016).

Questions for Reflection

1. As a psychologist moving to and opening a practice in a rural community, what ethical challenges do you think you might need to prepare for?
2. What practice area(s) do you think you might need consultation about from a colleague to help you navigate challenges related to Principle III (Integrity in Relationships)?
3. A research team from a city-based university approaches you to ask for your help with a research project to be carried out in your rural community. In familiarizing yourself with the project, you find you have ethical concerns. Community members hear about the project and ask your opinion. How do you respond?
4. Six months after moving to the rural community, your child crashes your family's all-terrain vehicle into a neighbour's fence. Your child is unharmed, but the neighbours are upset. In addition to being neighbours, they also are your clients. How do you respond?

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PART D

PRINCIPLE IV

Responsibility to Society

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Being Part of the Solution, Not Part of the Problem: High-Conflict Divorce, Family "Justice," and Responsibility to Society

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When parents are repeatedly embroiled in courtroom battles, they have less time and energy to devote to their children, as well as fewer financial resources to devote to their care. When parental time, energy, and resources are funnelled into litigation, children usually pay the largest price (Joyce, 2016; van Berkel et al., 2024). Children of high-conflict divorce[1] experience psychosocial problems at a much higher incidence than children whose parents divorce without excessive conflict (Kim, 2011), and carry some of these problems into adulthood (Johnston, 1994). In Canada, separation and divorce are embedded in an inherently adversarial legal system. This significantly influences how psychological services are provided in high-conflict divorce situations.

In this chapter, we first: (a) introduce ourselves in terms of Rønnestad and Skovholt's (2003) phases of counsellor development; (b) overview the issue of high-conflict divorce and its effects on children; (c) describe some of the systemic barriers inherent in the family justice system for the delivery of psychological services to these families; and (d) from our own perspectives and activities, provide reflections on important societal-level ethical responsibilities related to this area of practice, using Principle IV (Responsibility to Society) of the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association [CPA], 2017) as our framework. Finally, we invite psychologists and mental health practitioners involved in high-conflict divorce to take action to enhance their adherence to Principle IV by improving services to families experiencing high-conflict separation and divorce and supporting renewal of the court system.

About Us

Nicole: I am a recent master's graduate in counselling psychology and a former legal assistant. For as long as I can remember, my mother worked as a legal assistant. When I was little, my father worked out of town. It was not uncommon for my mother to collect my two sisters and me after school, pick up some take-out food, and take us to her office where she finished her work. Her dedication and hard work taught me that what she did was important to her and the clients she served. As I grew up, my mother continued to demonstrate the same work ethic, impeccable professional conduct, and much empathy towards her clients.

Wanting to follow my mother's example and be in a job that helped others, I started working part-time for a family lawyer during high school. I did not interact with the clients, but I performed duties that supported the progression of their cases, requiring a higher level of professionalism than most after-school jobs. In addition, working for a family lawyer taught me about the often-caustic nature of divorce. I came to believe that the inherently adversarial legal system created a culture that does not support effective communication or healthy dispute resolution. Later on, during graduate studies in counselling psychology, I took a scholarly interest in divorce and learned about the negative long-term consequences for many families.

Ten years elapsed between first working in the law firm and completing my undergraduate psychology degree. By the time I entered graduate school, I was again working as a legal assistant. However, I was now working with my mother, who became my first professional mentor. Learning from her instilled in me diligence, as well as attention and empathy toward clients, traits that I carried into graduate school.

As I engaged in the rigorous reflection required in my graduate program, I noticed parallels between my work as a legal assistant and the attitudes and skills required of professional counsellors; namely, crisis management and the ability to deal with ambiguity, uncertain outcomes, and comorbidities. Our ethics course, based on the *Canadian Code of Ethics for Psychologists*, reinforced many values of the legal profession. I was intrigued by the explicit focus on *Responsibility to Society.*

Drawing from Rønnestad and Skovholt's (2003) six stages of counsellor development, I saw that my growth as both a legal assistant and as a graduate counselling student reflected three of their themes: (a) beginning practitioners rely on external expertise, whereas senior practitioners rely on internal expertise; (b) as professionals develop in their careers, their anxiety declines; and (c) external support is most important at the beginning of one's career and at transition points. I experienced a strong need for external support in the form of mentors who could support me to manage my anxiety, and who could be role models for me. My training as a legal assistant informed what I sought in a practicum placement—an environment with external supports that could help me manage my anxiety around the new roles I was taking on. With the help of supportive supervisors, I moved from the beginning-practitioner phase to the novice-professional phase (Rønnestad & Skovholt, 2003), where my anxiety gave way to a general sense of competence.

As a legal assistant, I noticed that there were few services available for family law clients. As a novice counsellor, I found that even senior colleagues shied away from high-conflict families and worried about the possibility of a regulatory complaint. I thought, "Someone needs to do something," and realized that Principle IV required me to use my unique position with one foot in the legal profession and one foot in the counselling world to be one such "someone."

Jeff: I also find the Rønnestad and Skovholt (2003) model helpful and am very comfortable with my current phase as a senior professional. I have been a registered psychologist for 33 years, working 25 of them mainly with families embroiled in high-conflict separation and divorce. I am one of the few senior psychologists in Alberta working with these families.

In middle age, moving into an academic position in a practice-oriented program, mentors encouraged me to leverage my connections in the family law arena to develop a scholarly agenda in high-conflict divorce. However, feeling weary of high-conflict families, I avoided this for seven years. I kept working in the family law arena to supplement my income but did not want to think about it more than I had to. However, when a family lawyer I knew was advocating for implementation of a program to prevent high-conflict situations in post-separation parenting by teaching parents communication and self-regulation skills, I offered to co-ordinate the research and evaluation. I finally stopped avoiding high-conflict divorce in my academic life, and now have a small group of students, including Nicole, who are researching in this area.

After many years of using my clinical skills with families embroiled in high-conflict divorce, I often felt like a cog in a flawed and slow-to-change system, wondering if I was playing a complicit role in its adversarial nature. The satisfaction of supporting a child and parent to reclaim their relationship after the child has refused to see that parent for months or years, or of uncovering family dynamics and devising recommendations about parenting time, has given way to the feeling that I should be making more of a difference.

My experience of a loss of satisfaction with a particular aspect of my work is not uncommon among senior practitioners (Rønnestad & Skovholt, 2003). Like others in this career phase, teaching and supervising have become great sources of satisfaction. Although I am not thinking about retirement soon, I do think about the legacy I will leave and how I can help build capacity in the system as well as competence in individual practitioners. I want to escape the "intellectual apathy and . . . boredom” (Rønnestad & Skovholt, 2003, p. 26) that some senior practitioners experience. I have the good fortune to hold an academic position that gives me the flexibility to pursue my scholarly interests and disseminate my work. However, taking Principle IV seriously requires me to use my academic position as a privilege and a platform to help develop society in beneficial ways.

“High-Conflict”: An Overview

Divorce produces challenges in the lives of most families who experience it. Approximately 80% of divorces proceed without conflict and litigation, and with a modicum of respect and civility. Another 10 to 15% require just one court appearance to resolve a contested issue. This leaves about 5 to 10% that are highly litigious (Carter & Hebert, 2012). In these families, parental conflict does not abate; the co-parenting relationship is so problematic that special attention is warranted (Amato, 2010; Deutsch, 2008; Lebow, 2019).

These high-conflict relationships are characterized by antagonistic interaction between ex-partners, and often include hostile disengagement, poor communication, and ineffective decision making. Parental decision making is impaired to such an extent that issues like holidays, school placements, extracurricular activities, and minor schedule changes may be litigated. Elevated emotional reactivity between the parents amplifies the annoyance that is felt from simple miscommunications or mere differences in parenting style into volatile mutual interactions. Immediately blaming the other parent for minor lapses in parenting is common. Although both may be at least adequate parents, differences in parenting style or practices are magnified and/or seen as evidence of pathology. Parents sometimes engage in amateur, usually internet-aided, diagnosis of the other parent. Some parents litigate to reduce or restrict the parenting time of the other parent, sometimes out of heightened suspicion and reactivity, and sometimes to gain the upper hand in ongoing litigation (Carter, 2011; Eddy, 2016; Eddy et al., 2020; Johnston, 1994; Lebow, 2019). Allegations of domestic violence, mental health issues, substance abuse, and personality disorders are more likely in these families (Carter, 2011; Eddy, 2016; Eddy et al., 2020; Johnston, 1994; Kelly, 2000). Allegations and counter-allegations of serious problems create complex situations that psychologists must unravel to work effectively with these families. High-conflict divorce also takes its toll on the parents’ physical and psychological health (Barnett et al., 2005; Burman & Margolin, 1992; Ditzen et al., 2011).

Children and High-Conflict Divorce

In high-conflict situations, research indicates that there is a substantial risk children will undergo psychological and emotional harm, as well as experience adjustment issues, erosion of their relationship with parent(s), academic problems, etc. (Carter, 2011; Johnston, 1994; Kelly, 2000; Lebow & Newcomb Rekart, 2007; Shumaker & Kelsey, 2020, Strohschein, 2012). Some children align themselves with one parent and decline contact with the other as a strategy to manage their response to the parents' conflict.

We have seen many situations in which the parents' conflict significantly exacerbated a child's problems. For example, Jeff was seeing 10-year-old Mikalya (a pseudonym) for her anxiety. Overall, she was a well-functioning girl who did well in school, had many friends, loved her extracurricular activities, and generally exercised a fair degree of independence for a girl her age. However, her anxiety spiked when her parents were in the same physical location for functions like school concerts. Poignantly, she lamented, "My head was going back and forth like I was watching a ping-pong game. I was watching where my parents were sitting in the gym. I was so worried about what they would do that I forgot the words to the song."

Systemic Barriers in High-Conflict Separation and Divorce

There are several systemic barriers that make the family justice system difficult for clients to navigate, and for psychologists and other mental health practitioners to provide effective services. These are: (a) the inherently adversarial nature of the legal system; (b) access to justice; (c) service fragmentation; and (d) the appropriation of psychological constructs by the family justice system.

Adversarial Legal System

Commonwealth countries and the United States have common law legal systems (Bryan, 2006), which are distinguished by two main features. First, they are bound as much by precedents of previous court rulings ("case law") as they are on legislation. Second, the parties in a legal dispute are defined as adversaries. These features are present whether the legal dispute pertains to product liability, criminal charges, or a disagreement over parenting time (e.g., "Kramer vs. Kramer" [Fischoff et al., 1979]; "The People v. O. J. Simpson" [Alexander et al., 2016]). Legal education instills in lawyers who practice in such a system the responsibility to be zealous advocates for their clients. Accordingly, when a couple divorces, their legal interests, not the children's interests (whether legal or psychological), are represented directly. Although the *Divorce Act* (1985), last amended in 2021, states that judges must be guided by the best interests of the child in deciding parenting issues, it is generally parents who are represented by legal counsel—not children. When a judge determines that parental conflict impairs the ability of the parents to separate their needs from the children's, the judge may appoint legal counsel for the child(ren), based on the assumption that children also have interests and are entitled to legal representation (Birnbaum, 2005; Lovinsky & Gagne, 2015). However, our experience has been that this may simply add another voice to the adversarial cacophony. Although the legal world views parties as individual entities, each with their own rights, we see "family justice issues [as] primarily social and relationship problems that contain a legal element" (Alberta Justice & Solicitor General, 2019, para 7). Zealous legal advocacy on behalf of an individual client often exacerbates conflict (Eddy, 2019).

In spite of this bleak picture, several practices have been found to be effective in reducing conflict between parents. First, most provinces and territories now require that divorcing parents participate in parent education regarding communication skills and the effects of separation and divorce on children (e.g., Alberta Justice, 2024; Bacon & McKenzie, 2004; Ontario Ministry of the Attorney General, 2024).

Mediation also has been helpful. It is intended to help divorcing couples to express their positions and negotiate to reach an agreement. Typically, mediation is brief and structured (ranging from 1 to 10 sessions), focused on developing agreements about specific issues (Emery et al., 2005). All Canadian jurisdictions provide some public funding for family mediation services (Family Mediation Canada, 2022). Like most government-funded services, waiting lists may affect availability, and services may be available only in larger centres.

Psychologists who are competent in mediation typically support parents to resolve parenting issues (e.g., parenting time, decision making). Other separating couples require assistance to resolve financial issues (e.g., property division, child and spousal support), which is more often done by lawyers who are knowledgeable about the relevant case law and legislation. Usually, mediation is "without prejudice," meaning that the content discussed (including any agreements reached, but later rescinded) and the behaviour of the parties may not be revealed in court. Once agreements are reached, they are usually drafted into a court order (i.e., a "consent order"), which after review and endorsement by a judge, is binding.

Parenting co-ordination is a relatively new alternative dispute resolution process, usually implemented after a finalization of a court order for parenting arrangements. It is useful when high-conflict parents have a history of protracted litigation and require ongoing support to make decisions (Brophy et al., 2020; Coates et al., 2004; Higuchi & Lally, 2014; Kelly, 2008). Ideally, a parenting co-ordinator (PC) meets periodically and proactively with parents to aid decision-making on recurrent issues (e.g., vacation, extracurricular activities), to suggest practical applications of the court orders, and to coach parents to communicate with each other. PCs educate parents about the developmental needs of children and how specific actions might affect the children, support parents' joint decision-making, and in some jurisdictions, arbitrate issues to make binding decisions. The goal, ideally, is to prevent recurring litigation. There is preliminary evidence of the benefits of parenting co-ordination both for families and the courts (Brophy et al., 2020; Henry et al., 2009; Higuchi & Lally, 2014; Scott et al., 2010).

Access to Justice

Divorce can be expensive, and legal fees are out of reach for many low- and middle-income parents. Many parents self-represent, requiring them to face arcane rules, processes, and deadlines. In most Canadian jurisdictions, there are at two levels of court where a separating partner can initiate a court action.[2] The less formal and more accessible provincial or territorial courts (presided over by provincial or territorial appointees) are permitted to rule on the division of property, financial support applications, and parenting for all separating parents (married or not), but are not permitted to grant divorces. Superior courts (presided over by federal appointees), which have stricter processes and deadlines, only differ in jurisdiction in their authority to grant divorces. Some separating parents are confused about where to initiate a court proceeding. Moreover, Canada currently experiences a shortage of judges, particularly at the superior court level, leading to long waiting lists and crowded court dockets (Leblanc, 2023; Pritchett, 2018).

To address these issues, six provinces (Manitoba, Newfoundland, New Brunswick, Nova Scotia, Prince Edward Island, Ontario, and Saskatchewan) have adopted unified family courts (UFCs) that deal with all family law matters (Canadian Forum on Civil Justice, 2002; Department of Justice Canada, 2018; Ross, 1998). These courts provide greater access and simplified processes and reduce overlapping jurisdiction. In addition to UFCs, the chief justice of the Supreme Court of Canada established the Action Committee on Access to Justice in Civil and Family Matters (ACAJCFM, 2012), which identified several strategies for improving access to justice for family law clients. Reform is moving slowly; however, the blueprint for increasing access to justice has been developed (Federation of Law Societies of Canada, 2019).

Service Fragmentation

How do psychological services fit in? In addition to the confusion and complexity that parents sometimes experience navigating two levels of court, there are a diversity of dispute resolution and therapeutic services—both publicly and privately funded—with little co-ordination among them. Psychologists working in organizations may be accustomed to being able to liaise with a designated case manager, as found in entities like the child protection system, hospitals, residential treatment, or disability management services. The case manager co-ordinates services based on awareness of the needs of various individuals, avoids duplication, and supports complementarity and interdisciplinary practice. However, this kind of co-ordination seldom happens in family law matters. In some jurisdictions, judges can decide to hear all the applications involving a family prior to a trial. There may be several therapeutic and dispute resolution professionals involved (e.g., a mediator, PC, or child therapist) that have been jointly retained by the parents. Other professionals (e.g., a psychologist assessing a parent's risk for substance misuse, interpersonal violence, etc.; or a parent's individual therapist) may be working to help one of the parents, possibly also to support the client's position in litigation (Canadian Forum on Civil Justice, 2002; Department of Justice Canada, 2018). A judge may manage legal issues, but there is typically no neutral co-ordinator with an eye on the psychosocial health of the whole family.

To remedy this, some jurisdictions have adopted a publicly funded triage model (Manitoba Family Law Reform Committee, 2018; Salem, 2009) aimed at referring separating parents to appropriate services upon their first contact with court. In this way, high-conflict cases can be referred immediately to more comprehensive services such as risk assessment, bilateral evaluation, or direct court involvement.

Appropriation of Psychological Constructs

"A little learning is a dang'rous thing" (Pope, 1709, Part II). Psychological constructs such as attachment, diagnostic categories, parental alienation, parenting capacity, personality, risk of violence, and many others have found their way into family law discourse. Some of these constructs are better established in the psychological literature than others. Here are a few examples.

ATTACHMENT

Attachment (Ainsworth & Wittig, 1969; Bowlby, 1969) is a well-established construct with a strong research base and contemporary clinical applications in child psychotherapy (e.g., Aktar, 2012; Baylin & Hughes, 2016; Booth & Jernberg, 2010; Oppenheim & Goldsmith, 2007). Unfortunately, in litigation, a parent may be motivated to demonstrate their child's attachment to them is "better" than their attachment to the other parent. When Jeff has testified, lawyers have asked him if a child "is attached" to a parent, whether attachment to the parent they are representing is "secure," and whether attachment to the other parenting is "anxious" or "insecure." These questions are based usually on a very simplistic understanding of these constructs.

RISK OF PHYSICAL VIOLENCE

Another example of appropriation of psychological constructs relates to the assessment of the risk of interpersonal violence, which is a serious, but low base-rate behaviour. Of course, the presence of risk factors for physical violence increases the statistical probability that an individual will commit a violent act. Several times, Jeff has been examined by lawyers seeking to suggest that the opposing client will "probably" commit violence. Few lawyers and fewer lay people understand that just because one's risk of violence is higher than in the general population, this does not make violence certain, or even likely. If a psychologist does not understand the actuarial basis of risk factors and risk assessment, they run the risk of accepting a cross-examining lawyer's overly simplistic proposition and misrepresenting psychological data (Harris & Rice, 2007).

PARENTAL ALIENATION

Although attachment and risk assessment have well-established research foundations, the constructs of "parental alienation" and "parental alienation syndrome" do not. Gardner (1998, p. 9), who coined the term, states:

> The *parental alienation syndrome* (PAS) is a disorder that arises primarily in the context of child custody disputes. Its primary manifestation is the child's campaign of denigration against a parent, [which] has no justification. It results from the *combination* of a programming (brainwashing) parent's indoctrinations and the child's own contributions to the vilification of the target parent [Italics in original].

Although there are situations when parents actively denigrate the other parent and a child refuses contact with them, PAS as a syndrome is not empirically supported. However, the concept of PAS has pushed researchers and clinicians to develop more nuanced conceptualizations about children who decline contact with one parent. The concept of parental alienation is now generally thought to be an oversimplification that overlooks systemic and contextual factors (Clemente & Padilla-Racero, 2016; Dallam & Silberg, 2016; Johnston & Sullivan, 2020; Katz, 2003; O'Donohue et al., 2016). There are now coherent models (Kelly & Johnson, 2001; Polak & Saini, 2015; Sullivan et al., 2023) to explain children's refusal of contact with a parent and to guide intervention.

Unfortunately, the questionable construct of parental alienation has found its way into popular culture. We both have seen many parents who assert that they have been the target of parental alienation when their children challenge their authority, or when they and their children experience conflict. For some, the construct of parental alienation is a way to externalize blame for their own possible mistakes in parenting their child.

DIAGNOSES

As a final example of the appropriation and oversimplification of psychological constructs, Jeff provides a personal anecdote. As he was in court waiting to give evidence, the judge paused the proceedings to deal briefly with a seemingly routine matter. Lawyers for the director of Child Welfare and for a mother had agreed that she had made sufficient progress for her young daughter to be returned home. In turn, the lawyers asked the judge to replace the Temporary Guardianship Order with a Supervision Order, which would permit Children's Services to return the child home but require the mother to comply with the case plan. The judge replied, "Just wait right here. This mother has been diagnosed with borderline personality disorder. The only effective treatment for that is Dialectical Behaviour Therapy, and it takes a minimum of 18 months. I'm not returning this little girl until that's been done." Although the judge clearly had the power to accept or reject the joint request of counsel, and it was admirable that he (Jeff assumes) had attended training to learn about clinical issues and practices he might encounter as a family court judge, he effectively was acting as his own expert witness in this case. His oversimplified knowledge led to further separation of the child from her mother.

Regulatory Risk to Psychologists and the Resulting Competence Gap

Because of the high-stakes nature of services related to separation and divorce, psychologists doing this work experience more complaints against them than psychologists in other areas of practice. A parent who already feels wounded by marital dissolution and aggrieved by the other parent's conduct, and who ends up with less parenting time after a psychologist has been involved in some way, may blame the psychologist. They may believe the psychologist was biased, incompetent, or both, and may complain to the psychologist's regulatory board (Bow et al., 2010). Bow and Quinnell (2001) found that 35% of 198 psychologists doing child custody evaluations had received at least one regulatory complaint, and 10% had been sued for malpractice. Kirkland and Kirkland (2001) surveyed the 61 members of the Association of State and Provincial Psychology Boards (ASPPB). The 34 regulatory bodies that responded to the study received 2,413 complaints pertaining to child custody issues, with 27 (1.1%) finding that the psychologist's practice was inadequate. One author has even suggested that custody evaluators be given immunity from regulatory complaints (Koller, 2005).

The Canadian context is similar. Between April 2022, when the College of Alberta Psychologists began to publish hearing tribunal decisions on their website, and January 2024, 3 out of 6 decisions describe psychologists' misconduct in high-conflict parenting matters. The annual reports of the College of Psychologists of Ontario (CPO) between 2007–2008 and 2016–2017 indicate that 16 out of 53 (30.18%) complaints originated in custody/access and child protection work. In Saskatchewan between 2005 and 2018, 30% (6 out of 20) of reported findings of fault by psychologists originated in child custody work (Saskatchewan College of Psychologists, 2018). Encouragingly, CPO's annual reports indicate a steady decline from the 2007–2008 peak, with only three out of 83 complaints (3.61%) in 2017–2018 concerning custody-access and child protection work. However, overall, the data seem to indicate that, despite being only a tiny proportion of psychological services delivered, practice with families in high-conflict divorces draws a disproportionate number of complaints.

It is not surprising that practitioners seem to be repelled by this work. For instance, Jeff recently taught a workshop on family therapy with high-conflict post-separation families. One of the participants, the director of a rural child and adolescent mental health clinic, told him that she had offered to bring two of her staff to the workshop. She offered to cover travel to a major urban centre (with much better shopping!), two nights of accommodation and meals, and (hopefully) useful training. Both the staff members to whom she made the offer declined, stating, "If we take this training, you will make us work with these families." We also have heard of situations in which child and family therapists have withdrawn their services from children because the parents' conflict was too difficult for them to manage, thereby depriving children of services when they are likely to need them the most.

The work seems to elicit anxiety and repel even experienced psychologists. With a small pool of experienced practitioners, the pool of potential supervisors competent to work with high-conflict divorcing families is also small. This is highly problematic, given that supervisors are required to be competent to do the work their supervisees are doing (APA, 2014; ASPPB, 2015; Council for the Accreditation of Counseling and Related Education Programs, 2011; CPA, 2009). Anecdotally, it seems that supervision in this area is often "the blind leading the blind" (Chang, 2018), leading to a competence gap and exacerbating the shortage of needed services.

Personal Efforts to Honour Principle IV (Responsibility to Society)

The factors we have just described help explain some of our earlier comments about the strong need for support and the feeling of being a cog in the system. Given that the systemic barriers fuel, and are fuelled by, societal-level problems, we find it helpful to frame our experiences through the *Code*'s Principle IV. This assists us in recognizing what we have accomplished, gives us the confidence to persist, and helps us prioritize where and how to focus our personal efforts and support the initiatives of the psychology community. System change is required.

Principle IV (Responsibility to Society) (CPA, 2017) calls on psychologists to add to the knowledge base of psychology and promote the welfare of all. Individually and collectively, we have an ethical responsibility to support the appropriate application of psychological knowledge to social policies and initiatives, and to do so toward "just and beneficial purposes . . . [reflecting] respect for the dignity of persons and peoples, responsible caring, integrity in relationships, and responsibility to society" (Values Statement, para 4).

We do not believe that those who work in the family justice system are intentionally eroding respect for the dignity of persons and peoples, responsible caring, integrity in relationships, or responsibility to society. Lawyers, judges, and other professionals are doing their best to advance the welfare of clients within a system that is flawed. The system serves most divorcing families adequately. But we believe that the barriers we describe above constrain the system, resulting in poor outcomes for the 5 to 10% of separations considered high conflict. Below we describe some of the activities we have engaged in that we believe support the five values of Principle IV.

Development of Knowledge

Under Principle IV, the value *Development of knowledge* urges psychologists to contribute to the generation, transfer, and mobilization of knowledge, and to keep abreast of new developments in the field. How have we been doing this? In our work together as researcher and research supervisor, we recently completed a second research study on a program called *New Ways for Families®* (NWFF). This program is "a structured parenting skills method intended to reduce the impact of conflict on the children in potentially high-conflict divorce" (Eddy, 2019). Nicole presented preliminary results of this research in June 2018 (Lipp et al., 2018) at the conference of the Association of Family and Conciliation Courts, which is an international organization of lawyers, judges, and mental health professionals. This enabled Nicole to connect with the larger community, see the potential of system advocacy, and sample the broad range of scholarly work in the field. Jeff is currently conducting a controlled effectiveness study of NWFF. Control-group data will be made available to researchers who wish to use the same dependent measures. In addition to generating conference presentations, publications, and a completed thesis, we have found that our relationship supports our mutual interests and spurs us to further develop knowledge about high-conflict divorce.

As another example of the development of knowledge, in 2016, Jeff and a colleague served as guest editors of a special issue of the *Canadian Journal of Counselling and Psychotherapy* on counselling interventions in divorce (Chang & Kier, 2016). Included were three articles that dealt specifically with high-conflict parenting situations (Amundson & Lux, 2016; Chang, 2016; Rauh et al., 2016). As editors, we provided students and colleagues with opportunities to collaborate and contribute, and to enhance their engagement in work in the high-conflict divorce arena. In addition to this special issue, Jeff has manuscripts in preparation on such topics such as NWFF, clinical supervision of therapists working with high-conflict families, and a model of family intervention when children or adolescents experience mental health problems exacerbated by parents' conflict.

Still another example is that, in 2018–2019 and 2019–2020, staff and students at the Calgary Family Therapy Centre (CFTC), where Jeff works as a part-time consultant, focused on families considered high-conflict, using an approach called *Research as Daily Practice* (St. George et al., 2015). As a team, the staff and students discussed particular families, their emotional and clinical responses to them, distinguished commonalities, documented their conversations, and repeated the process every four to six weeks for two years. One team member suggested that it might be more useful to think of high-conflict co-parents as "high-discrepancy," meaning that parents saw the situation very differently, but in a way that made sense to them. In Jeff's view, this reframing in the context of supportive collegial and supervisory relationships contributed to a striking development: Practicum students in clinical social work and counselling psychology (and the whole staff for that matter) became more curious about high-conflict separating families than fearful of them. The CFTC team developed a community of practice and a community of inquiry simultaneously (Ethical Standards IV.1, IV.2, and IV.3)—a contribution to closing the "the vast cultural chasm of research and practice" (Imber-Black, 2011, p. 1).

Beneficial Activities

Psychologists can support the value of *Beneficial activities* under Principle IV by contributing to the growth of others both within and outside the discipline of psychology. This includes supporting students to understand their ethical obligations, helping to ensure that the discipline of psychology contributes to the betterment of society, and emphasizing the importance of being personally accountable for one's practice and professional activities. As one example of trying to do this, Jeff has engaged in several activities that support community capacity in working with high-conflict separation, divorce, and parenting. These have included consultation with individuals and organizations about how they can respond to post-separation high-conflict parents. Also, as a research supervisor, Jeff was thrilled to support Nicole to connect with her co-presenters, the developer, and two experienced practitioners of *New Ways for Families*®. He also has presented at conferences and workshops, where audiences seem hungry for guidance on the topic of high-conflict separation and divorce (Ethical Standard IV.4). In addition, as Jeff particularly enjoys clinical supervision, he has accepted many requests to consult to other clinical supervisors whose supervisees are working with high-conflict parenting cases (Ethical Standard IV.5 and IV.10). He also has consulted with and trained school division staff about how to support students whose parents are embroiled in high-conflict co-parenting, and with counselling agencies on how to manage the intake process and clinical work.

In all of his work related to the value of *Beneficial activities*, whether as a consultant, workshop presenter, teacher, or expert witness, Jeff does everything he can to ensure that the psychological principles on which he bases his work are represented accurately, and with sufficient nuance, so as not to be misunderstood (Ethical Standard IV.11). He takes particular care with this when acting as an expert witness, given that a judge may make decisions that affect the lives of children and parents largely based on his evidence.

Respect for Society

Under the value of *Respect for society* of Principle IV, psychologists have an ethical responsibility to understand and join with the organizations with which they work, respect pre-existing history, customs, and rules, and be accountable to the communities they serve. During the time that Jeff has been providing psychological services in the family law arena, he has tried to honour this value by working to understand the particular culture of the family court system. He has developed strong professional relationships with many family lawyers and judges. Although he does not relish being cross-examined, he accepts it as the way in which our common law legal system finds the "truth." Above, we noted the tendency of those in the legal system to appropriate and misuse psychological constructs, put forth their positions as counterarguments for the opposing party's positions, and select only the part of the narrative that benefits their client (Ethical Standards IV.15, IV.16). As a consultant and a trainer, Jeff strives to orient others to these aspects of the legal system, so they too can carry out the aspirations of the *Code* (Ethical Standards IV.17, IV.18).

Development of Society

Ethical Standard IV.19, under the value of *Development of society*, urges psychologists to "act to change those aspects of the discipline of psychology that detract from just and beneficial societal changes, where appropriate and possible." In our view, psychology and other mental health professions are essential to the operation of the family justice system. Psychologists and other mental health practitioners possess competencies that can help children heal, and help parents reduce conflict and make effective joint decisions on behalf of their children. Furthermore, as evaluators, psychologists also can provide valuable evidence to judges.

However, we both have seen instances in which high quality psychological services are not deployed optimally. Because of service fragmentation, parents often are not referred for services quickly enough. Given our inherently adversarial legal system, the parents must agree to dispute resolution or evaluation services unless they have been ordered by the court to participate in these services. Jeff has seen many times when "the system"[3] responded too slowly to obtain psychological services for families in dire need, providing time for conflict to develop and fester. Some jurisdictions have remedied this by mandating triage, in which parents are required to meet with a counsellor or mediator before their matter can proceed to court.

Another issue is cost. The hourly fees for specialized assessment services can be 50 to 100% higher than therapy fees. A "voice-of-the-child assessment" (Chang, 2016), designed to ascertain a child's "true" sentiments about their situation insulated from their parents' influence, can take 20 hours, including report-writing time. A bilateral parenting evaluation, in which parents, the children, and their relationships, are assessed (Chang, 2016) can use between 50 and 60 hours, including report writing. This is cost-prohibitive for many people. In order to provide services that are timely and affordable, significant reform would be necessary to fund services and arrange them so that a co-ordinator mandated by the court would screen and direct parents into appropriate services.

What can we, as individual psychologists, or as a community of psychologists, do to alleviate this? When possible, we both have participated in initiatives to try to enhance the system. As just one example, after defending her thesis, Nicole contributed to developing a community of practitioners in Vernon, BC, to discuss how to better serve families experiencing high-conflict separation. As another example, Jeff accepted an invitation to participate in *Reforming the Family Justice System*, an initiative led by the Court of King's Bench of Alberta, Alberta Justice, and the Law Society of Alberta. The potential reforms being discussed could address many of the barriers we identify above, namely, early dispute resolution, parent and family education, research and evaluation regarding the operation of the family justice system, legal education, enhanced access to legal advice, and streamlined court processes. Whenever involved in this and other initiatives (Ethical Standard IV.19), Jeff has striven to present psychological knowledge and its limitations accurately. When advocating for psychological services, he strives to: (a) draw from his knowledge of the context and history of psychological services in the family law arena in Calgary and province-wide (Ethical Standard IV.20); (b) maintain current knowledge (Ethical Standard IV.21); and (c) keep abreast of how the field is developing (Ethical Standard IV.24). However, in his systems advocacy (Ethical Standard IV.22), he also is careful to acknowledge the limitations of psychological knowledge (Ethical Standard IV.23) and takes care to speak out if he thinks the knowledge is being misunderstood or misused in the development of social policies and practices that discriminate against or could harm marginalized populations. (Ethical Standard IV.25).

Extended Responsibility

Nicole is advocating for the development of services in her community. As a senior psychologist in his community working with high-conflict families, Jeff supports other mental health practitioners and lawyers in their efforts to exercise responsibility to society by inviting them to collaborate on the design and delivery of more, and more affordable, intervention services. Jeff recognizes his responsibility to urge his research and clinical supervisees to serve society by developing services, donating his time, and striving to be an example in this regard.

A Call to Action

Although at opposite ends of our career paths, we are both passionate about providing and improving counselling and psychological services and about contributing to system change for families experiencing high-conflict divorce. We are both looking ahead. Now that Nicole has completed her master's degree, she is taking her knowledge forward into a community counselling agency and advocating for change in the Okanagan Valley of British Columbia. Jeff looks forward to better using the platform provided by a faculty position to help build community capacity, enhance the competence of others, and advocate for system change.

We both strongly believe that psychologists and other mental health practitioners have a great deal to offer the family justice system. With psychology's knowledge of family dynamics, mental disorders, child development, conflict and conflict resolution, methods of behavioural change and emotional healing, and many other relevant areas, psychology has much to contribute. In fact, we believe it is not an exaggeration to say psychologists and allied mental health professionals are indispensable. Yet, the family justice system presents a number of barriers that make navigating the system difficult for clients and creates less than optimal conditions for delivering effective psychological services.

In this chapter, we have situated ourselves in terms of Rønnestad and Skovholt's (2003) phases of counsellor development, outlined the critical practice area of high-conflict separation, divorce, and co-parenting, and described its toll on children. We described some of the barriers to the optimal delivery of psychological services in the family justice system (including our concern about the competence gap in the field for working within the context of high-conflict separation and divorce) and described our current thoughts and efforts regarding upholding the principle of *Responsibility to Society.* We recognize that not everyone will be as passionate about these issues as we are. We hope that reading this chapter might inspire you to provide some services or help back community initiatives that will alleviate the suffering of children, adolescents, and adults experiencing high-conflict divorce.

Questions for Reflection

1. Drawing from your own experience or that of someone close to you, reflect on what parents and children need to navigate a divorce. What gaps are there in your home community for helping parents and children to meet these needs? What would have to happen to fill these gaps? Who would have to take action?
2. Do an internet search on available resources for children and adults experiencing divorce in your community. What are they? How would you integrate these into your practice?
3. Imagine you are interested in specializing in high-conflict divorce. Examine the practice guidelines developed by the Association of Family and Conciliation Courts (https://www.afccnet.org/Resource-Center/Practice-Guidelines-and-Standards). Based on these guidelines, how might you plan for your professional development?
4. Summarize your personal values about divorce and post-divorce parenting. What key influences or experiences shaped your values? How might these values influence your work with divorcing families?

NOTES

1 In this chapter, we use the term "high-conflict divorce" to describe highly conflictual interactions that may include protracted or recurrent litigation, irrespective of whether the former couple had been legally married or not.

2 These have different names in different jurisdictions. For example, in British Columbia, the lower court is called the Provincial Court, in Alberta it is called the Alberta Court of Justice, and in Ontario it is called the Ontario Court of Justice. The superior courts, all with the same basic jurisdiction, are called the Supreme Court of British Columbia (which is not in fact "supreme" given that it is subordinate to the British Columbia Court of Appeals), the Court of King's Bench of Alberta, and the Ontario Superior Court of Justice.

3 Jeff cannot think of a better way to identify the "culprit." This has happened when "everybody had been doing their job" appropriately. Over-scheduled court calendars and busy lawyers, exhaustion of financial resources, and filing deadlines are all part of "the system" that often lets families down—which is the very point of this chapter.

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14

Teamwork Required: Supporting First-Responding Organizations to Become Emotionally and Psychologically Safe Workplaces

Shelley L. Goodwin, M. A. Suzie Bisson, Heather C. Power, Karen White

When reflecting on the career paths you thought about or tried out in your life, what made you decide to choose one occupation over another? When pondering the options, did you seriously consider the possibility that a particular career might lead you to develop a mental health condition? Did you reflect on the possibility that the work environment and its impact on you might eventually lead you to change career trajectory? If you did consider those factors, how much weight did they have in your final decision to pursue (or not) this career? Witnessing violence or the results of violence is part of what first responders do when they report for duty every day and this increases the risk of developing mental health difficulties (Setlack et al., 2020). Understanding this often-ignored career side effect and looking at viable ways to help those on whom we rely during a crisis is what we want to explore in this chapter.

The writing of this chapter is motivated by Principle IV (Responsibility to Society) of the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association [CPA], 2017). This principle speaks to us because it advocates for the development of structures and policies that actively incorporate Principle I (Respect for the Dignity of Persons and Peoples), Principle II (Responsible Caring), and Principle III (Integrity in Relationships) (CPA, 2017). This principle also speaks to us because it recognizes that, for changes to take place, active engagement and collaboration between multiple levels of society and within organizations are essential (CPA, 2017). Our own experiences, when combined with listening to the employment experiences of our clients, family members, and friends, and the recent world events as we write this chapter in the summer of

2020, impel us to add our voices to the need for improving the quality of people's experiences within organizations. Our experiences also motivate us to suggest that organizations can benefit greatly from inviting and collaborating with outside supports that can help improve employees' experiences. In addition to advocacy, we hope that this chapter will encourage readers to reach out, collaborate, and partner with organizations for the purpose of supporting the development and active implementation of policies that focus on fostering an organizational approach where all employees feel respected, physically and emotionally safe, supported, and appreciated. Furthermore, we hope that this chapter will encourage people to speak up and recognize that their voice matters.

Who Are We and Why Is This Chapter Important to Us?

Shelley: After seeing the Royal Canadian Mounted Police (RCMP) Musical Ride perform, my naïve 12-year-old heart was set: I would join the RCMP and ride horses for a career. Five years after joining the RCMP, I was accepted into the Musical Ride and spent three and a half years riding the famed black horses touring North America. During tour (which usually lasted five to six months a year), I realized that I enjoyed helping my peers through challenges related to our being away from our families for extended periods of time. This inspired me to join the RCMP employee assistance program when I transferred off the Ride and moved to the British Columbia (BC) Lower Mainland. Several years later, a retirement offer and graduate school acceptance (within five days of each other!) opened the door to my current career as a psychologist. Today, I have a rural-based private practice where I work primarily with first responders from policing, corrections, paramedicine, active military personnel, and veterans' sectors. My family believes in service to the community and country. For example, my dad was a WWII veteran who lied about his age (15) to serve overseas, while my husband is a former RCMP police dispatcher. Serving those who serve or have served is a firmly ingrained quality and privilege for me. Understanding the risk associated with serving is a daily part of my life, as both my husband and I have been diagnosed with post-traumatic stress disorder (PTSD) related to our police service. However, post-traumatic growth is also equally part of my life.

Suzie: When I joined the military at the age of 17, I was completely ignorant of the possibility that serving one's country could have a detrimental impact on a person's mental health. At that time, the Canadian military was renowned for its peacekeeping role—a reputation earned as a result of its participation in a number of the United Nations' directed missions (Pocuch, 2019). As the years went by, my naïvety started to be replaced by a more realistic understanding of the impact certain work environments can have on a person's mental health. I eventually left the military and became a counselling psychologist with a primary focus on providing mental health services to people impacted by trauma. Through my work, I have spoken with active military members, Canadian veterans, and people who have served their country of origin as members of the military before immigrating to Canada. I recognize some of the struggles they face; I have seen these same struggles in my colleagues returning from overseas missions, including from Rwanda, Somalia, Bosnia-Herzegovina, and Iraq, among others. As a veteran, being part of the writing process of this chapter was important to me. Military members play an important role in Canadian society and like that of first responders, the nature of their work is unique. Meeting their mental health needs through prevention, timely interventions, and advocacy is a necessity.

Karen: I started my firefighting career with five other amazing women in the fire service at a time when women were just starting to enter the fire service. Shelley and I worked together in Richmond, BC, and we spent many night shifts discussing the challenges of being a woman in a non-traditional career, and the challenges of the first-responder culture both in policing and firefighting. I loved the thrill of responding to calls and the opportunity to push my physical abilities. I was raised in a family where my father, who was a construction superintendent in Vancouver, never differentiated people based on their gender. He saw people as capable or not capable, hard working or not. I worked for 5 years at Vancouver International Airport Fire Rescue Services and 10 years at Richmond Fire Rescue Department. The challenging environment helped me to see that I wanted to help other first responders. While working full time, I completed my undergraduate degree at Simon Fraser University in their Leadership Development Program for Justice and Safety Professionals. I then pursued my graduate studies at Royal Roads University in their Leadership and Training in Public Safety master's degree program. I am now pursing my Bachelor of Social work degree at Dalhousie University. Currently, I am employed at the North Vancouver RCMP Crisis Intervention Unit/Victim Services and have spent the last ten years working in crisis intervention. My commitment to promoting ethical, accessible, and relevant mental health services drives my desire to be part of this writing team. My life partner is also a firefighter; so, on many levels, this work is personal to me and I am passionate about it.

Heather: I began my career as a psychologist with a particular interest in learning more about the underpinnings of "abnormal behaviour." I wanted to know why some individuals experience mental illness and others do not. What protects some individuals, and not others? Through my work as a psychologist treating individuals experiencing a variety of mental health challenges in their lives, it has become increasingly apparent to me that "abnormal behaviour" is often, in fact, quite normal when you consider the particular context of each person's individual experiences. I have treated first responders who question why they have developed mental health symptoms and who judge themselves harshly for this. In my experience, it is when individuals begin to see that their symptoms actually make sense based on what has happened to them that they can accept their conditions and begin the process of healing. I feel privileged to be able to help other helpers who contribute to the well-being of so many people and to our society as a whole.

In this chapter, we use our experiences working in organizations recognized for their first-responding activities to advocate for more intentional collaboration (i.e., prevention and intervention) between mental health providers and first-responding organizations. We also chose to include publicly known stories available through open sources to highlight common threads among first responders' experiences. Speaking up can be both rewarding and challenging. Speaking up can also lead to unintended and disempowering repercussions. In writing this chapter, we seek to be a voice for those who are not yet ready to use their own.

Who Are the First Responders?

A significant portion of first responders' work consists of resolving situations that involve time pressure—sensitive situations where information is quickly changing, and where there is a possibility that people can get hurt or die. According to the Mental Health Commission of Canada (MHCC), first-responder occupations include firefighters, paramedics, police officers, border services officers, corrections personnel, emergency dispatchers, public safety officers, and emergency response managers (Kirschman et al., 2014; MHCC, n.d.). In addition to these professions, we chose to include military personnel based on their peacekeeping and combat responsibilities; their medical, rescue, and civic emergency response responsibilities (e.g., responding to large-scale fires, flooding, pandemics, and ice storms); and the similarity of the organizational structure to those of the other occupations listed above.

Organizational Structure, Culture, and Mental Health Stigma

To be able to do their work effectively, first-responding organizations tend to have an organizational structure that enforces a predominantly top-down approach whereby personnel need to follow relatively strict chains of command and processes, and where teamwork is essential. The personnel's level of influence on the organization's goal-setting and decision-making processes is based on each person's hierarchical position. This type of structure helps to bring consistency and predictability when responding to unpredictable, emotionally charged, and dangerous situations.

The mindset of the organization as it relates to mental health influences the extent to which the staff is comfortable openly expressing and accessing support for their mental health struggles. This influence is further compounded by the person's own perspective on mental health and how they think that expressing their struggles might influence their career. For instance, some military members choose to not seek support even though they are aware that they might be suffering from post-traumatic stress (S. Bisson, personal communication, December 2018). From their perspective, trying to avoid receiving a PTSD diagnosis, for instance, makes sense, because such a diagnosis might limit their chance for promotion, undermine their ability to serve, redirect their career trajectory (e.g., a member working in a combat unit might be redirected to a non-combat occupation and/or medically released from the organization), and/or alter their sense of identity. In work environments where teamwork and mental toughness are crucial, a team may not want to work with a member struggling with mental health issues (e.g., a person suffering from flashbacks) out of concern it might endanger the safety of the rest of the team. In organizations such as the military, where everyone has something in common with everyone else, (e.g., boot camp experiences, common acquaintances, a uniform, and a shared identity), being able to fit in and demonstrate one's value to the team is viewed as highly preferable. This tendency to avoid or even deny mental health issues reduces the chances of being teased, harassed, bullied, and/or left out. Therefore, keeping one's mental health struggles hidden as long as possible is, at times, perilously viewed as the best option.

In addition to their uniform, first responders have a distinct culture (Jones, 1995; Kirschman, 1997). This includes a language that involves frequent use of acronyms and calling each other "my brother or sister in uniform" to differentiate them from the siblings in their family of origin. Similarly, the nature of first responding is such that people working as different kinds of first responders tend to know one another (e.g., police officers, paramedics, and firefighters may respond to the same call). This is how Shelley (RCMP officer) and Karen (firefighter) became friends. As a result, first responders tend to form a community with strong connections, including making time to socialize together outside of work. They tend to welcome other first responders more easily than those from outside the first-responder world. As such, when those who are not first responders attempt to become part of the conversation, they can be left behind and excluded (Kirschman et al., 2014). Often, the explanation for sticking together is "they get me," which brings a perceived inherent sense of safety and security. "Having each other's back" is a life-or-death belief that is indoctrinated into each person during training. It is this loyalty and belief that carries a protective element, but that also can be distressing when there are "real and perceived breaches in these relationships" (Whelan, 2016, p. 13). For example, if those relationships are impacted such as when someone experiences a mental health difficulty and they are excluded or feel excluded from the group, the impact of that exclusion and isolation can be that much more difficult.

Not only do first responders have their own language, their perspective on life is also culturally specific and constantly reinforced by their work experiences. Being part of a first-responder organization is unlike any other experience. This is why retirement for military members, for instance, and adjustment back to civilian life can be so challenging (Cathcart, 2017). Being part of a first-responding organization also makes it easier to recognize one another (e.g., after retirement or when dressed in civilian clothes), even though we never met before. For example, Suzie and Shelley have experienced recognizing former military members and first responders because of their footwear. Regardless of the weather, their shoes/boots almost always meet the military's standard for shininess!

Recognizing that mental health stigma continues to be prevalent in first-responding organizations and that it often prevents many from seeking help (Chapman, et al., 2014) is important. Understanding why first responders and military members are reticent to trust a mental health professional is imperative. They tend to see a mental health professional primarily as part of the hiring process, when involved in critical incidents, before and/or after deployments, and for fitness-for-duty evaluations. These are circumstances under which, if they are not performing well, their careers may be at risk. This leads to the perception of needing to be cautious and at times suspicious around mental health professionals.

Health services for military members, for instance, are paid for by the federal government and are provided by military personnel (e.g., physicians, dentists, psychiatrists, social workers) or contracted civilians (e.g., psychologists). For example, psychosocial support is provided by military social workers, addiction counsellors, and nurses, and does not require a referral from a military physician (Jetly, 2018). To access the services of a psychologist or a psychiatrist however, a military member must obtain a medical referral from a military physician (Jetly, 2018). There may be times when a military member independently seeks the support of a mental health professional who is not connected with the military. When this occurs, military members are responsible for the costs of the visits (by virtue of being attached to the federal government, they do not have a provincial health care card) and need to use their own time (i.e., not during work hours).

Another important source of mental health support for military members comes from military chaplains. Sharing one's concerns with a chaplain can be viewed as a less intimidating and a first step towards obtaining needed mental health support. Military chaplains can be found on every military base and are responsible for the pastoral and spiritual care of military members and their families. Military chaplains are soldiers with officer rankings who understand the culture and the lifestyle. They are regularly sent abroad to connect with Canadian troops, especially during critical incidents. They are often the ones who inform a soldier's next of kin when critical injuries or a death has occurred. While some chaplains have extensive training in psychology, they are not required to have it. When needed, they can refer military members to a military social worker or a military physician for additional support. There are also times when a military chaplain will receive a referral to support a military member (Jetly, 2018). This happens, for instance, when spiritual care is needed to address the impact of trauma that has injured a person at a soul level (psychotherapy is helpful with cognitions and emotions but there are times when the psychological injury impacts a service member at a much deeper level than the mind and heart).

What is important for mental health therapists to understand is that in addition to the nature of the first responders' and military members' profession, the system in which they work also influences the manner in which mental health services are sought and received. This includes understanding that their work is unlike what is often portrayed in the media, television shows, or movies. It also includes an ability to support the individuality of first responders within a culture that promotes unity. It is necessary to understand that first responders frequently come into contact with mental health clinicians only when there has been a critical incident or when they are being investigated for fitness for duty, and that these factors increase their suspiciousness (Bohl, 1995). When mental health professionals are too curious about calls, too judgemental of their actions, too distressed by gory details, or ask too many questions that are perceived as irrelevant, first responders are less likely to trust them. If the initial contact with a mental health professional does not go well, the first responder may quickly close the door to any further contact. According to Kirschman, Kamena, and Fay (2014), it is difficult for first responders to seek help and takes "very little to turn them off" (p. 5). Kirshman et al. go on to state that the single most noted error clinicians tend to make when working with this employment group is not understanding what first responders do, "why they do it, and the culture in which they operate" (p.5). Finally, they also note that those who work with police (i.e., uniformed officers and contracted civilians in supporting roles such as dispatchers and surveillance monitoring) are "entering a closed culture with high levels of distrust for outsiders" (p. 5). Furthermore, first responders are trained to assess situations quickly, identify the influencers, and follow their intuition regarding people's actions and intentions. Their training becomes the foundation upon which they live life. Accordingly, they tend to be as proficient as the mental health professionals at reading verbal and nonverbal messages. They may be able to assess the mental health professional before the first two questions have been asked. Their opinions are formed quickly, and decisions are made quickly and decisively, with rarely an opportunity for a second chance (Jones, 1995; Kirschman et al., 2014; Wester & Lyubelsky, 2005). "Cops have 'shit detectors' that are miles wide; it's what keeps them safe. They are trained and rewarded to look for what is wrong or out of place before they look for what is right or good . . . Reading people is their stock in trade" (Kirschman et al., 2014, pp. 14–15). This becomes relevant from the very first moment you meet a first responder because "from the minute you open your office door they'll be sizing you up, looking to see if they can trust you, if you can tolerate what they have to say" (pp.14–15). In fact, Shelley would argue this evaluation is occurring when they call to arrange an appointment for mental health services. If there is no trust, quite simply, there is no second session. Moreover, by virtue of being a relatively tight-knit community, first responders may share with their colleagues their experience with a mental health professional. This can impact the manner in which subsequent first responders present themselves to that professional. Needless to say, understanding this is key for those who wish to work successfully with first responders.

Changing the Culture and the Stigma

Over the last decade or so, evidence of the extent of mental health challenges faced by first responders has grown rapidly, and many are speaking out collectively. Nicholas Hennink, a Moose Jaw (Saskatchewan) paramedic with 16 years of experience who struggles with PTSD, started *Project Warrior* in an effort to reduce the mental health stigma that impacts first responders (Canadian Broadcasting Corporation [CBC], 2018, December 23). After 35 years of service, a recently retired firefighter, Cammie Laird from Clearwater County, Alberta, is advocating for more provincially funded mental health support for first responders (CBC, 2019, January 5). Dave McLellan, an Ontario police officer with 30 years of experience, created *Boots on the Ground*, a mental health help line for first responders, as a result of seeing too many of his colleagues suffer (CBC, 2018, December 2). Ontario chief coroner Dr. Dirk Huyer reported that nine police officers died by suicide in 2018, and he sought to assemble a team for the purpose of understanding what is happening and offering recommendations that would support police officers' mental health (CBC, 2019, January 4). Retired Senator and General Roméo Dallaire is widely recognized for having spoken openly about his mental health struggles as a result of his United Nations mission during the genocide in Rwanda. He has advocated tirelessly for more mental health support being made readily available to military members. The spouses and parents of military members also are speaking out and asking for support to help them learn about mental health so that they, in turn, can help their loved ones (e.g., CBC, 2014, March 4, 2014). These are just a few examples of people using their voices to influence change.

Using Our Voices to Affect Women's Experiences

Originally, first-responding organizations were comprised exclusively of men. In the 1970s, this slowly began to change. The RCMP began to accept women into their ranks in 1974 and by 2016 women made up 21.6% of personnel (RCMP, n.d.). The Canadian average for women in policing is now 21% (Statistics Canada, n.d.). In paramedicine, the numbers are higher, at around 30% (Severson, n.d.). The Canadian Armed Forces have permitted women to be employed for over 100 years. However, it was only in 1985, after the enactment of the *Canadian Human Rights Ac*t and the *Canadian Charter of Rights and Freedoms*, that comprehensive integration occurred. Today, women in the Canadian Armed Forces make up almost 16% of all personnel (Government of Canada, 2019). The first-responding organization that has the lowest representation of women is firefighters. Despite hiring women since the late 1980s, women make up only 4% of all firefighters in Canada (Statistics Canada, 2017). Introducing women into these first-responding organizations, which have their own culture of machismo, has created a much-needed social structure change. The process has been slow, and it is only recently that discussions are occurring regarding the harassment, bullying, and gender-based discrimination that has been and is continuing to be experienced by women in these professions.

As a firefighter, Karen worked at a fire hall in Richmond, BC in the late 1990s. In this hall, one female firefighter who was experiencing workplace harassment and discrimination committed suicide. In 2015, Karen left firefighting, and currently works as a civilian in the policing services. Karen chose not to remain silent and was interviewed, along with other female firefighters by the CBC's *The Fifth Estate* (2015, December 6) in their investigative reporting episode that focused on the cross-Canada issue of gender-based discrimination, harassment, bullying, and sexual assaults in firefighting organizations. This documentary described the profession of firefighting in Canada as being hostile, unsafe, toxic, and unwelcoming to women. The public response was primarily empathetic to the women. Responsibly addressing the toxic nature of a work environment, which can be hidden in back rooms and behind closed doors, can bring visibility to the problem. National television is one vehicle for doing so. Although Karen was aware of the potential of negative feedback and adverse interactions that might be directed at her from past and current co-workers, she believes that her decision to participate in the interview reflected a clear responsibility to speak out and to be accountable to women as a social group and to society as a whole. Through this experience, she met other women firefighters in the country who were struggling with similar challenges and issues. In addition to bullying and harassment, this included PTSD, depression, suicidal ideation, anxiety, and other mental health issues that rose out of being first responders.

When Shelley left the Nanaimo, BC detachment for the RCMP Musical Ride, she was replaced by an eager, young, dedicated recruit named Janet Merlo. Twenty-five years later, Janet would go on to be one of the two named complainants of the Merlo-Davidson gender-based class action lawsuit against the RCMP (Merlo, 2013). When it was announced, Shelley wanted to show solidarity with her fellow female members and joined the class action lawsuit. However, she was uncertain how visible she wanted to be in her participation. Not only was Shelley seeing members in her private practice who were talking about this lawsuit, but she also was talking with troop mates (i.e., colleagues she went through training with) and friends who had previously worked for the RCMP about joining this action. Not all were in favour of joining the lawsuit. From those who were no longer working in the RCMP, Shelley frequently heard comments like, "Yeah, it was bad, but it is over"; "It was so long ago"; or "I can't do anything about it, they would just do it more." From those still working, Shelley would hear things like, "It's only a couple of members who are mean, and I just try to avoid them"; "If I join that lawsuit, someone might find out and it would just make it worse, because I will get labelled as a trouble maker"; or "Not a chance I'm going to say anything, because I would like to get promoted someday."

Shelley realized that showing solidarity could mean quietly joining, but not saying anything about it. Or it also could mean being willing to tell people that she had joined, although she realized this was likely to open her up to negative personal and professional consequences. As she was in private practice located in a small rural community and a large portion of her clients were first responders, there was a chance that Shelley could lose some of her clients if they found out that she had joined this lawsuit, thus impacting her (and her family's) financial well-being. Knowing the position she held in the community where overlapping relationships are a reality, and the ability to leverage that position to bring support and validity to those who have experienced, or are experiencing, discrimination, Shelley decided to be forthcoming and tell her personal friends, colleagues, and, if asked, her clients as well. Her decision was made after taking into consideration Principle I (Respect for the Dignity of Persons and Peoples), Principle II (Responsible Caring), Principle III (Responsibility to Society) and Principle IV (Responsibility to Society). Further, being aware of the research literature related to gender-based discrimination, Shelley was able to use this to strengthen her resolve to be honest. She also wanted to promote growth and healing in an organization she still is proud of, even though it is going through serious growing pains. In this way, Shelley was able to be forthright with herself and others by recognizing the time, perseverance, and patience that was required, while also deciding what was the best use of her time, energy, and talents.

This lawsuit was not the only one. Women in the Canadian Armed Forces have been successful in obtaining a Federal Court approved settlement on 25

November 2019, as a result of a Canadian Armed Forces–Department of National Defence sexual misconduct class action lawsuit (see https://www.caf-dndsexualmisconductclassaction.ca/). While helpful to raise awareness, lawsuits do not address organizational culture and stigma. Ongoing support is equally needed and important for everyone who attempts to make social issues visible. Sadly, not everyone is able to openly speak up yet.

The Role of Media

The media has been helping by reporting more frequently on the issues and the tragedies impacting first responders. On 17 December 2018, CBC reported that Corporal Nolan Caribou, an infantry reservist, completed suicide on 18 November 2017. He had been experiencing bullying and harassment and, despite having asked for support from his superiors a year prior, no action had been taken. The media also reported that the Merlo-Davidson class action suit was bigger that predicted, pointing to the pervasiveness of harassment in the RCMP (CBC, November 20, 2018). Further, CBC (2018, October 25) interviewed Calgary police officers who shared that they were overworked, understaffed, and demoralized, and that their needs were being ignored. These are just a few examples of highly problematic work environments; however, they tell a poignant story and highlight some of the challenges faced by first responders.

Through the support of the media, the general public can become more acutely aware of the concerns impacting first responders. The reactions of the public can influence first-responding organizations and related governmental funders to become more serious in their efforts to support these important societal services and the people who provide them. Moreover, media exposure serves to support first responders and their family members (who read the articles or watch the programs) by breaking down the isolation they may feel as a result of their mental health struggles and helping them identify to whom they can turn for hope and support.

Demonstrating Responsibility to Society

Principle IV of the *Code* clearly acknowledges that we as a profession have a responsibility to society—not just to individual clients, but to the community, the country, and society as a whole. As psychologists, we have a wealth of information about mental well-being, and one of the missions of psychology organizations is to share this knowledge in as many ways as possible (American Psychological Association [APA], n.d.; CPA, n.d.).

The Power of Teaming-up!

The many examples mentioned so far show that there is an urgent need to address the culture within first-responding organizations. This culture is reflected not only in organizational policies, but also dependent on the influencers within the organization. In trying to understand the culture, we need to consider relevant influential factors relating to power, position, and privilege within the organization. Specifically, whose voice can be heard the most? Whose words do people tend to pay more attention to, and why? How accessible are established processes for those experiencing victimization? What are the consequences for those who courageously speak up? What are the repercussions for those who are responsible for the victimization? Pondering on these questions can help to shed light on how organizational cultures are fostered over time and how they can be improved.

Sitting in a meeting in Ottawa, Shelley heard about an Alberta initiative to increase psychologists' knowledge about the culture within paramedicine. At the time, Heather and Shelley were both on the executive of the Association of Psychologists of Nova Scotia (APNS). They have a passion for advocating for our profession and the people they serve, and saw an opportunity, as highlighted in Principle IV, to partner with others and to use evidenced-based psychological knowledge to promote systemic change. They approached their colleagues on the executive of the APNS about working on this collaborative project. With the support of these colleagues, Shelley reached out to the provincial paramedic organization, Emergency Health Services (EHS), which provides emergency services to Nova Scotians with their fleet of ambulances, a Life Flight helicopter, and a fixed wing aircraft. When Shelley reached out to them, EHS was increasing its organization's response to employee wellness, including developing a Peer-to-Peer team (P2P). The idea of peer support was made popular during the 1980s as it was part of the new model of critical incident stress management (Everly & Mitchell, 1997). More recently, the MHCC defined peer support as "a supportive relationship between people who have a lived experience in common . . . the experience that individuals or groups have in common is in relation to a mental health challenge or illness. This common experience might be related to their own mental health or that of a loved one" (Sunderland et al., 2013, p. 7). The goal is for employees to receive support from peers who have received training in how to support those who are experiencing a mental health issue. Through their shared lived experience, there is an opportunity for deeper connection and understanding and as a result opportunity for health and recovery.

Within EHS, P2P teams consist of paramedics who have been trained to provide mental health awareness, knowledge, and emotional support to their peers. After hearing of Shelley's idea to increase Nova Scotian psychologists' understanding of the culture within paramedicine, EHS saw this as an ideal opportunity to increase psychologists' understanding of its organization and also a way to build a province-wide roster of trained clinicians that can be used for referrals when a paramedic needs mental health services. It also allowed for an ideal partnership within the mental health community (once again, in line with Principle IV), in which the members of different professions with similar objectives could offer reciprocal education and training of benefit to each other and to the public.

A day-long workshop for psychologists was created. Although Heather and Shelley are not providing the training directly, they were part of the organization of and the initial impetus for this initiative. The workshop includes a two-hour training session, presented by a paramedic, on paramedic culture in the morning, while the afternoon is spent discussing the diagnosis and treatment of PTSD in paramedics specifically. The afternoon session is provided by a psychologist who has extensive experience in first-responder trauma symptom expression. The workshop is limited to 20 people so that the experiential aspect can be managed. The experiential component includes three different training experiences that foster the psychologists' understanding of paramedics as a profession, including listening to recorded radio transmissions and trying to get the necessary information from the transmission in high stress situations. Another involves being in the back of an ambulance that is driving quickly and around corners, with each participant attempting to thread small beads on a string, which simulates starting an IV on a patient. The final activity involves small groups of four or five individuals placed in the back of the ambulance and having a list of tasks to complete, simulating the cramped space in which paramedics must provide emergent patient care. Currently, approximately 60 psychologists have been trained in the culture of paramedicine in Nova Scotia during the past three years and the organizing committee currently is looking at other learning opportunities now that pandemic restrictions permit this type of gathering. EHS is one partner in a "tri-service" with police and fire agencies in the metro Halifax/Dartmouth area. Using this already established partnership, the committee is looking at taking the next step, which is to train psychologists in the culture of these other first-responding organizations. In this way, Heather and Shelley are helping to organize the training of psychologists, but also helping to increase first responders' understanding of the culture of psychology, as there is a great deal of intermingling between the professions during these training days. This mutually respectful relationship allows for the transfer of knowledge, and for respect for each professional identity and way of operating, with the goal of enhancing both professions. The approach of psychologists being part of P2P teams and, for those departments who have more financial resources, having psychologists employed by first-responder departments is becoming more common (Chamberlin, 2019). In an effort to address the need for continuing education, increased competency levels, and further scientific rigour in training within the mental health profession and the first-responder community, Shelley is now in the beginning stages of planning, with collaborating partners, a two-day Atlantic conference focusing on resiliency and post-traumatic growth.

For those interested in increasing their familiarity with first-responder cultures we suggest exploring training opportunities both online and in person. Training opportunities can also be found through internship experiences (organized and self-generated experiences) and through private practices catering specifically to first-responder populations. Choosing internships and employment opportunities that enhance your connection to clients from first-responding organizations and to perhaps more knowledgeable colleagues can help to further develop your knowledge on best practices and first-hand experience. For instance, there are Operational Stress Clinics located throughout the country and the Department of National Defence is frequently recruiting for mental health positions on military bases. Contacting the department or the division health services officer of a first-responding organization to explore referral processes may also be an option. Further, independent reading resources are readily available (e.g., Gilmartin, 2018; Kirschman, 2014; Stone, 1999; Whelan, 2016), including the work of Carlton and colleagues (2018) from the University of Regina who offer ongoing, informative and rigorous research-based publication on the subject. Lastly, in addition to remembering the importance of presenting in a professional manner (e.g., being on time, culturally aware, and treating individuals who present from a different culture with humility) and avoiding asking impertinent questions about crime scenes or investigations, having knowledge and training in the recommended treatment modalities of the issues most commonly encountered by first responders is essential (e.g., the APA practice guidelines for PTSD treatment [APA, 2017]).

In keeping with Principle IV, there is a responsibility to be sensitive to the challenges faced by society and a willingness to use psychological knowledge to effect positive social change (de la Sablonnière, 2017; Wester & Lyubelsky, 2005). This responsibility includes working towards eradicating mental health stigma within first-responding organizations, providing sustainable, preventative, and timely interventions to all first responders working in rural and urban areas, and addressing the particular challenges faced by women and people from minority groups within first-responding organizations. Although there are many people within first-responding organizations who are trying to effect positive change, they often lack the position of power to invoke change at the higher level of management—receiving additional support from the field of psychology would help validate the needed change process and bring much-needed accountability to first-responding organizations by having professionals inside the organizations who are knowledgeable in organizational structures, well prepared in the research that supports these organizational changes, committed to healthy work practices, and able to identify and change existing problematic trends. Having a psychologist who is knowledgeable and willing to advocate for these changes within the management structure can help facilitate the change that is needed.

Early in her career, Karen was able to identify areas within the fire service that needed urgent change. From her personal experience, interest, and academic studies (which allowed her to delve into the research literature), she was able to identify several topics that needed attention. These included leadership, altering the organizational culture, increasing the critical mass of women, mentoring women firefighters to support their rise to senior fire service ranks, establishing professional codes of conduct, educating and training to prevent bullying and harassment, and strengthening policies and procedures that support these initiatives. Karen had a district chief who mentored her and encouraged her to develop professionally as much as possible, and to attempt to rise to the ranks of senior management so that organizational change could happen. Unfortunately, she learned that this would not be enough to evoke the necessary healthy changes.

Prior to Karen's departure from the department, she met with senior fire management and the city's human resource designate. She discussed with them the organizational culture and environment, and that it was too toxic for her to continue her career as a firefighter. She provided examples of how women currently employed in the service were suffering due to the organizational culture. By this point, Karen had realized she needed to make a change and shift her focus to her own mental wellness by removing herself from the toxic work environment and pursuing academic studies. This became a turning point in her career; yet her passion for improving the availability of appropriate mental health services within the fire service, as well as accessible services outside of the organization, continued. In doing this, Karen realized that she could be a stronger advocate for women firefighters if she was no longer in the fire service and was able to speak freely about the challenges without fear of repercussion from her firefighter colleagues.

Karen has since worked with the International Association of Fire Fighters union to assist with implementing mandatory anti-harassment and bullying training; she also works with senior management on issues affecting women and the need for change. As a result of CBC *Fifth Estate*'s (2015, November 6) reporting, the public placed pressure on the city to operate like any other industry with respect to accepting diversity and working towards positive progressive change (Canadian Television News, 2019, December 12). Since being called to account in the media and the community they served, the Richmond fire department has been able to achieve most of the goals that were unachievable when Karen was working there. They have hired a female deputy chief as well as a manager who, as part of her portfolio, has the objectives of increasing diversity (not just women but visible minorities) and creating policies that reflect the demographics of the department. Some of the significant changes include: mandatory harassment and bullying training has become a yearly event; a code of conduct has been created; mentoring women for senior roles occurs; debriefing and defusing sessions after call outs have been increased; and there is increased access to mental health services to all employees at no cost. Karen is encouraged that in 2020 the department has 21 women and ethnically diverse firefighters. This impressive organizational change occurred by working collaboratively with an external team highly knowledgeable in organizational culture change, the psychological needs of organizations that are changing, and the mental health needs of first responders.

First responders can suffer significant psychological health consequences from their work, especially when they try, but are unable, to affect needed change in their organizations. Sometimes they have to give up their careers because of these consequences. When this happens, accessing all available resources is important. This not only includes emotional, physical, and social supports, but also financial.

The Disability Tax Credit (DTC) is a non-refundable federal tax credit given to people who have a disability. The intent of the DTC is to provide greater tax equity for those who may incur more expenses as a result of having a disability. In 2006, changes were made to the federal legislation that made it more difficult for those with a mental health diagnosis to receive this tax credit. The groups that brought this to light included veterans' groups who were finding that veterans who had previously qualified for the DTC were now being denied the tax credit because of the increasingly restrictive criteria. The CPA, as part of a mental health alliance group, wrote letters to government agencies to draw attention to this discrimination and request that a review be initiated. Shelley sits on the Professional Affairs Committee of the CPA and supported this letter writing initiative.

Interprofessional committee work, like the work of the CPA noted above, allows us to share our psychological knowledge with others. This can be done on many levels. Although the example above points to an opportunity at a national level, provincial and local initiatives also exist for engaging in activities that further develop and enhance the psychological resources available for first responders, such as sitting on panels, committees, and being part of working groups. In Nova Scotia there is a multi-agency group that is tasked with identifying resources that can be shared with first responders who experience a psychological injury. The group includes representatives from groups of first responders. It also includes health professionals (e.g., primary care providers), government representatives, and representatives from the Workers Compensation Board. Psychology's knowledge and skills are keenly sought by such groups, and we have an opportunity to develop and disseminate such knowledge to first-responding organizations and to be a collaborating partner when we engage in this way. This is an area for which we can invoke change and, thus, it is worth our time and effort to help.

Conclusion

It seems that the potential for psychological injuries is inherent in the challenging nature of some occupations. The work of first responders is no exception. A number of elements contribute to the particular difficulties faced by first responders, including exposure to traumatic events, a high level of responsibility in addressing life and death situations, significant organizational challenges, and concerns about the impact of stigma in disclosing and addressing the mental health issues that arise. Although many gains have been made in addressing these issues, much work still needs to be done to bring awareness and understanding of these challenges and to promote evidence-based improvements in the quality of life for first responders.

The field of psychology can help address some of the mental health issues faced by first responders. As a profession, we have an ethical responsibility not only to the individual clients whom we treat, but also more broadly to society as a whole. The mental well-being of our first responders is very important to the well-being of all citizens given that they are the people everyone else turns to in times of great need. In addition to offering direct services to address mental health symptoms experienced by first responders, psychologists can use their expertise to address challenges in the culture of first-responding organizations. It is this latter point that has been the focus of this chapter. Further, this approach to better serve our first responders can involve engaging in initiatives to reduce stigma; offering education and training opportunities within our profession and to other professions regarding ways to minimize psychological injuries, effectively addressing such injuries when they do arise; working directly with first responders in a mutually respectful and collaborative way in order to promote positive workplace cultures; and advocating to government and industry for larger-scale changes. The future is ripe with possibility for improving the psychological well-being of our first responders, our workplaces, and our society as a whole. We are excited to be part of it.

Questions for Reflection

1. Crimes against children are heartbreaking and first responders see the results of these crimes first-hand. How would you advocate and promote the use of psychological research to provide intervention strategies to support the mental health of

the first responders whose work involves responding to and/or investigating these crimes?

2. Each type of first-responder occupation has its own culture, and psychologists have a responsibility to be culturally competent. What are some of the ways to acquire competence regarding first responders' cultures?
3. A police officer, who is a veteran, notices that many of the homeless individuals that he meets on the street are also veterans and are struggling with mental health issues[1]. As a psychologist, you are asked for help. Using Principle IV as a framework, what ideas can you offer?
4. You are a psychologist invited by a correctional service organization to help address the low morale that has been plaguing employees. Keeping Principle IV in mind, where do you start?

NOTE

1 When he was a member of the Calgary Police Service Mountain Bike Unit, veteran of the Canadian Armed Forces, Detective John Langford, noticed that many of the homeless individuals he met on the street were veterans. He worked with Veterans Affairs Canada to help the homeless veterans he met connect with case workers who could help them access services. Through his advocacy work, the Calgary Homeless Foundation purchased a 16-unit condominium with 24/7 on-site support specifically for homeless veterans. During an award ceremony where he was recognized for his work, Langford stated "What I sincerely hope you can take away . . . is the knowledge that it's not always easy to fit back into society for some of those men and women in uniform, especially when they've given so much of themselves to make the world a better place" (CBC, 2012, May 9).

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15

Taking Hold of the Reins: Responding to the Ethical Need for Professionalism in Equine-Facilitated Psychotherapies

Anne M. C. Barnfield, Shelley L. Goodwin, Jaqi Allan, Shannon D. Boyce

Pulling open the barn door we are greeted by the smell of fresh hay, a whinny, and big brown eyes looking at us expectantly; our hearts swell with joy and, without noticing, our shoulders drop as we release the tension that we have been holding. Comfort and a sense of contentment settle into our bodies. Welcome to the barn!

Each author of this chapter has opened that door numerous times in their lives, and it is that sense of welcome and comfort that has drawn us to work in the field of equine-facilitated psychotherapy. We share a deeply personal understanding that being around a horse can be psychologically beneficial. In the horse world there is a widely cited fun quote that reads, “My therapist told me I need a stable relationship in my life, so I bought a horse.” This saying expresses what horse people already strongly believe—horses are good for our well-being, nurture us, and are there for us; we benefit from having them in our lives. In recent years, this belief has moved out of the barn and into a growing field in psychology, in which horses are incorporated into therapeutic interventions. For almost a century, horses have been actively used to help those with disabilities experience achievement and empowerment; however, it is only in the past two decades, through equine-facilitated psychotherapy, that horses are being used to help people achieve improved mental wellness. The importance of ethically developing and implementing equine-facilitated psychotherapy will be explored in this chapter with respect to Principle IV (Responsibility to Society) of the *Canadian Code of Ethics for Psychologists*, (Canadian Psychological Association [CPA], 2017).

Since it does not rely on language as the mechanism for interaction and change, equine-facilitated psychotherapy, like other animal-assisted therapies, overcomes a perceived limitation of traditional psychotherapy, namely its reliance on verbal communication (Wilson et al., 2017). By working with a horse, equine-facilitated psychotherapy provides therapists with a way to engage with the client in a less direct manner, allowing the client to engage in the psychotherapy experience in a way that a traditional office setting would not allow. Horses have helped teens who have experienced abuse to develop self-confidence and those with attachment difficulties to understand relationship skills (Lentini & Knox, 2015). Horses also have helped youth with autism understand personal space and boundaries, bereaved adults work through grief, and police and military veterans who experience the symptoms of post-traumatic stress disorder (PTSD) to connect with family (Russell, 2013; Symington, 2012). As horse enthusiasts, we are aware of the psychological benefits that come from being around horses, and as clinicians we also believe that equine-facilitated psychotherapy can provide opportunities to help populations who may not be served easily with traditional forms of talk psychotherapy.

Equine-facilitated psychotherapy can range from individual to group sessions, with considerable structure and exercises, to no structure or prescribed interventions. Given this variability, it can be difficult to evaluate the efficacy of interventions or therapeutic approaches. However, promising recent systematic reviews are providing empirical support (Srinivasan et al., 2018; Trzmiel et al., 2018). Equine-facilitated psychotherapy, like other forms of animal-assisted intervention, is still lacking the large-scale randomized controlled studies that would facilitate a standardized approach. There is a need for rigorous, scientific evaluation that could provide the next level of empirical evidence needed. The lack of standardization (i.e., a consistent approach to how equine-facilitated therapy is conducted) places equine-facilitated psychotherapy outside the mainstream empirical literature and on the margin of traditional psychotherapy practice.

Because of this lack of standardization, clinicians encounter challenges if they are thinking of providing equine-facilitated psychotherapy. Such challenges include: (a) addressing whether clinicians should recommend this form of psychotherapy to their clients; (b) how to work with colleagues who may not have sufficient equine and/or psychotherapy training; (c) how to work cooperatively in a multidisciplinary setting; and (d) how to obtain appropriate training to competently provide this type of service. Needless to say, these issues can create ethical challenges for practitioners who wish to engage in this new and evolving area of clinical practice. It is from this context that we hope to engage the reader in considering the development and implementation of effective, ethical equine-facilitated psychotherapy for mental health issues.

In this chapter we will provide a collective examination of what ethical equine-facilitated practice can look like, focusing our attention on Principle IV (Responsibility to Society) of the *Code* (CPA, 2017). We begin by introducing ourselves and explaining why we are writing this chapter together. We will then: (a) briefly outline the history and describe several forms of equine therapy; (b) outline the major ethical challenges related to honouring Principle IV; (c) share some personal stories of facing these issues, and how we handled them; and (d) give our view on where we need to go from here. In doing this, we will look at how we have tried to build an ethical bridge between the two worlds (equine and psychology) that we know so well, so that we can support the ethical development and provision of equine-facilitated psychotherapy in an effective, principled, and purposeful manner.

Who Are We, and Why Do We Embrace Equine-facilitated Psychotherapy?

Anne: I am a faculty member in psychology at Brescia University College at the University of Western Ontario. From a start in biopsychology and experimental psychology, I gradually moved into human behavioural research and then eventually to investigating the effects of activities and therapies involving equines. The move into the equine world in some ways was inevitable, given my personal interests; in other ways, it was accidental. The serendipitous moment came ten years ago when a student wanting to engage in research in an independent study course asked me to supervise her. Both of us were horse riders and interested in the benefits of physical activity for mental health. Out of our discussions as to what to study for the research project, we decided to investigate the effectiveness of therapeutic riding (defined more fully later in this chapter) for children at a summer camp. From the implementation of that first student study, I became a researcher into the effects of therapeutic riding and equine-facilitated psychotherapy (e.g., Barnfield & Mitchell, 2018; Carey et al., 2013), and a therapeutic riding volunteer (leading and side-walking). At the same time, my interest in riding increased from simple once-a-week lessons, to leasing a horse, to eventually having one of my very own. My equine partner[1], Lilliput, is a Canadian Warmblood sport horse. We practice and compete at the local level in hunter-jumper and dressage riding. I also have been involved with several national and international organizations that promote equine-facilitated psychotherapy, including the Canadian Therapeutic Riding Association (CanTRA), the Certification Board for Equine Interaction Professionals, and Horses in Education and Therapy International (HETI).

Shelley: "Horses are not my whole life, but they make my life whole." I don't know who originally said this, but I have understood its sentiment for many years.

In my younger years, when I was with my pony, I felt complete, as though the final piece of the puzzle was snugly put into place. I have been riding since I was seven and have a scar on my chin to prove it! A tumble off my pony, Kandy Kid, didn't stop me then and other falls since have never deterred me from seeking the freedom I feel on the back of a horse, or the connection I sense when nuzzled into their necks during "barn time." In my first career, I rode throughout North America as part of the Royal Canadian Mounted Police Musical Ride. Riding those famed black horses was a dream come true for me, but it also allowed me to meet my current riding partner, Nell, who is a Canadian horse, which is Canada's national horse breed. Now, as a doctoral-level psychologist, I have obtained training in equine-facilitated psychotherapy and conducted research in equine therapy. I have a busy small independent rural practice and act as a peer reviewer for journals that sometimes publish articles related to animal-human interaction research. I also publish freelance articles about equine-facilitated psychotherapy in mainstream publications in an effort to provide psychological knowledge translation to the general public (Goodwin, 2009) as well as to mental health providers (Goodwin, 2011; Goodwin et al., 2017).

Jaqi: As a masters-level clinical social worker I have focused my career on mental health, in both hospital and community settings, with particular attention to issues of relevance to the LGBTQ community and to children with disabilities. As a member of an interprofessional team, I have conducted research on equine-facilitated psychotherapy and enjoy being around collaborating equine partners, whom I find to be such graceful beings. I also enjoy four-legged companions that are smaller in size (cats and dogs) and have been their live-in companion and adopter—and, I would say, they have been mine in return.

Shannon: As a doctor of veterinary medicine, I own a mixed-animal veterinary practice in rural Nova Scotia. Ever since I could speak, I have been thoroughly obsessed with horses, and I strongly believe that when they are "in your blood" you just can't help it. I have three equine partners in my life—a senior Paint horse named Tom, who is a wonderful pasture pet, and two American Quarter Horses named Luke and Abby. Luke and I train and compete together in a variety of events including western pleasure, trail, and horsemanship riding at American Quarter Horse breed shows in the Maritimes. Abby is my new up-and-coming show prospect. Being a veterinarian is a taxing and stressful job at times; however, when I am with my equine partners, whether training, competing, or simply grooming and cleaning stalls, I experience first-hand the benefits to my personal mental health. Recently, I started volunteering with a local therapeutic riding program and have helped during their horse shows, where all athletes are equal while beside or astride a horse.

All four of us share a committed enthusiasm for engaging in collaborative authorship, ethical practice, equestrian life, and for seeing equine-facilitated psychotherapy develop, and have chosen to write this chapter together. It is important to us that we help students and professionals new to the field have access to scholarship that addresses the ethical issues of therapy provision in this new and evolving area of clinical practice.

What is Equine-Facilitated Therapy (EFT)?

Therapeutic riding has existed in various forms for centuries—Hippocrates (whose name means "Horse Power") wrote about the benefits of using horse-riding for rehabilitation in the 5th Century BC (Riede, 1987). However, a major modern turning point was in 1952, when Danish Olympian Dame Lis Hartel, who was paralyzed as a result of polio, brought the therapeutic effects of riding to the general public's attention when she won a silver medal in Grand Prix dressage. This demonstration of the beneficial effects of riding created both interest and demand. When not on a horse, Dame Hartel required a wheelchair to be mobile; her performance and success in riding showed how horses can help people with physical disabilities increase strength, endurance, and flexibility. The connection between Dame Hartel and her beloved equine partner, Jubilee, was evident, with Jubilee altering her response to riding aids (use of leg pressure, rein contact, etc.) depending on whether Dame Hartel or someone else was riding her. After retirement from international competition, Dame Hartel, with the benefit of her personal experience of not only the physical, but also the social, emotional, and psychological benefits of riding, went on to assist in the development of therapeutic riding.

There are three types of therapy involving equines: therapeutic riding, hippotherapy, and equine-facilitated psychotherapy (see Goodwin et al., 2017). Although this chapter is focused primarily on equine-facilitated psychotherapy for mental health issues, it is important to have a basic understanding of the other two types for comparison. The most common is therapeutic riding which uses trained volunteers and certified therapeutic riding instructors to deliver horse-riding experiences. The focus of therapeutic riding is on teaching riding and horsemanship skills to develop confidence and self-esteem (CanTRA, 2018). Although there may be some personal well-being benefits obtained, therapeutic riding is not primarily focused on treatment of mental health issues.

Hippotherapy is a word that is derived from the Greek language and means treatment with the help of a horse. It is the second-most common form of equine-facilitated therapy. In this approach the horse is not used for development of riding skills, but more as a therapeutic "tool." The goals of hippotherapy may include improvement of a client's gross or fine motor or self-help skills, or improvement in such abilities as communication. While therapeutic riding uses trained volunteers and certified therapeutic riding instructors, hippotherapy therapists have training, and must be credentialed, in a particular profession such as physical or occupational therapy, or speech-language pathology. Treatment plans are developed, and interventions are established, based on specific therapeutic goals. As hippotherapy has been practised for considerable time, an established and expansive research base is available to support it (Bass et al., 2009; Carey et al., 2013; Gabriels et al., 2011).

The third, and most recently developed, type of therapy is equine-facilitated psychotherapy, which is the focus of this chapter. It is an experiential form of psychotherapy that includes horses and sometimes can be called different names, including equine-facilitated wellness, equine-facilitated counselling, equine-assisted psychotherapy, and equine-assisted/facilitated psychotherapy (see Hallberg, 2008). This form of psychotherapy can include a number of activities with horses (e.g., grooming or driving), as well as riding. In equine-facilitated psychotherapy, therapeutic treatment goals may include enhancing self-esteem and dealing with self-help issues, addressing boundary awareness, and other personal growth and development concerns. More recently, some clinicians are branching into treating clinical diagnoses such as anxiety, depression, and PTSD, and research is being conducted to validate this clinical work (Lentini & Knox, 2009; MacLean, 2011; Wilson et al., 2017). Anne was involved recently in a study on the effectiveness of equine-facilitated psychotherapy for military veterans with PTSD, the preliminary results of which show beneficial effects of this therapy for such personnel. Similarly, the Department of Veterans Affairs has collaborated with Can Praxis (an Alberta-based organization focused on treating veterans and active military members utilizing equines in psychotherapy) and the Canadian Institute of Military and Veteran Health Research to complete efficacy trials of equine-facilitated psychotherapy with veterans having a diagnosis of PTSD (Loney, 2015). Results are not yet available but are eagerly awaited. Equine-facilitated psychotherapy views the horse as a sentient partner that deserves respect in the process (Hallberg, 2008). Although horses do not have the same level of reasoning as a human being, the horse is treated with respect, and every effort is made to provide them with work that they enjoy. In using this approach, horses are not seen as tools that we use but as sentient beings that are perceptive to human emotion and very capable of feeling (Nakamura et al., 2018; Scopa et al., 2019; Smith et al., 2016). As noted earlier (in note 1), while some may see horses as *tools* in the therapeutic setting, we see horses as partners, working with us willingly to aid others.

Practicing Equine-facilitated Psychotherapy Today

Due to the growing popularity of equine-facilitated psychotherapy and early results suggesting its benefits (e.g., Barnfield & Mitchell, 2018; Carey et al., 2013), several third-party benefit providers now fund this modality (e.g., Albany NY Veterans Affairs; Heroes Equine Learning Program—charity [H.E.L.P.]; Veterans Affairs Canada). With the opportunity to add this type of therapy to a private practice, many clinicians are taking it on with vigour.

The Emergence of Credentialing Bodies

The field has progressed to the point that we now have two recognized organizations advocating for specific training requirements for those working with horses in psychotherapy. It has only been since 2017 that CanTRA published their accreditation standards for their Equine-Facilitated Wellness certification (CanTRA, n.d.). These standards detail the different levels of training available for the regulated mental health professional as well as the equine expert. The standards provide guidance and guidelines to ensure safety that until now has been missing. For example, they clarify that "in no circumstance does CanTRA condone a situation where more than one unrestrained horse and/or more than one client are in an arena together at one time" (CanTRA, 2018). As each of us has seen, some practitioners have had several clients in the arena with one or two horses. In balancing our clients' safety and that of our equine partners, it is important to not overwhelm either the clients or the horses, as this can place both at physical and psychological risk. CanTRA has partnered with the credentialing body, the Certification Board for Equine Interaction Professionals, to further promote the appropriate certification of persons working in both education and therapy settings.

Equine-Facilitated Wellness Canada (EFW-CAN) is another Canadian organization that provides credentialing for Canadian mental health practitioners who wish to provide equine-facilitated psychotherapy. Developed at about the same time as CanTRA's guidelines, the EFW-CAN credentialing requirements are slightly different and require mental health practitioners to be "members of a professional association" (Equine Facilitated Wellness Canada, n.d.) but not necessarily of a regulated profession, and to have training in the area of equine-facilitated wellness. There also are different classifications for practitioners who identify as "learning professionals," such as those in education, nursing, life coaching, and literacy training.

There is no doubt that a lack of adequate training and regulation of practice can place the public at risk. Credentialing of practitioners is one way to reduce the risk to the public by ensuring qualified mental health practitioners are providing services. Yet we also need to consider the importance of having equine partners who are chosen for this demanding job based on their suitability. Horses are large fight-or-flight animals that, if not well trained and handled, can cause significant injury to clients very quickly. Quite simply, some horses have the aptitude, physical strength, and personality for this type of work, and others do not. It's important that the right animal is selected for the job (Kitchener, 2018). Secondly, if the therapist is not properly trained, the client may receive inadequate and/or inappropriate treatment for their mental health issue, putting the client at risk of harm. In addition, if the therapist does not have adequate training in equine behaviour and management, there are risks of harm to the equine partners from unsafe interactions and heightened stress reactions (Horses and Humans Research Foundation, 2019). It is important also for the therapist or assisting equine expert having a strong emotional relationship with their equine partner—being able to "read" the horse's emotional state, to understand their responses, and to know when situations are stressful to the animal.

Ethical Interprofessional Collaborative Practice (IPC)

Interprofessional collaborative practice (IPC) is an approach that promotes engaging community members and breaking down silos between professions (Canadian Collaborative Mental Health Initiative, 2006; Goodwin et al., 2016). As we have learned, a number of organizations recommend that equine-facilitated psychotherapy be conducted in a team fashion, with a horse expert, a mental health practitioner and an equine partner working together (CanTRA, n.d.; Equine Assisted Growth and Learning Association [EAGALA], 2018). Thus, IPC between disciplines involved in equine-facilitated psychotherapy is seen as optimum (Timmons & Fine, 2015). In an equine-facilitated psychotherapy environment, membership on ICP teams may go beyond members of traditional mental health disciplines (e.g., speech-language pathologists, occupational therapists, recreation therapists) and include not only the mental and physical health providers and horse experts, but also stable managers, veterinarians, farriers, equine massage therapists, and equine chiropractors.

Mental health professionals, as well as other collaborating partners in equine-facilitated psychotherapy, are to be guided by their own profession's code of ethics. In addition, all partners should be aware of each other's codes and endeavour to practice to the highest standard across those codes (Bourque & Horney, 2016; Canadian Association of Social Workers [CASW], 2005; CPA, 2017). Most codes, if not all, have an expectation that professionals will promote the development of knowledge and promote innovation within their field in ways that benefit the welfare of all human beings and of society as a whole (Bourque & Horney, 2016; CASW; CPA). *Principles of Veterinary Medical Ethics of the CVMA* contains a similar principle for veterinarians as well as promoting the welfare of animals (Bourque & Horney, 2016). Thus, as we promote and practice equine-facilitated psychotherapy with an IPC approach, it is important to have a firm understanding not only of our profession's code of ethics but of all collaborating partners' code of ethics.

Through our experience, we have come to know that good equine-facilitated psychotherapy includes a strong support circle surrounding the therapeutic team (psychotherapist, equine expert, and equine partner), ensuring that all are well cared for. Just as we humans need self-care such as our medical doctor, massage therapist, and chiropractor, our equine partners have their own self-care team, which can include veterinarians, equine massage therapists, farriers, and equine chiropractors. When ridden by novice riders, horses may experience back issues and muscle strain as the novice rider begins to adjust to the movement of the horse. Just as humans go to professionals to seek pain relief for their muscle strains, having a veterinarian, massage therapist, or chiropractor available to the horse can be of great benefit. Although these professionals may not be involved in the therapy session per se, you will see how they can play significant roles in assisting the provision of equine-facilitated psychotherapy, maintaining our equine partners' health, conducting research, and being part of the process of ensuring confidentiality. The interprofessional aspect of equine-facilitated psychotherapy is an underexplored area that is ripe for future research.

Unlike traditional therapy, equine-facilitated psychotherapy may be conducted in a large barn, arena, or both, with a horse expert or other horse handlers in attendance. In this situation, those involved in the provision of therapy must consider the welfare and well-being of both the client and the horse, but also be aware of the presence in the stable environment of barn staff, other horse owners, members of the public, and other professionals (e.g., veterinarian, farrier, equine chiropractor), who may be coming and going. This environment means the therapist is not able to provide the level of privacy and confidentiality of a traditional therapy office. As such, the situation presents a multitude of ethical challenges which we try to capture below.

Our broad interdisciplinary approach is woven into the examples chosen from our lives. We explore the challenges of implementing equine-facilitated psychotherapy, including sometimes choosing not to implement this intervention, into our professional practice. Where needed, we have modified and disguised the details to protect and maintain the privacy and confidentiality of those involved.

Ethical Challenges Related to Competence—Shelley's Story

As an early-career psychologist, I won a free trip anywhere in North America that Air Canada flies. As I picked up my prize, I knew that this was my chance to attend an equine psychotherapy training opportunity that had been on my bucket list for several years. At the five-day training course there were 10 participants with varying educational and clinical backgrounds, and equine experience ranging from considerable to next to nothing. As the training unfolded, I heard participants with no horse experience and/or who were not regulated as health care providers say that they were planning on adding equine-facilitated psychotherapy to their practice. As the week progressed, I began to question how to ethically introduce this therapeutic model into my own rural-based practice and maintain confidentiality in the process. I also openly questioned the lack of scientific rigour in the psychotherapy approach we were learning. I walked away with more questions than answers. I also walked away worried that some of the participants, despite the trainer's clarity in laying out the requirement to have additional training before being certified to provide equine-facilitated psychotherapy, were planning to offer this therapy immediately after this short course.

As this was a new field of practice, there were no standardized protocols available and, once home, I was left with a feeling of it all being "airy-fairy." Although I had practiced as a clinical psychologist for eight years at that point, there was no clinical therapist in my area with experience in equine-facilitated psychotherapy. This meant I had no one to consult with locally. In my barn, located in my backyard, I had the ideal therapeutic horse, a Canadian mare named Venus. She was 23 years old and "unflappable." She would fit the bill perfectly, but it would mean having clients in my barn, which was only 20 feet from my house. I became concerned that this situation would result in losing my personal life-space to my work. Furthermore, promising confidentiality on my property, with family members frequently stopping by, neighbours in close proximity, and everyone knowing what type of work I do, would be next to impossible. I began to doubt its transferability from my personal experiences of wellness to the general public. I questioned how my regulatory body would view this new type of therapy. I worried my colleagues would think I was not being professional enough. I worried that if I did this, I would be associated with people providing this intervention who were not being ethical, and I didn't want to be tarred with the same brush. I was confused and conflicted about my next step.

All this uncertainty was too much for me at that point. The lack of clarity was something I was not comfortable with. Although I believed that being around horses is good for people, and I liked the quote often attributed to Winston Churchill, that "there is nothing so good for the inside of a man as the outside of a horse," I also believed then, as I do now, that it is important that when we provide the public with a service we need to be providing a competent service. I knew I needed to be comfortable and confident in order to provide this service, and I just wasn't. Defining what competent service looked like was difficult at that time because of the early stages of the development of this intervention, but I did have my *Code* to help guide me with this decision. I decided to work in the field by conducting research-related activities and scholarly writing, as well as freelance writing, in an effort to engage in knowledge mobilization—taking the current research and putting it into the public's hands. This also gave me time to figure out how to provide a confidential service and not lose the personal refuge of my barn to my professional life.

In several of our offices (Anne, Shelly, Shannon), we have pictures of our horses. From these pictures, it would not be hard to conclude that we have knowledge of horses. As a result, we often are asked questions about the efficacy of this emerging form of therapy; therefore, it was not surprising when, several years ago, one of my clients approached me with the idea of receiving equine-facilitated psychotherapy. They knew that I had horses and thought that I could provide equine-facilitated psychotherapy to them instead of the traditional in-office therapy they were currently receiving. At that point I was not doing equine-facilitated psychotherapy and declined. However, I recognized that I had a responsibility to my client to explore options in the local community and beyond. I decided to contact my provincial psychology association, which maintained a private practice referral registry, to see if there was anyone in the area or province that provided this service and who was credentialed.

From my experience with horses, I realized that I would feel more comfortable providing a referral to a practitioner providing equine-facilitated psychotherapy where both a therapist and a horse expert are in the session. After careful consideration of all aspects, I searched for a therapist who was regulated by a governing body and had psychotherapy in their scope of professional practice. The closest I found was three hours away. I spoke with my client about this and they decided that it was too far to travel. However, they identified other issues they had that could benefit from equine therapy, specifically occupational therapy-related problems. There was a credentialed and certified equine therapy provider locally who could meet these needs. This opportunity allowed the therapy sessions to be claimed through my client's allied health benefits—an issue for those who have to rely on health benefits to pay for therapies.

Ethical Challenges Related to Research—Anne's Story

As a scientifically trained person, I strongly believe in the importance of continuing to conduct research to further evaluate the efficacy of equine-facilitated psychotherapy. I am saddened, however, by the constant difficulties in pursuing such research and the negative attitudes often encountered from those with the power to permit or deny such research. Research by experimental psychologists like me helps to establish practices that are evidence-based (a cornerstone of professional practice for clinicians) and supports the capacity of other professionals and non-regulated health care providers to strive for the highest ethical standards of practice possible within the development of new theoretical approaches, which is inherent in Principle IV. Despite these difficulties, we all—Anne, Jaqi, Shelley, Shannon—have participated in research related to horses and some of us have conducted our own research related to equine-facilitated psychotherapy.

Conducting any type of research is frequently challenged by the need for funding, and difficulty in finding both participants and the time to conduct the research. Those involved in equine-facilitated psychotherapy research often experience difficulties in getting to do such research because of lack of understanding of *what* this type of therapy actually is and *how* it is applied. Unlike other areas in psychology, EFP research comes with even further difficulties, including lack of knowledge about this emerging field by funding agencies, academic institutions, and research ethics boards (REBs). I have run into difficulties in being able to evaluate the effects and effectiveness of equine-facilitated psychotherapy because of this issue. Any research related to, or run from, a government-funded institution (such as a university), or using government research funding, must abide by the *Tri-council Policy Statement on Ethical Conduct for Research Involving Humans* (Canadian Institutes of Health Research et al., 2018). As part of this policy, all institutions must have an REB, which oversees research to ensure that it adheres to the policy guidelines. It is only after REB approval that research can proceed. The problem with the emerging field of equine-facilitated psychotherapy is that members of a REB often do not have any experience with, or knowledge of, this form of therapy. My research on equine-facilitated psychotherapy for military veterans and first responders (emergency services personnel) suffering from PTSD had to go through such REB scrutiny. As my work involved therapy, it went to a "full board" Health Sciences REB (HSREB). The interdisciplinarity of equine-facilitated psychotherapy, which occurs with our interprofessional collaborative practices (ICP, as mentioned earlier), means that several different sets of ethics standards may apply. In this case, both "practice" and "research" issues for such work need to be considered. With the HSREB, it seemed that a lack of comprehension regarding the equine-facilitated psychotherapy setting led to misunderstandings and delays. It is, of course, necessary to protect research participants from harm, but research in this field is also necessary for proper evaluation and to understand how the therapy best works. From personal experience, I can say that achieving REB approval in this field can take a lot of time and effort!

A specific example of an REB-related issue which I encountered was what I thought was over-protectiveness of participants. Potential participants in equine-facilitated psychotherapy research often are very keen to take part—they see equine-facilitated psychotherapy as an interesting and potentially helpful intervention and often are excited at the prospect of being involved. *Responsibility to Society* involves co-operating with societal structures designed to protect members of society; however, we also have a responsibility to engage in research to evaluate potential benefits to society. The REB seemed quite apprehensive, however, and required what I considered to be extreme measures regarding enrolment and voluntary participation. Interestingly, one of the study participants interviewed as part of the military veterans with PTSD and equine-facilitated psychotherapy research wanted to take part in equine-facilitated psychotherapy because of early experiences with horses and his love of these animals, while another had no horse experience at all but was intrigued by this aspect of the therapy. Both participants told me that they found the whole experience interesting, pleasant, and beneficial. Not one participant in any study has ever voiced a negative opinion about participating in equine-facilitated psychotherapy; the only regrets expressed have been that the experience did not go on for a longer time. The outcomes of some of this work on equine-facilitated psychotherapy were presented at the HETI 16th International congress in 2018 (Barnfield & Mitchell, 2018).

More Ethical Challenges Related to Research—A Story from Jaqi and Shelley

Another example regarding ethical issues in research is from several years ago when, early in our experiences with equine-facilitated psychotherapy, we participated in a mixed-method research project as part of a multidisciplinary research team. Part of the work included educating fellow team members about the importance of using standardized intervention practices so that efficacy could be determined. We recommended pre- and post-intervention surveys and inventories, explaining why they were important. Although there was some initial resistance as this approach was new to many of the other multidisciplinary team members, the recommendation was accepted by the team. For members who went on to present the project's findings at provincial and national conventions, the importance of this approach to data collection became obvious when their convention submissions were accepted at quality conferences. These same team members have gone on to do more great work, not only in research, but also clinically. Helping colleagues and community resources to be more informed and conscientious with data collection and reporting is part of the ethical values of the *Code* (CPA 2017) highlighted in Principle IV (Responsibility to Society), captured under *Beneficial activities* and *Development of society* (Ethical Standards IV.1; IV. 20). The research may be a big or small project but, regardless of the size of the project, we believe we are contributing to our profession and to new development in our field. It can be exciting for any professional to promote and grow their profession in this way, and that was true for us.

Ethical Challenges Related to Disseminating Knowledge—As Experienced by all Authors of this Chapter

Presenting and publishing research findings, especially in an emerging field, is an important task in developing evidence-based practices and informing others of developments in the field. All of us have participated in presenting or publishing our research, or both (e.g., Barnfield & Mitchell, 2018; Boyce & Goodwin, 2017; Goodwin et al., 2017, Goodwin et al., 2016). Although important and exciting, it can sometimes be challenging to find time for this additional work in our busy lives and, being honest, the money to do it. Anne is the only one of us who is in academia full time and who receives some time and financial remuneration for writing and presenting research. Even then, to get funding is difficult. Government funding bodies (at least in Canada) are reluctant to commit money to "unfounded" practices (funding for Anne's equine-facilitated psychotherapy research work to date has come from a private foundation's gift and from the college where she works). The rest of us are in clinical practices where, if we decide to attend a national or international conference, we do so at our own expense, both financially and time wise. If we are writing an article for publication, we do so at the expense of our personal time, away from our families, horses, and fun activities. If we are travelling to conferences, we do so at the expense of fun travel with our families. The time and financial costs are considerable, with the average publication taking 100 plus hours to write (not including research time), and the costs of attending most national conferences easily starting at $1,000 for hotels, travel, and registrations fees. International conferences can cost three times that amount. Needless to say, this is a considerable investment. The rewards are also considerable, however. This includes the personal satisfaction of knowing that we are contributing to the growth of our field, introducing our clients to another option in mental wellness intervention, collaborating with colleagues, developing meaningful relationships with other professionals, adding to our publication lists, and acknowledging our responsibility to society. Shelley discovered a less obvious benefit of knowledge dissemination recently when she attended the American Psychological Association annual convention and discovered a booth in the exhibitor's hall that was promoting the ethical practice of equine-facilitated psychotherapy. They had several books and promotional materials available. Shelley was excited to see these practitioners and had a lively hour-long discussion with them. This is a great example of how knowledge dissemination can take equine-facilitated psychotherapy out of the margins or, you could say, out of the barn, bringing it into the professional realm and adding visibility and credibility to this emerging psychotherapy. It also facilitates practitioners dialoguing and potentially collaborating with like-minded colleagues.

More Ethical Challenges Related to Disseminating Knowledge, Confidentiality, and Interprofessional Collaborative Practice—Shannon and Shelley's Story

Information is also disseminated informally. A veterinarian, for example, can be compared to a person's hair stylist. Just as people tell their hair stylist everything, horse people talk with their veterinarians—a lot! Veterinarians are in many horse barns and get to hear what is happening in each one. It is not unusual to spend hours with a veterinarian as they do annual shots, care for a sick or injured horse, or provide end-of-life care for a beloved equine partner. During these times in the barn, people talk and inevitably share what is going on in their lives. Stable hands talk, owners talk, grain delivery folks talk, research participants talk, and clients in equine-facilitated psychotherapy talk too. So, having people in the barn who know the importance of not carrying talk from barn to barn becomes ethically important to ensuring confidentiality of clients and research participants. Shelley grew up, and still lives, in a small rural community, and is intimately aware of the importance of maintaining appropriate ethical boundaries while also, hopefully, maintaining personal relationships (Schank et al., 2010; Schank & Skovholt, 1997; Schank & Skovholt, 2006; Truscott & Crook, 2013). Shannon, who practices with guidance from her own profession's code of ethics, is aware of Standard III. C.1, which specifies that "veterinarians have a responsibility to maintain the integrity and dignity of the profession and be worthy of the trust and respect of colleagues, clients and other health care professionals and the general public" (Bourque & Horney, 2016, p. 6). She also is aware of Standard III. B. 8, which specifies that "veterinarians . . . should protect the personal privacy of patients and clients. Veterinarians should not reveal confidences unless required to by law or unless it becomes necessary to protect the health and welfare of individuals or animals" (Bourque & Horney, p. 6).

An example of interconnections within the horse community starts with Shannon, a veterinarian who works with Shelley's farm. They sometimes play in trivia quiz match teams against each other (Shannon's team usually wins). A colleague of Shannon is Shelley's neighbour. When Shelley's 32-year-old mare developed a rare mammary gland tumour and needed to be euthanized, they wrote an article together for *The Canadian Veterinary Journal* (Boyce & Goodwin, 2017). Through the years, they have shared several clients (the clients have told them so), yet they have never discussed this connection between themselves. Being aware of each other's ethics code allows professionals to engage in interprofessional collaboration with comfort and with respect. The horse community is small and, as horse people, they are aware of small-community ways relevant to the equine community. As is common with many small communities, they are mindful of numerous intersecting relationships amongst the membership.

They each have ridden with clients on rides, having shown up for the event not realizing the other would be there. One of them frequently rides with a physician referral source and several healthcare providers who are members of an animal assistance non-profit group to which they belong. These relationships are important social connections, but also provide important interprofessional connections and supports within the developing field of equine-facilitated psychotherapy. When future opportunities for IPC arise, they will continue to manage the ethical challenges related to this work and will strive to uphold the standards of our various ethical codes so as to benefit all members of society.

Future Directions

Interest in equine-facilitated psychotherapy is increasing amongst the general public and professionals. This leads to issues regarding regulation, client safety, and the ethical application of this new form of psychotherapy. Principle IV (Responsibility for Society) (CPA, 2017) is particularly relevant to the development of this new psychotherapy. All of us (Anne, Shelley, Jaqi, and Shannon) have encountered people who are providing what they advertise as equine-facilitated psychotherapy. Although these individuals may have horse experience and may be registered mental health care providers, they often lack specific equine psychotherapy certification or credentials. Unfortunately, most members of the general public do not know the difference between registered and unregistered professionals, making this a significant issue for public safety. Not only may members of the public not be receiving services from a trained mental health professional, but they also may not be receiving services in a physically safe environment with equines who have been chosen for their ability to do this very demanding type of work (Kitchener, 2018). Working with colleagues whom we trust in this ground-breaking work, while also reading literature, conducting research, and checking with colleagues throughout the world who are engaged in this field, are all part of ethical practice.

Just as all seasoned horse owners know that they will get bitten by a horse a few times, have their toes stepped on a few times, and experience an unceremonious dismount (fall) off their horse a few times, the dedicated equine-facilitated psychotherapy practitioner also must learn to navigate the inevitable ethical challenges of their practice. We have shared some of ours so that you may learn how we have navigated such ethical challenges. We have shared our enthusiasm for and commitment to equine-facilitated psychotherapy and hope that you will join us in our ongoing pursuit of developing this new and exciting form of psychotherapy so that future generations will benefit.

Questions for Reflection

1. Would you be comfortable recommending equine-facilitated psychotherapy to a client? If yes, why? If not, what would help you become more comfortable with recommending such therapy?
2. You are a psychotherapist with limited experience with horses but would like to provide equine-facilitated psychotherapy. How would you develop competence to provide such psychotherapy? What role would supervision play in your development, and what would you look for in a supervisor?
3. In developing any new psychotherapy, how do the ethical responsibilities of researchers and therapists overlap and/or interact?
4. You are asked by a friend who has a child diagnosed with autism spectrum disorder if you know a place that offers equine-facilitated psychotherapy. You can only think of one place, but they provide therapy to veterans with PTSD. Is this an appropriate referral for you to make? Why or why not?

NOTE

1 The term "partner" is used to acknowledge our relationships with these other beings. Within the therapeutic field, horses are sometimes viewed only as tools or instruments. We disagree with this approach as it diminishes the role of the horse and does not recognize the need for a team approach with a willing and engaged *partner*.

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PART E

Ethical Decision Making

16

Ethical Decision Making: An Idea Whose Time Had Come

Carole Sinclair

In modern-day psychology, the phrase *ethical decision making* is an integral part of our language, literature, and everyday thinking. However, it was not much of a part of any of these things when the first *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association [CPA], 1986) was being developed. In fact, according to PsycNet, the phrase "ethical decision making" with respect to professional or experimental ethics had appeared in the title or abstract of only one publication prior to 1981. Despite this, there was a heavy emphasis on it in the first edition of the *Canadian Code.* Why and how did this come about? What happened to it over the next three editions of the *Code*? What did we learn along the way? In this chapter, I will provide some of the backstory and try to answer these questions from a personal point of view[1] by drawing from my memory of the events that led us along our path. (My apologies to those who also are part of the story and may remember it somewhat differently.)

The Serendipitous Beginning

My personal involvement in the development and evolution of the *Code* goes back more than four decades and occurred somewhat serendipitously. Having graduated with a doctorate in psychology in 1973, and wanting to be registered as a psychologist, I needed to arrange for the required year of supervision. David Randall (then of Ontario; now of Saskatchewan) agreed to do this. As it happened, David had agreed to supervise two other recently minted doctoral graduates (Sonja Poizner and Karen Gilmour-Barrett) and suggested that, in addition to individual supervision, we meet as a group every other week or so. We agreed to this, and at the end of the year of supervision and passing the oral exam and the Examination for Professional Practice of Psychology (yes, the EPPP has been around that long!), the three of us became registered as psychologists. However, we did not want to stop our group meetings. We found the interaction and support of the meetings to be highly beneficial, as there were few other psychologists in our places of employment at that time, and our meetings filled a gap for us. David agreed to be part of the continued group meetings and, in his wisdom, suggested we find a project to work on together, as he thought this was more likely to motivate us to meet regularly.

At the time, David was a colleague and friend of Jean Pettifor (to whom this book is dedicated) and was active in CPA's Applied Division (Jean was Chair of this division). He let us know that Jean had formed a Committee on the Practice and Delivery of Services as part of the Applied Division, and she was interested in putting together some sub-committees devoted to looking at the need for practice standards for specific areas of practice. As David, Sonja, Karen, and I all were involved in various branches of children's services at the time, we agreed to become the sub-committee on Standards for Children's Services. Little did we know where this would lead!

Over the next two to three years, we immersed ourselves in the topic of standards. What were the elements of a good standard? What is the role of standards in improving the quality of services in any area of practice? What kind of standards did children's services need? What was the relationship of practice standards to ethics? What was the difference between practice standards and ethics standards? Answering these questions involved our regular meetings, much reading and discussion, annual reports to the Applied Division, presentations of our thoughts and ideas at annual CPA conventions (Gilmour-Barrett, 1977, Sinclair, 1977; Sinclair et al., 1975), and a publication (Sinclair, 1980).

In addition to being chair of the Applied Division and a member of the Board of Directors, Jean had an abiding interest in ethics, and had begun to publish regular articles on the topic, including a regular column in what was then called the *Canadian Psychological Review*[2] (e.g., Pettifor, 1979b, 1979c, 1980). About 1978 or 1979 (my memory is a bit fuzzy on exactly when), Jean let us know that the CPA Board was seriously considering the development of a made-in-Canada code of ethics for psychologists to replace the American Psychological Association (APA) code, which had been adopted and was being used across Canada at the time. She had taken an ongoing interest in the work of our group and was familiar with the fact the work had included thinking about practice standards in the context of ethics. In addition, from a purely practical point of view, she let us know that she thought that to make sure "things got done," the initial steps toward a Canadian code should be taken on by a group that lived close together and could meet frequently at no financial cost (money was even tighter in those days). She asked if our sub-committee would be willing to take on the task of exploring the issues involved in developing a made-in-Canada code and come up with a proposed plan. Somewhat naively, and with little understanding of the enormity of the task we were taking on, we agreed.

Stage One—The Eye Opener

Some of those we consulted about our new task advised us that it was a simple one—that the APA code (APA, 1977) needed only a few changes in language and standards to fit the Canadian context. However, Jean and many others encouraged us to take a deeper look into what might be needed. Being a somewhat unshrinking group, and with our appetites whetted by our previous work on standards, we chose the latter path. Over the next year, we engaged in a review of the psychological, interdisciplinary, and international literature on the nature and purposes of ethics codes, including opinions regarding the strengths and weaknesses of existing codes. At the end of the year, we concluded that four main purposes of ethics codes could be identified in the literature. These were: (a) to help establish a group as a profession; (b) to act as a support and guide to individual professionals; (c) to help meet the responsibilities of being a profession; and (d) to provide a statement of moral principle that helps the individual professional to resolve ethical dilemmas.

The literature we reviewed indicated that the APA code (as well as the codes of other professions) had both strengths and weaknesses with respect to each of these purposes.[3] For instance, there was little question that the APA code had helped establish psychology as a profession in both the US and Canada and was helpful and supportive with respect to what it covered. However, there were concerns that it did not provide guidance and support for issues related to evolving areas of practice (e.g., community psychology, working with groups, children's rights, and research with vulnerable populations), which were not covered in the code. The opinion seemed to be that ethics codes would always be at least a little behind the developments in any profession. They had difficulty keeping up. There also was a belief that ethics codes cannot (and should not be expected to) cover everything—no code was or could be exhaustive. As such, in addition to ethical standards for well-established areas, it was thought that it would be helpful for ethics codes to provide guidance for handling ethical issues arising from new areas of activity, or areas not otherwise covered in a code. The listing of specific behavioural standards in the current code was viewed as valuable, but not enough.

With respect to the third purpose of ethics codes (to help meet the obligations of being a profession), it was clear that training in ethics was beginning to be recognized as important in psychology programs, and the APA code was being used in the training. However, research (e.g., Baldick, 1980) indicated that the effectiveness of such training was a bit disappointing. Of specific relevance to this chapter, the most frequent and consistent concern was that codes of ethics in general, and the APA code in particular, did not meet the fourth purpose well (i.e., to provide a statement of moral principle that helped resolve ethical dilemmas). Although codes often named the ethical principles they espoused, it was done in a way that was not helpful (e.g., when responsibilities to the client, research participant, employer, funder, or society are in conflict; or when the ethical principles themselves are in conflict).

In our literature review, we observed several problems we thought might explain the above concerns and criticisms. Most existent ethics codes outlined their underlying principles or values in a brief statement before listing their standards. However, there often was little attempt to connect the behavioural standards that followed to any of the principles or values. In our previous work on standards (e.g., Gilmour-Barrett, 1977), we had proposed that explicitness was a key dimension in enabling the educational and judicial value of any standard; that is, explicitness about the purpose of the standard, or the ethical principle(s) or value(s) from which the standard is derived. Interpretations of a standard not so linked could (and often did) vary. In some cases, a standard could be interpreted to support a specific principle or value (e.g., respecting the dignity and worth of an individual; protecting privacy). In other cases, a standard could be interpreted as very self-serving (to the profession or the individual professional) and not supportive of any specific higher-order principle or value. We also found that many ethics codes were not what we called conceptually cohesive. For instance, before listing its behavioural standards, the 1977 APA code made brief reference to five "values": (a) respecting the dignity and worth of the individual; (b) preserving and protecting fundamental human rights; (c) increasing knowledge; (d) promotion of human welfare; and (e) protection of human welfare. However, instead of organizing the standards under these values, they were organized under nine headings called "ethical principles." Four of these "principles" (Responsibility, Competence, Confidentiality, Welfare of the Consumer) could readily be seen to be related to underlying ethical principles or values; however, the other five (Moral and Legal Standards, Public Statements, Professional Relationships, Utilization of Assessment Techniques, and Pursuit of Research Activities) were simply areas about which to write standards. This type of problem was not limited to the 1977 APA code. We found several other similar examples. For instance, the 1978 code of the Canadian Medical Association started with a section of "Principles of Ethical Behaviour." However, it then moved to three sections of standards, namely "Responsibilities to the Patient," "Responsibilities to the Profession," and "Responsibilities to Society," none of which was tied directly to the listed principles. It was our opinion that conceptual cohesiveness in existing codes of ethics seemed to be a problem. This problem interfered with the individual professional's ability to understand the underlying principle, purpose, or value of a standard and to apply it to situations not explicitly addressed in the code.

At the end of this first stage of review, contemplation, and discussion—and after having tried out our ideas at our local provincial convention (Gilmour-Barrett, 1981; Poizner, 1981; Sinclair, 1981), and through reports and discussions at CPA meetings—we proposed four objectives for a new Canadian code. They were: (a) to develop a code that would be more conceptually cohesive and thereby serve as a better educational tool for training and ethical practice; (b) to develop a code that would be more inclusive of emerging areas of practice; (c) to give more explicit guidelines for action when ethical principles are in conflict; and (d) to explicitly reflect the most useful decision rules (i.e., ethical principles) for ethical decision making. At the June 1981 CPA convention in Toronto, after presenting our proposed objectives and rationale, we received strong endorsement for the objectives, and the instruction to "carry on"—to see what we could do to develop a code that would meet these objectives.

Stage Two—Where Do We Go from Here?

Following a brief period of celebration about how our hard work had made sense to others, we realized we had a huge problem: We had no concrete ideas about how to proceed. How on earth were we going to accomplish what we had said was needed and what we had now been asked to do? After some initial panic, we found inspiration from three main sources.

Meeting with a Provincial Ethics Committee

The first source of inspiration came as a result of news of our work spreading, I was fortunate enough to be invited to a meeting of the Ethics and Policy Committee of the Ontario Psychological Association (OPA). The invitation came from the then chair of the committee, Harvey Brooker, with the intent of providing a brief overview of our work, but also to stay for the entire meeting if I wished. At that meeting, the committee was working on the preparation of an ethics case book. The casebook was to be similar to the one originally published in 1967 by the APA, but with a difference—both were designed to present cases based on real, but anonymized, incidents, and to provide an opinion about the ethicality of the behaviour described. The difference was in the level of explanation regarding the opinion about the ethicality of the behaviours involved in the situation. Although, the APA casebook sometimes provided a brief rationale for the opinion, there were many that simply stated the behaviour was judged to be unethical without providing any rationale about why it was considered unethical. In contrast, the OPA Committee's intent for their casebook was to include the underlying rationale for their opinion regarding ethicality. At the meeting, in their discussions of the cases to be included, they consistently referred to ethical principles and values, weaving them into their opinions and explanations. I found the process to be both rich and intriguing. Later, in relaying the experience to other members of the sub-committee working on the CPA code, I commented on my impression that there was a great deal of collective ethical wisdom "out there," and capturing that wisdom could be enormously helpful to the task of developing a made-in-Canada code of ethics that met the agreed-to objectives for such a code. We just needed to find a way to capture the wisdom.

Literature on Ethical Reasoning and Decision Making

The second source of inspiration for us was the literature on ethical reasoning and decision making. As noted above, until 1981, only one article in the literature under professional or experimental ethics had contained the phrase "ethical decision making." Written by Rychlak (1968), the article explored the differences between scientific decision making and ethical decision making. However, as our extensive review of the ethics literature had shown, a steady movement had occurred during the 1960s and 1970s towards understanding that ethics was about much more than knowing and following rules or behavioural standards (e.g., Bersoff, 1975; Hines & Hare-Mustin, 1978; Pettifor, 1979a; Roston, 1976, Wiskoff, 1960). This movement led to many of the concerns and criticisms noted above about existing ethics codes. Emphasis began to be placed on the fact that professionals were faced every day with ethical decisions that were not easy to resolve, as they involved dilemmas—competing principles, values, and interests. Increasingly, the ethics literature had begun to use case studies or vignettes that provided brief descriptions of real or hypothetical situations to demonstrate and explore ethical issues, (e.g., CPA, 1978; Joseph & Peele, 1975; Pettifor et al., 1980; Simon, 1978). Although not using the phrase "ethical decision making," many of the vignettes addressed quandaries that did not seem to be addressed in ethics codes, and were intended to help develop both ethical sensitivity and critical thinking skills about those matters.

Kohlberg's Model of Moral Development

The third source of inspiration toward finding a methodology for developing a Canadian code came from our exposure to the work of Lawrence Kohlberg on the development of moral judgement. Two of us had attended summer training sessions by Kohlberg in the late 1960s and early 1970s and had incorporated his theories into a major doctoral paper and a doctoral dissertation during our training. However, all four of us were thoroughly familiar with his model (it was very popular at the time and taught widely in child development courses), and we had used it as one way of looking at the adequacy of ethics codes from the point of view of moral development (Gilmour-Barrett, 1981; Poizner, 1981; Sinclair et al., 1987).

Kohlberg's theory viewed moral thinking primarily as a cognitive, stage-related, developmental process (Kohlberg, 1969). He developed a series of hypothetical dilemmas to obtain samples of ethical reasoning, and proposed a three-level, six-stage model of moral development. The level of moral judgement was indicated by the *reasoning* used, not the final action taken. Kohlberg argued that the third level of moral reasoning (called the "Morality of Self-Accepted Principles") was the only level that allowed for the consistent application of ethical principles in solving ethical dilemmas.

Arrival at a Methodology for Developing the *Code*

Finally (and with some relief), we came up with a plan for developing the *Code*. Described in detail elsewhere (Sinclair et al., 1987), the plan grew out of our wish to base the *Code* on the collective wisdom of Canadian psychologists. This was our fourth source of inspiration. It involved taking a page out of Kohlberg's methodology of having participants (in our case, Canadian psychologists) answer questions about hypothetical dilemmas. In this way, it was thought that we might be able to capture the ethical reasoning and ethical principles of Canadian psychologists.

Thirty-seven vignettes of hypothetical ethical dilemmas were written, covering the applied, teaching, and research functions of psychologists. The vignettes reflected all the ethical principles and values of the 1977 APA code, as well as situations that put those principles and values into conflict. In addition, they included evolving as well as well-established areas and issues, and often had multiple contextual pressures that needed to be taken into consideration. In fact, we occasionally were told we had been somewhat "mean" in developing the vignettes—making some of them exceptionally difficult to resolve!

An invitation to participate was sent to a random sample of CPA members, but also to those known to have a special interest in ethics (e.g., members of ethics committees across Canada, teachers of ethics, etc.). In all, 59 Canadian psychologists accepted the invitation and completed what was required. Each was sent a sample of vignettes and asked to answer a series of questions about each one (see Sinclair et al., 1987, p. 6, for these questions). The questions were designed to explore not just the final course of action chosen, but also the reasoning process and the underlying ethical principles and values used by each participant in deciding on the course of action. A content analysis (Crano & Brewer, 1980) was carried out on the responses. Participants' rationales were listed, categorized, and re-categorized until four superordinate principles were identified: (a) Respect for the Dignity of Persons; (b) Responsible Caring; (c) Integrity in Relationships; and (d) Responsibility to Society (For further details, see Sinclair et al., 1987, and Sinclair, 1998).

Ethical Decision Making in Early Drafts of the *Code*

Prior to its approval by the CPA Board of Directors in 1986, about six drafts of the *Code* were circulated for feedback. The earliest drafts had many of the structural components of the final version. These included organization of the standards around the four identified ethical principles and beginning each section of the *Code* with a Values Statement that explained the ethical principle involved. It also included grouping the ethical standards around values associated with the ethical principle (e.g., including the values of "confidentiality" and "informed consent" under Principle I) and ordering the principles according to the weight each generally should be given when they come in conflict. However, the earlier drafts did *not* include any suggested model for ethical decision making. Such a model was added only to the later drafts. Why? How did this happen?

In the opinion of some persons we consulted early in the process, the planned preamble for the *Code* should be as short as possible (no longer than a page or so). This was based on the opinion that "no one ever reads a preamble"; therefore, we should not waste time on it. Furthermore, with respect to ethical decision making, we thought that the structural elements mentioned above were enough to meet the objectives of explicitly reflecting the most useful decision rules (i.e., ethical principles) for ethical decision making, and giving "more explicit guidelines for action when principles are in conflict."

As the feedback began to flow in, it was evident that there was much support for the elements of ethical decision making included. However, there also were repeated requests that we provide even more assistance for dealing with situations that were not covered by the *Code*; that is, more explicit assistance with ethical decision making. We were not sure what this would look like, but we were game to try. In addition, we began to realize that there were many other questions that were being asked and needed to be answered. What was the relationship of the *Code* to personal behaviour? What was the relationship of a code developed by a national psychology body to the provincial psychology bodies, including to the few provincial regulatory bodies that had been established at the time? What were appropriate uses of the *Code*? In response, it was decided that we needed to set aside the advice to keep the Preamble short and, instead, develop a Preamble that helped answer these questions and provided more assistance with ethical decision making.

Ethical Decision Making in Later Drafts of the *Code*

Fortunately, about this time, Ken Craig invited Alexander (Sandy) Tymchuk to a meeting of the Committee on Ethics. Ken had been a member of the CPA Board of Directors since 1982, becoming president in 1986, and had played a strong supportive role with the work on the *Code* once formal oversight of the *Code*'s development was transferred to the Committee on Ethics in the early 1980s.[4] Sandy was a professor at UCLA but had strong Canadian roots and was a CPA member. In addition, and highly relevant to our efforts regarding ethical decision making, he was the author of three of the first articles in the literature that had the phrase "ethical decision making" in their title or abstract (Tymchuk, 1981, 1982; Tymchuk et al., 1982). At this meeting, I remember Sandy strongly recommending that we include a specific model for ethical decision making as part of the *Code*—that he thought psychologists' ethical decisions had great impact on others, and something was sorely needed to help us make the best decisions we could. His observation was that ethical decision making was not something that came easily to most professionals.

I must admit that our first reaction was a bit skeptical (had we not already included enough?). However, the more the Committee on Ethics and the work group reflected on his suggestion and explored the literature on models for ethical decision making, the more open and intrigued we became with the idea. Consistent with other models of ethical decision making at the time (e.g., Rest, 1979; Tymchuk, 1981, 1982; Van Hoose & Kottler, 1977), and generic models of problem-solving, the model included in the Preamble in later drafts of the 1986 *Code* (and, eventually, in the approved version) outlined seven steps "that typify approaches to ethical decision making" (CPA, 1986, Preamble):

1. Identification of ethically relevant issues and practices.
2. Development of alternative courses of action.
3. Analysis of short-term, ongoing, and long-term risks and benefits of each course of action on the individual(s)/group(s) involved or likely to be affected (e.g., client, client's family or employees, employing institution, colleagues, profession, society, self).
4. Choice of course of action after conscientious application of existing principles, values, and standards.
5. Action, with a commitment to assume responsibility for the consequences of the action.
6. Evaluation of the course of action.
7. Assumption of responsibility for consequences of action, including correction of negative consequences if any, or re-engaging in decision-making process if the ethical issue is not resolved.

The section on ethical decision making that included the seven-step model ("The Ethical Decision-Making Process") also included two other important paragraphs (CPA, 1986, Preamble). One acknowledged that not all ethical decision making requires use of such a model—that some decisions are reached very rapidly, especially where clear-cut guidelines or standards exist and/or for which there is no conflict between ethical principles. Rather, the model was intended for those situations that do not have such guidelines or standards, or that are not easily resolved for other reasons. The other important paragraph emphasized the value of consulting with individuals or groups who "can add knowledge and/or objectivity to the decision-making process" when the situation called for use of a decision-making model and there was sufficient time to do so. This paragraph ended with, "Although the decision for action remains with the individual psychologist concerned, the seeking and consideration of such assistance reflects an ethical approach to ethical decision making."

The inclusion of this section on ethical decision making in later drafts of the *Code*'s Preamble received consistent positive feedback, and it became a permanent and significant part of the first approved edition of the *Code*. Although there have been refinements and updates over time, the inclusion of a section on ethical decision making and an ethical-decision model has remained a part of the *Code*'s Preamble through to the present time. Consistently, when Canadian psychologists were asked for feedback about what they value most highly about the *Code*, it has been one of the most frequently mentioned aspects. This was true for each edition of the *Code* (Sinclair, 1998, 2011, 2017).

What has not been mentioned thus far is that there was another section of the Preamble related to ethical decision making. In fact, as explained below, this second section was combined with the first section on ethical decision making into a single section for the fourth edition of the *Code*. This second section was called "When Principles are in Conflict." In this section, it was proposed that "although a firm ordering of the principles" was precluded by the complexity of ethical conflicts," the four principles of the *Code* generally should be given different weights when they are in conflict, and had been ordered accordingly. As such, Respect for the Dignity of Persons generally should be given the highest weight (except when "there is a clear and imminent danger to the physical safety of any known or unknown individual"), followed by Responsible Caring, followed by Integrity in Relationships, followed by Responsibility to Society.

However, in addition, this second section contained an important paragraph about the role of personal conscience, which also was destined (with some refinement) to become a permanent part of the *Code* (CPA, 1986, Preamble):

> Even with the above ordering of the principles, psychologists will be faced with ethical dilemmas which are difficult to resolve. In

> such cases, resolution is recognized to be a matter of personal conscience. However, in order to ensure that personal conscience is a legitimate basis for the decision, psychologists are expected to engage in an ethical decision-making process that is explicit enough to bear public scrutiny.

We believe that the *Canadian Code* was the first code of ethics for psychologists to acknowledge that personal conscience may have a legitimate role to play in some situations. I do not remember a lot of discussion about the inclusion of such a role, only that it received much positive feedback and also fit with the idea that the *Canadian Code* was an *ethics* document intended to assist psychologists in their ethical reasoning and decision making, not simply a compendium of rules to be followed.

In the few years following approval of the first edition of the *Code*, the emphasis on ethical decision making and its usefulness in teaching ethics received much attention and was the primary focus of articles published about the *Code* (e.g., Eberlein, 1987, 1988; O'Neill, 1989; Pettifor, 1989; Weinberger, 1989).

Changes Over the Next Three Editions

What were the refinements and updates for the second, third, and fourth editions? Why were they made? As mentioned above, based on a PsycLit search, the phrase "ethical decision making" in combination with the index term "professional ethics" or "experimental ethics" had appeared in the title or abstract of only one publication prior to 1981. However, during the following decades, there was an explosion of interest in ethical decision making across all professions. A 2020 PsycLit search indicates there were 51 such articles in the 1980s, 191 in the 1990s, 465 in the first decade of the 21st century, and 550 in the second decade of the 21st century. This increased interest brought new thinking and models. Although delving into the evolving content of this literature over time would be an interesting and worthwhile endeavour, it is not my intent to do so in this chapter. Rather, I will focus on the specific changes made to the *Code*'s section on ethical decision making over its next three editions, and some of the experiences and thinking that led to those changes.[5]

1991—Second Edition

The section "The Ethical Decision-Making Process" in the second edition of the *Code* remained word-for-word the same as in the first edition. The section "When Principles are in Conflict" received only minor editing, with no substantive changes (e.g., the title of the section was changed to "When Principles Conflict"). The paragraph on the role of personal conscience, however, received a significant change. This was due to concerns raised in the review of the 1986 *Code* about what "explicit enough" meant with respect to engaging in an ethical decision-making process. Some were worried that psychologists would use personal conscience as a facile defence (e.g., "my conscience told me to do it") or as a substitute for a proper ethical decision-making process. As a result of these expressed concerns, and after consultation with ethicists (Sinclair, 2011), the following statement was added to the paragraph:

> If the psychologist can demonstrate that every reasonable effort was made to apply the ethical principles of this *Code* and resolution of the conflict has had to depend on the personal conscience of the psychologist, such a psychologist would be deemed to have followed this *Code* (CPA, 1991, Preamble).

Happily, significant concerns about the *Code*'s inclusion of a role for personal conscience have not been raised since, and the 1991 paragraph in the second edition was brought forward into the third and fourth editions (CPA, 2000, 2017).

2000—Third Edition

The third edition of the *Code* brought a substantial change to the ethical decision-making model. The model went from a 7-step to a 10-step process, based on experience with the 7-step model and the much-increased attention to ethical decision making in the literature. The first added step to the model was "Identification of the individuals and groups affected by the decision." This came from the experience that Jean and I (and other Canadian psychologists) had had in carrying out ethics workshops during the 1990s, as well as feedback from Canadian psychologists who used the model when teaching graduate courses in ethics. It became the new first step of the model. We had observed that, in thinking through hypothetical dilemmas, participants often seemed to have a narrow focus regarding the impact of their ethical decisions (e.g., the psychologist and the client only vs. also considering the client's family, the employer, the community, the profession, etc.). This narrow focus, in turn, limited participants' identification of the ethical issues involved, the possible consequences, and the available courses of action. In our workshops, we informally added this step to the model and found that it added a richness to the group discussions that was not there before.

The second added step was "Consideration of how personal biases, stresses, or self-interest might influence the development of or choice between courses of action." I remember at first trying to talk Jean out of suggesting that this step should be added to the model. My rationale was that a similar statement was made in both Principle II and Principle III—one related to psychologists integrating self-awareness into their efforts to benefit and not harm others; the other to integrating it into attempts to be objective and unbiased. I thought that those statements would lead psychologists to evaluate their personal context and biases and take them into consideration in any ethical decision-making process, and that we needed to avoid the model becoming too complex. However, Jean, in her wisdom, very much disagreed, and we began informally adding the step to our workshops—once again finding that it led immeasurably to the quality of the group discussions and choices of a course of action.

The third added step was quite different from the two mentioned above and became the last step of the model, viz., "Appropriate action, as warranted and feasible, to prevent future occurrences of the dilemma (e.g., communication and problem-solving with colleagues; changes in procedures and practices)." From its first edition, the *Code* has stated in the section called "Uses of the *Code*" (CPA, 1986, Preamble), with only slight changes in wording, that "This code is intended to be a guide to psychologists in their everyday conduct and in the resolution of ethical dilemmas; that is, it advocates the practice of both proactive and reactive ethics." From the beginning, the *Code* has been seen to be proactive in that it helps us to anticipate and plan for ethical concerns (e.g., developing procedures and practices honouring ethical values like confidentiality, avoiding misunderstandings, etc.), as well as reactive (e.g., dealing with ethical problems we did not anticipate). It was not until the 2000 *Code*, however, that we formally introduced the idea into the decision-making model. I am uncertain why it took us so long to do this. It now seems self-evident that one of our ethical responsibilities when faced with an ethical dilemma is to try to find possible ways of preventing a similar dilemma from occurring in the future.

With each edition of the *Code*, at least two drafts were circulated for feedback prior to final approval. The 2000 *Code* was no different, and the changes mentioned above were very well received. There also was support for maintaining the other elements of ethical decision making brought forward from the two previous editions (i.e., having a model formally incorporated into the *Code*, ordering the ethical principles and assigning differential weights to them, providing a role for personal conscience, and emphasizing the importance of consultation).

2017—Fourth Edition

And now to the present. As noted above, after 2000, there was an exponential increase in articles in the interdisciplinary literature regarding ethical decision making. In addition, skills in ethical decision making and the resolution of ethical dilemmas became identified as essential for the expected core competence in ethics and standards (e.g., *Mutual Recognition Agreement*, 2001), and there was significant new thinking about ethical decision making and training in ethics. In preparation for a fourth edition of the *Code*, surveys had been circulated widely and there was continued strong endorsement of the emphasis in the *Code* on ethical decision making, including the inclusion of a model. Nonetheless, it was suggested that there was a need to update some of the content in light of what was seen to be significant new thinking about the role of character and virtue in ethical decision making, and the importance of combining the non-rational elements of ethical thinking and decision making with the rational in ethics training (e.g., see Korkut & Sinclair, 2020; Rogerson et al., 2011). With relatively minor changes in wording, all the above-mentioned major elements regarding ethical decision making in the 2000 *Code* were maintained in the 2017 *Code*. However, the previous two sections on ethical decision making ("When Principles Conflict" and "The Ethical Decision-Making Process") were combined into a single section called "Ethical Decision Making," and emphasis was placed on ethical decision making being a creative and self-reflective process, not just a deliberative one. To assist the self-reflective component, the third step of the ethical decision-making model added several further contextual considerations; and, finally, a responsibility related to character was added to the section "Responsibility of the Individual Psychologist." This responsibility was to "Engage in ongoing development and maintenance of their ethical sensitivity and commitment, ethical knowledge, and ethical decision-making skills."

Once again, strong support for the above changes was received from those responding to requests for feedback prior to approval. This does not mean that there were not suggestions for further changes or additional detailed explanations along the way. However, to prevent the *Code* from becoming too unwieldy or like a position paper, we fell back on what had guided us through all the editions; namely, to keep the *Code* as focused as possible on the essential messages, leaving the underlying dialogue and explanatory nuances to such vehicles as guidelines for specialty areas, academic articles, and manuals.[6]

The Role of the *Companion Manual*

And speaking of manuals, I cannot leave this chapter without trying to explain how and why the *Companion Manual to the Canadian Code of Ethics for Psychologists* came about, and the role that I think it has played.

After the flurry of work involved in getting the first *Code* to approval stage (CPA,1986), I was ready to take a bit of a break. However, that was not to be! Jean had another idea. In her work on CPA guidelines in the 1970s and early 1980s, she had helped produce resource materials (which always contained vignettes) to assist Canadian psychologists in the application of various CPA guidelines (e.g., CPA, 1978; Pettifor et al., 1980), and she was convinced that the *Code* also needed such materials to aid in its understanding, interpretation, and application. As the idea of a companion piece was floated within CPA, we received what can only be described as a loud shout of agreement. And, thus, about two years later, the first edition of the *Companion Manual* appeared (Sinclair, 1988). In addition to re-printing the 1987 *Canadian Psychology* article on the development of the *Canadian Code* and the CPA guidelines active at the time (e.g., *Guidelines for Therapy and Counselling of Women*; *Guidelines for the Elimination of Sexual Harassment*; *Guidelines for the Use of Animals in Research and Instruction in Psychology*), the *Companion Manual* also contained content written specifically for the purpose of helping psychologists understand, interpret, and apply it. This latter content included: (a) a running commentary on the *Code*, explaining the origins and meaning of some of its contents; (b) over one hundred vignettes of ethical dilemmas for teaching and practice purposes; (c) a chapter on the use of the *Code* in ethical decision making, including a chart of the principles and values for easy reference when thinking through the ethical issues involved, and the full or partial resolution of three ethical dilemmas using the *Code*'s suggested seven steps; and (d) an extensive selected bibliography.

Production of the *Companion Manual* was experimental. Although we had received a great deal of positive feedback about the idea, we had no idea whether psychologists actually would buy it.[7] As it turned out, there was no problem. So much so, each time the *Code* was updated, it seemed to be taken for granted that a new and updated edition of the *Companion Manual* would be produced. Jean and I agreed that this was important, and the next editions of the *Companion Manual* appeared in 1992, 2001, and 2017.[8] All the components of the 1988 *Companion Manual* were maintained through the next three editions. However, several changes and updates have been made over time: (a) three *Canadian Psychology* articles on the *Code* are now included; (b) the CPA guidelines included are those in current use; (c) the running commentary is more substantial and provides comments on the changes made to the *Code* over its various editions; (d) additional vignettes reflecting new and emerging ethical issues are included; (e) the bibliography has been updated; and (f) the chapter on ethical decision making reflects some of the most recent literature on ethical decision making and complete resolution of five ethical dilemmas using the chart of principles and values and all ten suggested steps of the current ethical decision-making model.

Some Personal Observations

Before ending this chapter, I would like to relay to you three observations that I sometimes mention to colleagues when reflecting on and wondering about the impact of the *Canadian Code*. The first observation is that, when speaking to groups that are interested in ethics but not used to using a moral framework like the *Code* for thinking through issues and dilemmas, they sometimes become very still and quiet. When first faced with this, I thought perhaps I was boring them, and they were trying to be polite about it. However, with experience and conversations with attendees, I came to realize that their quietness was a result of being very thoughtful and intrigued by what was being presented. It is hard to know exactly why they felt so intrigued. I am sure that many had been exposed to specific ethical principles before (although they may have labelled them somewhat differently) and understood the role and importance of values. However, in my conversations with them following the presentations, I had the impression that what intrigued them most was the overall moral framework of the *Code*—how it explains the principles, relates values to those principles, and recommends use of the framework for identifying and resolving ethical issues and dilemmas.

The second observation is not as positive. I sometimes hear that students, when being exposed to the ethical decision-making model of the *Code*, become overwhelmed and scrupulous, tending to see the steps as mandatory and inflexible, and trying to think of every possible issue, consequence, and course of action. This leaves them with the impression that ethical decision making is a cumbersome and unpleasant affair. Balancing this, however, is my third observation, namely, how frequently I hear seasoned psychologists comment on how helpful they find the suggested steps of the *Code*'s decision-making model and the *Companion Manual*'s chart of principles and values when thinking through a difficult situation. They find that these two tools help them to take a deep breath, step back from what is sometimes a highly emotional situation for them, and consider principles, values, and courses of action that they might not have considered otherwise.

Although the *Code* and *Companion Manual*, from their very first editions, had presented the ethical decision-making steps as "basic steps that typify approaches to ethical decision making" (CPA, 1986, Preamble), rather than as mandatory and inflexible, this obviously was not enough. To help correct the tendency for students (or others) to get the wrong impression about ethical decision making, the following paragraph was added to the most recent edition of the *Companion Manual* in the chapter titled "Use of the *Code* in Ethical Decision Making," which includes the resolution of five ethical dilemmas using the ten ethical decision-making steps and the chart of principles and values:

> Many psychologists across Canada have used versions of this approach to teach ethical decision making. The examples provided are not meant to imply that they are exemplars of how ethical decision making normally occurs or should occur; nor are they intended to imply that the decisions arrived at are the best solutions for the dilemmas. You may have other thoughts or better solutions. Rather, they are intended to demonstrate one way of using the *Code* to help identify and consider the multiple layers of issues and questions

> often present in difficult dilemmas, with the goal of building skills in ethical decision making through practice, experience, and the development of personal templates and heuristics for future problem solving . . . (Sinclair et al., 2017, p. 130).

Closing Thoughts

And so we have come to the end of the story about how ethical decision making became such a key and valued part of the *Code* and psychological ethics in Canada—from the beginnings of a small group working on the nature and values of standards of any kind and their relationship to ethics, to the decision to develop a made-in-Canada code of ethics, to the uncertainty of whether to include ethical decision making formally in the *Code*, to why in the end it was included, to the strong endorsement by Canadian psychologists, to what refinements and updates have been made over the four editions of the *Code*. Along the way, I have tried to highlight how the story included serendipity, confidence interspersed with doubt, great effort, and the contributions and wisdom of so many Canadian psychologists. I hope you have enjoyed the story. Thank you for your wisdom. Without it, we would never have had a story to tell. And, of course, without Jean, the story might have been substantially different.

Questions for Reflection

1. Think of one or two difficult ethical decisions you have made. What personal strengths do you think you were able to use in making the decision(s)? What personal weaknesses do you think made the decision(s) harder to deal with? What do you think you could do to build your strengths and offset your weaknesses for the future?
2. What criteria would you use to decide who to consult about an ethical dilemma? How would you approach them?
3. What do you think about the role of personal conscience in making ethical decisions? In what kind of a situation do you think you might rely on your personal conscience?
4. In the *Code*, one of our responsibilities is to engage in ongoing development and maintenance of our ethical sensitivity and commitment, ethical knowledge, and ethical decision-making skills. How are you doing this presently? How might you do it in future?

NOTES

1 Other perspectives can be found in three historical articles about the *Canadian Code* published in *Canadian Psychology* (Sinclair, 1998; Sinclair, 2011; Sinclair et al., 1987).

2 Now called *Canadian Psychology*.

3 Further details can be found in Sinclair et al. (1987).

4 Jean became a member of the Committee on Ethics in 1980 and, as such, continued in her role as catalyst, advisor, and motivator-in-chief throughout the *Code* development process.

5 Note to readers: Until 1986, the use of "we" generally refers to the members of the working group that developed the *Canadian Code* (Karen Gilmour-Barrett, Sonja Poizner, David Randall, and myself). The use of "we" beyond 1986 generally refers to members of the CPA's Committee on Ethics. After completing its oversight role with the approval of the *Canadian Code* in 1986, the Committee on Ethics assumed ongoing responsibility for the *Canadian Code* and its revisions, and the work group dissolved. Although Jean and I coordinated the Committee's work with respect to this responsibility, there were many different members of the Committee on Ethics over the course of the three revisions, all of whom contributed in some way to developments in the *Canadian Code*. Only a few of these are specifically mentioned in this chapter; however, the thanks of the Canadian psychology community are due to every one of them. Thanks also are due to the many psychologists and non-psychologists who so generously responded to our incessant requests for ideas and feedback over the years involved.

6 Suggestions for further detail and explanations were not limited to ethical decision-making. Another example is the use of technology, where there were suggestions to cover (and provide standards for) a wide range of technologies (blogs, social media, electronic records, etc.). Once again, we fell back on the same guidance.

7 The *Code* has always been free; however, there needed to be a charge to cover the cost of producing the professionally bound and printed *Companion Manual*.

8 Jean passed away in 2015. However, her contributions to the *Companion Manual*, including the content of its 2017 edition, was substantial. As such, she is listed as co-editor of the most recent edition.

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17

tâpwêwin: Speaking to Truth about Assessment and Indigenous Children

Meadow Schroeder, Stan Bird, Michelle Arlene Drefs, Michael Lee Zwiers

Introduction of Authors

Meadow: I am an associate professor from the Werklund School of Education, University of Calgary. I consider my path to becoming a school psychologist as part luck. I was a student who had a fairly easy time in school, but recall realizing at an early age that some of my friends learned differently and struggled to keep pace with their classmates. Witnessing the biological, cognitive, and social factors that influenced their education, I developed an interest in how children learn. This interest took a back seat when I entered university to pursue an undergraduate degree in music, but I soon found myself enrolling in psychology courses and switched majors in my third year. I was wondering what I was going to do with an undergraduate psychology degree when I discovered the field of school psychology. It seemed like the perfect pairing of education and psychology that I was looking for. After graduating with my Ph.D. in 2010, I worked in the field as a registered psychologist for a not-for-profit organization before being hired at the University of Calgary. During my 11-year tenure at the university, I have co-ordinated blended programs in school psychology and counselling psychology and served as director of practicum. Between 2018 and 2021, I was the academic co-ordinator for a Master of Education program in school and applied child psychology that consisted of only First Nations students. A collaboration with Manitoba First Nations Educational Resource Centre, the program was designed to meet the educational and learning needs of the students and to infuse Indigenous perspectives into the curriculum. In this role, I gained a deeper appreciation for the social inequities, racism, and barriers that are part of my students' lived experience, as well as their incredible resilience as they pursued an education.

Stan: I graduated from the University of Calgary in 2009 with my Ph.D. in applied psychology. Since then, I have provided school psychology services to rural and remote First Nations communities across Manitoba. My journey to this point in life had been indirect and fraught with uncertainty and challenges. At an early age, I was unsure of my path in life and where it would take me. I was born into a large family in the community of Peguis First Nation, about two hours north of Winnipeg. I have strong roots there and return in the summer to participate in ceremony. I was employed as an education counsellor for recent Grade 12 graduates and older adults. At a time in my life when I was seeking a new professional challenge, the superintendent of the local secondary school suggested I consider school psychology. School psychology was a totally foreign field to me, but it was encouraged as there was a dearth of First Nation school psychologists in Canada. As I went through the program, I struggled to reconcile my Indigenous background with the Western views of psychology. My learning was guided always by the question, "What does this mean for Indigenous peoples?"—"this" being anything related to the discipline of psychology. I found it difficult to find answers to that question on many occasions because I could not see how the psychology concepts and measures I was learning were applicable to First Nations peoples who differed in their culture, language, and everyday lived experiences. I also found there was a lack of literature on the topic that could validate my experience. At one point, I wanted to quit, and I felt it necessary to seek the advice of Baudwaywidun, the spiritual leader of the Midewiiwin people. He was not talkative or direct. Rather, he listened quietly and other than asking a few questions about my studies, he said very little. His words were simple, but as the months and years passed, they had a profound impact on my personal practice. He stated, "Once you learn what something is, you will understand what it is not." He was encouraging me to learn everything I could within my area to understand the relevance of it to my people. In my work, I witnessed how the funding model for education that has been imposed on communities has resulted in underserved children. The model forces educators to rely on Western methods of assessment and diagnosis to get support for students. In response, I strived to develop more culturally relevant psychology practices; however, my attempts have been met with limited success because political forces lack the will or desire to change—some of which we will elaborate on in this chapter. Despite these challenges, I credit Baudwaywidun for helping me see importance of honouring a people and their way of life. His words sustain me to this day.

Michelle: Prior to my 20+ years in the field of school psychology, as both a practitioner and academic at the University of Calgary, I had the privilege of being an elementary teacher. The majority of my teaching career was spent as a kindergarten teacher with the Dene Tha' First Nation in the northern Alberta community of Chateh. Located only a proverbial stone's throw from the Northwest Territories border, this was my first exposure as a southern Alberta city girl to remote northern living and the Dene nation.

It was while teaching in Chateh that I was first introduced to the field of school psychology. Every year a team of school psychologists would arrive to complete as many assessments as possible within a two- to three-week period. Prior to their yearly arrival, the principal would request that each teacher identify students they viewed as needing additional educational supports. Most years, I had not identified students for assessment owing to their young age and the fact that, for the majority of my students, Dene was their first and, upon entering school that year, only language. However, this particular year, I had referred James (a pseudonym) to be seen by the psychology team. His progress in learning English and basic kindergarten content lagged considerably behind that of his peers. I still readily recall the psychologist coming to my classroom to retrieve James so she could work individually with him. I had informed her that she would also need to take along the Dene-speaking educational assistant assigned to my classroom to translate because James spoke only a handful of English words. She responded that a translator was not necessary. Needless to say, when the psycho-educational testing came back indicating that the James had significant intellectual impairment, I was outraged. I knew virtually nothing of the field of school psychology or what constituted best practice, but knew that assessing a student in a language he did not even speak was poor practice. It was this incident that made me decide to become a school psychologist and work to know more and do better in my work with Indigenous populations. As I've given focused study to this area over the years, I recognize our field still has much to learn in terms of what constitutes the best and most ethical practice in working with Indigenous students, their families, and their communities.

Michael: I hold a master's degree in educational psychology and a Ph.D. in counselling psychology, with two years of postdoctoral training in clinical psychology. I am registered to practice psychology in the provinces of Alberta and Manitoba and hold an adjunct assistant professor position in education psychology at the University of Calgary. My first career was teaching in an inner-city elementary school with fewer than 200 students. I saw some students struggling to learn, to manage their emotions and behaviour, and to fit in, so I enrolled in a master's degree in educational psychology. In my first year, my principal asked me to be the school counsellor. When I protested that I had insufficient expertise, he said, "You'll do just fine," and patted my back enthusiastically. That was common in those days. So I decided to learn as much as I could about school counselling while setting up initiatives to support our students. I invited one of the school board's Native Home-School Liaison Workers, Edith Dalla-Costa, from Saddle Lake Cree Nation, to join us and run a bi-weekly group for our Indigenous students. She was enthusiastic and engaging, and word got around quickly so we soon had more than 20 participants. By attending, I began to learn a little about the Cree language and culture. In my school counselling role, I also met a number of school consultants, including psychologists. I was intrigued by school psychology with its specialized expertise in learning, development, and emotional functioning. I enrolled in school psychology courses to complement the required coursework for my degree. In those days, the specializations in psychology were not segregated, and my academic supervisor supported my taking whatever courses caught my attention! I have been working with Indigenous clients and cultural representatives since 1986, but still consider myself a novice in cultural understanding. As I learn about Indigenous cultures, I find I am actually learning more about myself.

Assessment and Indigenous Children

This chapter applies the ethical decision-making model from the *Canadian Code of Ethics for Psychologists* (2017) to a dilemma encountered by Stan in his school psychology practice. The dilemma is an example of the type of challenges school psychologists face in their work, especially when working with Indigenous peoples. We use this case to highlight considerations and difficulties practitioners may encounter when applying the ethical decision-making model to dilemmas arising from their work in support of First Nations communities, families, and individuals.

Stan's Dilemma

We landed in the fly-in community just as the sun was rising and could see the smattering of houses lined up around the bay.[1] Our plan was to spend the week conducting psycho-educational assessments in this First Nation community in Northern Manitoba, as we had done in past years. The community consists of approximately 5,000 residents, almost half of whom are under the age of 18. We knew we had a busy week ahead of us. We also knew we would be making only a small dent in the needs of the community school. Like most First Nations schools, the elementary school is chronically underfunded. Canada-wide, there are estimates of First Nations schools receiving up to 30% less funding compared to provincially funded schools (Drummand & Rosenbluth, 2013).[2] Although the federal government of Canada recently promised more funding for First Nation education (Government of Canada, 2019), schools are still dealing with the fallout of years of underfunding along with a significant increase in the population of Indigenous children (Drummand & Rosenbluth, 2013).

High-needs special education funding has a significant impact on a First Nation school's total operating budget. The system is set up such that when psychologists diagnose students with disorders or disabilities, schools can qualify for high-needs special education funding that is extra to the base budget. Special education funds afford a range of additional services deemed essential to the learning and success of such students. Such services include teaching assistants, interventions (e.g., reading and math programs, social-skills groups), resource teachers, and counselling services. After the application of complicated formulas, determined by the federal government, to account for the number of students who qualify for special education (see Drummond & Rosenbluth, 2013), schools are given a lump sum of funding. Principals then decide how to distribute it. As there is more need than this additional funding can serve, some hard decisions have to be made as to how funds are best allocated in support of students. Specific to this school, approximately 27% of students were eligible for special education funds, with many more students referred to a waiting list for school psychology services.

The principal greets us warmly as we arrive at her school just as the bell rang and students are entering their classrooms. She had not seen any school psychologists yet that year and needs to submit her request for funding by the end of the month. She provides us with a list of 32 students that were identified by the teachers and school, and for whom parental consent for assessment has already been obtained. We divvy up the list so we each would have eight students to assess over the next week, knowing of course that we might need to be flexible in the event that one of us encounters a particularly complex or time-consuming referral.

Stan started his day with Jonathan, a 10-year-old boy who has had ongoing learning challenges. The school is confident that he has a disability and is seeking help for him. Jonathan has excellent school attendance, having missed only three days this school year, and he has good relationships with his teachers. However, his academics are extremely weak, and he has begun to get in trouble for frequent acting out. Recently, he punched another student who made fun of him on the playground.

While meeting Jonathan's family, Stan finds out that Jonathan is currently living with his grandparents and father. His mother is staying with friends in Winnipeg. She has ongoing medical issues that require frequent and lengthy hospitalizations. Because of the high cost of travel, Jonathan has visited her only a couple of times in the past year. Not only is Jonathan worried about his mother's health, but he also has had a few extended family and community members pass away in the past year, including a cousin with whom he was very close. The grandparents and father seem loving and caring. They say that they see a lot of sadness in Jonathan and angry outbursts when things do not go his way. The family speaks nêhiyawêwin (i.e., Cree) at home and admits that their grasp of written English is not strong. Neither the father nor the grandparents can provide important details about his mother's pregnancy and delivery with Jonathon as his mother delivered Jonathan in the nearby city due to there not being a nearby hospital facility and they were not in attendance. By their account, development appeared normal. However, the father and grandparents indicate that Jonathan's mother would best be able to answer the developmental questions, but she is not healthy enough to speak with Stan.

When Stan reviews the scores of Jonathan's standardized intelligence test, the results suggest that Jonathan has an intellectual disability (a Full-Scale Intelligence Quotient [FSIQ] of 65). Although Jonathan has an average nonverbal FSIQ score with a standard score of 90, his other scores, including his verbal score, are much lower. Teacher observations of his adaptive functioning are consistent with the FSIQ, but his father left too many unanswered questions on the form for his reports of adaptive functioning to be scorable. With Jonathan's current FSIQ and teacher reports, Stan has a strong argument for diagnosing him with an intellectual disability and knows that the diagnosis will benefit him by allowing the principal to access funding to provide Jonathan with counselling supports and a part-time teaching assistant. However, Stan is concerned that other factors, such as English as a Second Language and emotional loss and its impact on motivation are negatively affecting Jonathan's performance on the intelligence test, the adaptive functioning measure, and his ability to cope academically. Furthermore, Stan knows that current standardized assessment measures often are criticized as lacking culture fairness and can disadvantage students of diverse cultural or linguistic backgrounds (Ortiz, 2019). Although First Nations students are a heterogenous group, they tend to perform lower than White students, particularly on tasks of verbal intelligence. However, the federal government's First Nations and Inuit Health Branch, which approves applications for funding, requires that diagnoses be made using standardized measures. To date, there are no measures developed specifically for use with Indigenous children, compelling Stan to use what is available. Considering the test limitations, Stan is concerned that this assessment presents an underestimate of Jonathan's true abilities. If this is the situation, giving Jonathan a diagnosis of intellectual disability that would follow him throughout his life would be misleading and potentially harmful. However, in not giving him the diagnosis, Jonathan is not likely to receive the needed counselling and teaching assistant supports.

Concerned about the implications of his decision, Stan decides he needs to consult with colleagues. Stan is one of only a few school psychologists with an Indigenous background in Canada. Without a strong network of Indigenous peers to rely on, Stan seeks us out for consultation. As a team, we share a longstanding interest and commitment in working toward understanding and adopting best practice approaches in our work with First Nations peoples. Although

Stan's impression is that many non-Indigenous school psychologists are unaware of the lived experiences of First Nations peoples, he has come to trust our judgement and insights because of our previous experience working with Indigenous communities. He is open to our perspectives but must ensure that his decision is congruent with the context and culture.

Step 1: Individuals and Groups Potentially Affected

After listening to Stan, we identify the primary individuals affected by any decision to be Jonathan, his family, and the school. Also potentially affected is Stan who has a professional reputation to uphold. If his decision harms Jonathan, his family, or the school, he risks developing a poor standing with communities. Before they hire contract psychologists, school administration (via resource teaching staff) will seek informal references from other communities. Performing poorly in one community may affect his chances of being employed by other communities. We also think that public trust in the school psychology field is a concern.

Step 2: Ethically Relevant Issues and Practices

Along with Stan, we identify a number of ethical values under the *Canadian Code of Ethics for Psychologists*' (2017) four ethical principles that we think are key to this dilemma.

PRINCIPLE I (RESPECT FOR THE DIGNITY OF PERSONS AND PEOPLES)

Under Principle I, it is important that the value of *General respect* be honoured. The community and the people within it need to be shown such respect, particularly when it comes to their cultural perspectives and values. There are many ingrained stereotypes and assumptions in mainstream culture that have been reinforced by colonialism and that are degrading to Indigenous peoples. In addition, colonialism has unapologetically trampled on Indigenous rights. As psychologists, we also have a duty to protect the value of *General rights* by ensuring psychological knowledge is neither misused nor misinterpreted in ways that undermine these rights. We also are expected to avoid *Unjust discrimination*. There has been a long history of discrimination against Indigenous peoples in Canada and psychology has actively participated in that discrimination (Canadian Psychological Association [CPA] & Psychology Foundation of Canada [PFC], 2018; Moorehead et al., 2015).

Although Indigenous cultures are varied across Canada, the culture of Indigenous peoples is distinct from Western cultures in many ways including their value systems, social structures, interpersonal relationships, languages, views about education, and views on health (Gone, 2008; Little Bear, 2000).

Some psychologists believe Western approaches to health and education can be applied directly to Indigenous communities without considering or accommodating for the cultural differences (Reynolds & Suzuki, 2012). Others unwittingly engage in discriminatory and insensitive acts because they lack cultural competence (Snowshoe et al., 2017). Regardless of intention, for many years our field has ignored the influence of culture on learning, resulting in a disproportionate number of Indigenous students being placed in special education classes or labelled as delayed or disabled (Newell et al., 2010; Robinson-Zañartu et al., 2011). Importantly, Jonathan deserves *Fair treatment* in the process. Being treated fairly in this context means using fair assessment methods and interpreting assessment results with his family, social, and community contexts in mind. For example, psychologists should understand and respect cultural differences in child development and child-rearing practices. Indigenous children's early learning experiences primarily include skill development facilitated by adult demonstrations and mentoring, oral storytelling, and co-operative activities (Rogoff et al., 2017), which are different from school-like methods of learning in Western cultures. School psychologists may misinterpret the learning behaviours of Indigenous children as indicative of a lack of ability (Ball, 2012; Rogoff et al., 2017) rather than the result of a mismatch between their early development and Western schooling.

PRINCIPLE II (RESPONSIBLE CARING)

As part of our commitment to responsible caring within this particular community, we also ask ourselves if we have the *Competence and self-knowledge* to complete assessments with Indigenous populations. As clinicians, we encounter two barriers to developing such competence and self-knowledge. First, school psychology has lagged behind other areas of psychology (e.g., counselling, educational) in attracting non-White practitioners and in its consideration of diversity in training models (Ansloos et al., 2019; Newell et al., 2010; Robinson-Zañartu et al., 2011). Second, a review of the literature finds very little research in school psychology that includes Indigenous peoples (e.g., Grigorenko et al., 2001; Nakano & Waltkins, 2013), and what little information is available tends to focus on a deficit model that highlights what Indigenous students cannot do (e.g., Nakano & Watkins, 2013). At the same time, there are few suggestions for how school psychologists might approach their practice differently and what impact their own background, culture, and biases might have in working with Indigenous children.

First Nation communities, especially those in rural and remote areas, often have had difficulty accessing psychology services (McIlwraith et al., 2005). There are a limited number of psychologists willing to travel to communities, and smaller communities do not have the resources to hire their own staff. Using contract psychologists has limitations for a number of reasons. Perhaps most salient is the reality that "time is money" so band councils hire psychologists to complete as many assessments as possible to meet criteria for the funding model. Too often, these contractors have little vested interest or time in developing relationships with educators and families, understanding the context in which students reside, or considering the appropriateness of their practice. An example is Michelle's experience, referred to earlier, as a teacher with a psychologist who refused to use an interpreter when working with kindergarten-aged children who had been exposed to English for less than a year. It is not uncommon for assessments to be rushed, resulting in significant errors that in turn lead to conclusions or diagnoses that are seemingly biased, based on incomplete information, and/or lacking in cultural appropriateness (CPA & PFC, 2018). To compound the issue, the band council does not have the training and expertise to evaluate the work of the contractors; they evaluate competence by how much the psychologist accomplishes in a visit and the amount of funding this provides to the school for additional resources. Furthermore, because this work takes place on federal lands, the psychological regulations of individual provinces do not apply. As a result, some psychologists are empowered to disregard standard practices and act in a way that leads to assessment for profit. Our group wants to interrupt this approach by providing quality assessments that incorporate a more culturally sensitive approach. This is not an easy undertaking. Even Stan, who is Indigenous, had to find ways to integrate the Western model of psychology with his culture through his on-the-ground experience, instead of relying on formal training. Thus, although the four of us bring our unique backgrounds working with Indigenous groups to our practice, it has been ad hoc and without the benefit of evidence-based training. This tension between goals of reconciliation and graduate training is described eloquently by Schmidt (2019) from Cape Breton University who highlights the desire of universities to Indigenize their curricula. They rely on newly hired Indigenous faculty to change campus culture in the face of subtle (or not-so-subtle) racism. The four of us could have chosen not to take the contract with the community. Yet, without other professionals who have more competence and with communities desperate for services, we have decided to provide our services while making every reasonable effort to honour the value of *General caring* and ensure that our practice does no harm.

As part of Principle II, we need to engage in *Risk/benefit analysis* with respect to the course of action being advised or chosen. Stan's assessment of Jonathan must be thorough enough for him to consider and decide what might benefit him. Furthermore, the school, his family, and even other community members involved in his development, should be able to understand how Stan's diagnostic decision is of benefit. We know our tools are not as culturally relevant as we desire to maximize the potential benefits of the assessment process. To compensate, we must look beyond the test scores and consider Jonathan in his current context.

PRINCIPLE III (INTEGRITY IN RELATIONSHIPS)

One of Stan's concerns about his decision is upholding the *Code*'s Principle III (Integrity in Relationships), which contains such values as *Accuracy/honesty* and *Straightforwardness/openness*. As a First Nations person, he is well aware that many Indigenous people perceive the current educational system, to which school psychologists are affiliated, as a continuation of the legacies that have oppressed their ways of life (Elias et al., 2012; Snowshoe et al., 2017). Indigenous people have had their children taken away—first through the residential school system, then by the "Sixties' scoop," and today with an overrepresentation of Indigenous children in care and youth in juvenile detention. Given the historical and ongoing colonialism that Indigenous people experience, they may feel distrust of the system and those who work within it. For many, Western approaches to health contradict traditional teachings and understanding of the world (e.g., Struthers & Eschiti, 2005). While the school wants to have Jonathan assessed because they want to help him academically, his family may find the goals of the assessment confusing and may question the intentions of the school.

Understanding how history has affected communities, Stan recognizes the importance of establishing trust with the family by being truthful and honest about his activities while also being aware of his personal biases. Truthfulness is integral to an Indigenous value system that includes honesty, caring, and respect. As part of Indigenous teachings, truthfulness is interconnected with other values. For nêhiyawak (i.e., Cree), "truth" is law. Although there is no direct translation of "truth" in Indigenous cultures—in nêhiyawak society, it aligns with the term, *tâpwêwin*. It is a spiritual way of knowing that is based on the creative process observed in the natural world (i.e., the cycle of the seasons, the cycle of life), and is tied to the law of *pimâtisiwin*, which comes from *pimatci*, or "to follow Mother Earth." (Jeff R. Wastesicoot, personal communication, July 14, 2020). In this respect, truth is a "state of being" found in the repeated actions of the individual. Repeated actions determine whether an individual mirrors the creative process found in the natural world and whether this is their state of being.

Similarly, honesty is an important Indigenous value, and is associated closely with sharing (Little Bear, 2000). Sharing is found in relationships. Little Bear explained that the cultural teaching of sharing involves an understanding that everything has life and is part of the continuous change that is creation. The customs of the people, like songs, ceremonies, stories, and dance, provide the means to share one's understanding of creation, and in a sense, share life so that others may have life. Indigenous people know that it is impossible to know with certainty what someone else knows. We are dependent on what others choose to say or share, and their words are given life with breath. Through breath, which like wind, is life-giving, their words are given life. Untruthful practice is not life-giving and is harmful to the reputation of the psychologist and the relationships he has with others, including other communities (since families often communicate with each other). If the psychologist is not truthful in their actions and words, others will not trust the psychologist.

For us, there does seem to be an element of "truthfulness" to this ethical decision making that relates to the limitations of our profession. Not only should Jonathan's family understand what they are agreeing to with the assessment, but we must endeavour to ensure they understand the implications of diagnosing or not diagnosing an intellectual disability. Such a diagnosis would help Jonathan access services. At the same time, it should not be considered lightly. If we are wrong and intellectual disability is not an accurate diagnosis, Jonathan might have difficulty removing the label and he could suffer long-term consequences. We must consider the implications of giving a diagnosis that will potentially follow Jonathan for the rest of his life.

PRINCIPLE IV (RESPONSIBILITY TO SOCIETY)

Principle IV requires that we situate the dilemma within the societal context. Jonathan's current functioning is partly an outcome of the historical treatment of Indigenous peoples. The psychology profession has been part of a system that has reinforced colonial values and it is our duty to prevent ongoing racism. We can do this by engaging in *Beneficial activities* that promote social change—one of the values of Principle IV. Such activities include taking a critical stance on psychology's role in colonization, encouraging better services for communities, and making psychologists accountable for their work.

The decision about Jonathan should incorporate the Principle IV value of *Respect for society*, particularly the subculture within which Jonathan is situated. We should have an adequate knowledge of the culture, social structure, history, and customs of his community. As identified earlier in this chapter, we acknowledge the limitations of our cultural competence. Yet, that does not mean that we cannot seek out guidance from community members and respectively consider their perspectives, systems, and customs. By upholding Principle IV, we have an opportunity to contribute to the *Development of society* by promoting practices that create societal change and avoid the misuse of psychological knowledge.

Step 3: Consideration of Biases, Pressures, Personal Needs, Self-Interest, and Contexts

When we consider the dilemma Stan is facing, we recognize our own biases as they relate to the cultural and historical background specific to this assessment and our work in this community. Aware of some of the troubling practices other psychologists employ, these experiences have shaped who we are as psychologists and constantly challenge us to be mindful about making the best decisions possible when working with Indigenous students and working to ensure we do not sustain damaging colonial practices.

All four of us appreciate that we are visitors to this community, which carries a complex political, social, and relational dynamic. We value a strength-based perspective in our work. We know that our work captures only a snapshot of the child on one given day, with relatively minor consideration of the child's broader environment. Based on how Jonathan is performing under formal assessment conditions, he appears to have many delays in his functioning; however, outside of the testing room, he may excel in other situations. If Stan had the time and opportunity to talk with Elders of the community, they might be able to offer a perspective of Jonathan that is quite different to a Western-education perspective, which tends to align itself with a pathology-centred medical model (Gutkin, 2012). Additionally, without his mother to give us information about his developmental background and without seeing the child in his environment, Stan risks making a diagnosis devoid of context.

For us, the use of standardized test measures with Indigenous children is a big concern. The academic and cognitive performances of Indigenous children have been compared unfairly to White, middle-class children using standardized tests that assess what White test developers deem important (Neegan, 2005; Rogoff et al., 2017), and are based on norms from predominantly White students who have access to enhanced educational opportunities through a better-funded educational system, not to mention better health, nutrition, and housing. As a result, Indigenous students are at a disadvantage. Additionally, Indigenous values and needs are rarely considered. For example, Indigenous children living in rural and remote areas acquire practical or adaptive skills that match the demands of their environment (Findlay et al., 2014; Grigorenko et al., 2001). Elders and family members might value children's ability to identify wild plants, catch fish, and hunt. In contrast, the same skills are not seen to be essential for urban children who instead need to know how to cross a busy road, buy things from the store, and navigate public transit. We recall, for example, a veteran psychologist's account of his early days testing in a northern fly-in Indigenous community. He had just completed testing a young boy who obtained a FSIQ score within a range that would suggest he would have profound deficits in his ability to reason, problem solve, and plan. Yet, when a winter storm rolled in and caused white-out conditions that seemingly made it impossible for the psychologist to return to the airplane at the end of the day, it was this young boy who was selected by school administrators to successfully navigate the psychologist back to the airstrip on a snowmobile.

Language has had a particularly complicated relationship with formal testing (Cormier et al., 2018). Many psychologists value verbal scores over nonverbal scores such that average or higher verbal scores in the presence of lower nonverbal scores are given a learning disability designation, whereas the reverse is viewed as low cognitive ability. We have seen other students like Jonathan who have verbal comprehension scores so low on intelligence tests that it pulls down their FSIQ, sometimes dropping it to the intellectually impaired range. In this context, it is critical for us to understand how language is used in the home and community. Children are encouraged to learn by observing, and interrupting or questioning Elders and adults can be viewed as inappropriate or disrespectful. Too much talking while on a hunting trip can scare off animals, which affects the family's food supply or income. In an educational context, children's silence might be seen by teachers as a disadvantage for learning without recognizing that it is a reflexive process that is learned early in childhood. The language development of Indigenous students has been affected by historical inequities in the education that their parents received, as well as by the decimation of Indigenous languages (Statistics Canada, 2018). Many isolated communities have developed English dialects that are a blend of English or French with Indigenous languages (Ball, 2009; Thorburn, 2014). A recent graduate student of Meadow's grew up in a fly-in community where children attended a residential school run by French-speaking nuns who taught them in English. This resulted in an entire isolated community with a unique vernacular and accent.

We recognize the issues in assessing Indigenous children with instruments that reflect the dominant culture's knowledge and values (Eriks-Brophy, 2014). Language encodes values, a way of thinking, and ways of acting that are integral to culture (Battiste, 2000). Consider for a moment the cultural and historical references made every day in the English language. A few examples to consider are: "Let's Google that," or "To go Dutch on a date." Indigenous Elders believe that, if their communities can hold onto language, they will never lose cultural knowledge and the underlying values that are tied to it (Battiste, 2000). Language is unwritten history. Unfortunately, to complicate clinical practice, English, or a dialect of it, has become the dominant mode of communication in younger generations, so the values and worldviews perpetuated through the English language becomes the standard. Thus, Indigenous children's language is influenced by adopting a colonial language that is contradictory to their people's ways of understanding and interacting with the world (Schroeder et al., 2020).

As a team, we also have been influenced by Stan's perspective on the situation as an Indigenous person. There are very few Indigenous school psychologists in Canada. Stan is one of a handful of clinicians who brings a personal understanding of Indigenous knowledge and culture to school psychology practice. Part of Stan's hesitation with making the diagnosis of intellectual disability stems from his unease with giving a diagnostic label of "disorder." Although not all Indigenous people embrace traditional perspectives, seeing children as disabled is a deficit-based view that is contrary to an Indigenous worldview. Instead, children are seen as sacred beings who bring gifts to their community. This understanding is tied to how Indigenous peoples view human development and spiritual connectedness. The gifts of children can come in different forms such as being a good hunter or something as simple as helping another person learn a life lesson. If a child has a problem, they work to find solutions and draw on strengths, and have little interest in assigning a label.

Aside from his Indigenous spiritual belief about disabilities, Stan is concerned that a diagnosis may further marginalize Jonathan within his family and broader community. In Indigenous communities, all adults are responsible for raising children through a strengths-based lens. Children will learn skills when they are ready, and adults strive to find ways to support their development. If Stan gives Jonathan a label for the problem, his family may no longer see themselves as agents of change and see the responsibility for the child in the hands of educators. If Stan is to consider the intellectual disability diagnosis, he needs to better understand how the family views this diagnosis and any potential harm it might cause.

Competing here with our inherent primary biases and consideration of cultural factors are several external factors. In particular, we recognize that we work within a primarily Westernized education system, both in terms of its delivery and funding models. We feel pressured by the principal to diagnose Jonathan so she can access services for Jonathan. We like the principal and the school staff. We see how hard they work in an underfunded school. Sometimes, the principal has difficulty finding enough money to pay for basic materials such as books, paper, and pencils. Special education funding helps supplement basic needs for all students, not just for students with special needs like Jonathan. If the principal cannot access extra funds, it hurts all the children in the school. When we look around, we feel some responsibility to help. We also have a contract with the community that helps pay our bills. If the principal is not happy with the outcomes of our decisions, the band might not award us with another contract in the future.

Step 4: Alternative Courses of Action

After some discussion we identify three courses of action.

ALTERNATIVE 1

Stan could diagnose an intellectual disability but explain to the principal and family that he suspects the diagnosis is not an accurate explanation for Jonathan's learning problems. Stan then could work with the school staff and family to develop a learning plan that addresses Jonathan's learning needs, have them monitor his response to the plan, and reassess him after he has had an opportunity to respond to the plan.

ALTERNATIVE 2

Stan could explain to the principal why it is not in the best interests for Jonathan to be diagnosed with a disorder that does not accurately explain his learning problems. He could offer to provide some professional development for the school staff and family regarding behaviour management and the effects of trauma on children's functioning. Additionally, he could help the family develop an appropriate homework plan with the teacher. Part of this work could additionally involve encouraging the school to adopt more school-wide approaches that focus on high-quality instruction and universal screening of all children in the general education classroom. This assumes that if the colonial impacts specific to this situation are accurate, it would be reasonable to assume that other students are similarly impacted.

ALTERNATIVE 3

Stan could delay making a diagnosis until he can follow up with Jonathan's mother when he returns to the city, asking her about Jonathan's early development. In the meantime, Stan could utilize community members to work with Jonathan and piggy-back or partner with existing services and supports within the community. The next time he visits, Stan could try to arrange unobtrusive observations of Jonathan outside of the school environment to get a better sense of his adaptive skills. If Jonathon meets criteria for a diagnosis, Stan could work collaboratively with the school, community, and Jonathan to develop targeted programming.

Step 5: Short-term, Ongoing, and Long-term Risks and Benefits

If Stan were to diagnose an intellectual disability, Jonathan would benefit from funding and the school personnel would be satisfied with the outcome. However, when we look at Jonathan in context, we see an angry, confused little boy who has a supportive family but who needs help processing the loss of his cousin and his other relatives. To some degree, he also has experienced the "loss" of his mother. It is quite common for members of First Nation communities to lose family members and friends to disease, suicide, and death as the result of systemic violence. With ongoing, multiple, and unpredictable deaths, adults do not have the time or the skills to process one death before the next death occurs. Jonathan's family cares about him, but as they try to manage their own grief, the effects of intergenerational trauma can be profound and sometimes make this impossible.

However, Stan risks misdiagnosing Jonathan. We are cognizant of the limitations of our standardized testing with this population and without a prior testing history, we are unsure how much his current social-emotional functioning is affecting his test scores. Additionally, we need to consider that Jonathan's nonverbal scores were within average limits, pointing to some key capacities that should not be ignored. Further, adaptive functioning was only reported by the teacher because the family was not able to accurately answer the questions. By not considering the context in which Jonathan is situated, his family might see the label as unhelpful and deficit-focused. Stan needs to consider the effect that a loss of trust might have on his relationship with the family. One problem with labels is that they tend to stick around and are difficult to remove from students' files even if a reassessment has different findings. Stan needs to have faith that the school will take the time to address what he suspects are the underlying causes of Jonathon's learning problems (i.e., delayed language and trauma) rather than treat him like a child with an intellectual disability. He also needs to trust that the school will be willing and able to schedule Jonathan for reassessment after they have carried out the advised educational plan. Unfortunately, with all the other children waiting for an assessment in the community, Jonathon may never receive an updated learning assessment. With extensive wait times, a loss of motivation to learn and school dropout become real concerns.

By not making a diagnosis, Stan would be asking the school, home, and community to support Jonathan within their existing resources. They may not have sufficient resources to include another child in a finite special-needs support system, or the interventions they are able to put in place may not be adequate. For instance, Stan has seen schools ask children to attend school half of the week so that special-needs resources can be shared amongst more children. With the resulting missed school time, these children are not receiving adequate education or special-need supports. A potential risk of this for Jonathan is that, if his needs remain unmet, he may become angrier and more aggressive within the school context.

The third alternative of delaying a diagnosis until Stan can gather more information would mean a more thorough assessment needs to be conducted. Stan would be more confident in his conclusions. However, there remains a risk that Jonathan's mother will not be reachable when Stan returns to the city, or that she is not able to provide any more information than he already has. There is also the chance that Stan will not be back in the community for a long time, so waiting to conduct an observation of adaptive skills would mean that the services he puts in place until a diagnosis, if any, could be made may not be the types of services Jonathan needs. While this option helps Stan better determine if a diagnosis is warranted, an additional difficulty is that it does not resolve any of the two-worlds issues identified above, such as the appropriateness of diagnoses from an Indigenous perspective.

Step 6: Choice of Course of Action

Following consultation, Stan decides that Alternative 2, which includes not diagnosing an intellectual disability, is the best course of action available to him at this time. It upholds the principle of respect for the dignity of persons and peoples, including non-discriminatory assessment. It is more likely that weaker English language development, combined with social and emotional challenges, is affecting Jonathan's learning rather than a general cognitive delay. Despite the school's need for funding, Stan believes that Jonathan deserves an assessment that considers his situation within the school, home, and community context.

Step 7: Action

Stan meets with the school personnel and Jonathan's family to explain his assessment findings. Together, they decide on some strategies that teachers can use to manage Jonathan's behaviour and support his learning in the classroom. They identify ways the family can be more involved in his education, including having better communication about homework by having a calendar that Jonathan brings back and forth to school. Lastly, Stan suggests Jonathan access some community-based supports that might support Jonathan's social-emotional development, especially his struggles surrounding the absence of his mother, loss of extended family, and fears of losing other family and friends. Before he leaves, Stan identifies some key professional development opportunities for school personnel that he could provide on his next trip to the community.

After the meeting, Stan discusses his decision with the principal and offers alternative ways to support her. He recommends that, instead of focusing only on assessment in the school, a consultation model would be more culturally relevant for all students, not just for Jonathan. Compared to assessments, consultation is more flexible and focuses more on emerging needs and response to intervention.

Step 8: Evaluation of the Results

The principal is not pleased with Stan's decision. She turns down Stan's suggestion to focus more on consultation. She does not see the value of consultation if it does not lead to funding needed to provide services for her students. She has limited dollars for school psychology services, and she believes that diagnosing for dollars is the best use of the money. She asks Stan to reconsider his decision, arguing that she had seen other students with similar profiles who other psychologists had diagnosed with an intellectual disability. She does not see the harm in the diagnosis if it is a means to get funding that would ultimately provide support for Jonathan. Stan explains that misdiagnosing Jonathan could be more harmful over the long-term than the short-term benefits of the diagnosis. As the 2018 report by the CPA and the Psychology Foundation of Canada stipulates, "Psychologists administering assessments should help clients understand that the function of assessment is to inform treatment and provide access to services, rather than merely provide a label or diagnosis" (p.19). If the label follows Jonathan into adolescence and adulthood, he might be provided supports that ignore the context in which Jonathan is situated, particularly his past trauma. He also could be denied access to other education opportunities because he will be seen as intellectually disabled instead of someone with English language delays that affect his learning.

Step 9: Responsibility for Consequences

Still believing he made the right decision, Stan does not give in to the principal's wishes. He notices that the principal's goodbye as he leaves the school is not as warm as her welcome greeting. However, he plans to keep in touch with the principal with the intent of forming a better relationship with her. He has not given up hope that he can convince her there are better ways to support her students.

Step 10: Action to Prevent Future Occurrences of the Dilemma

Stan's situation is reflective of an underfunded education system that struggles to serve Indigenous students with special needs. Financial- and resource-strapped schools are seeking extra funding in the form of high-needs special education, but can only access it through formal assessments and diagnoses. Often, however, assessments are conducted by professionals with little-to-no understanding of Indigenous ways of knowing and living. They use instruments that are not relevant to the experiences of children and use a diagnostic system of labelling children with disabilities, which conflicts with Indigenous views of children.

It is clear that our profession needs to advocate for change. As clinicians, we will continue to work at becoming knowledgeable about the cultural, linguistic, and social differences between Western and Indigenous societies, particularly the divergent perspectives on children's development and education. When we travel to communities, we will try to educate band councils and school personnel about the potential benefits of alternative models of service (e.g., consultation, response to intervention) that are strength-based approaches. Although assessment will be necessary in some instances, we will seek first to find solutions to problems and avoid labelling students using a medical model. These proposed changes to clinical practice will mean spending more time in collaboration and community engagement and will likely be more costly. This model also may lead to reduced funding overall for the school if fewer students are identified as high-needs. Should this occur, we view our role as helping advocate alongside our education partners to draw attention to reduced funding levels and the resulting harm to children (and communities). Furthermore, we will join other voices, including those of Indigenous psychologists, who are fighting to bring about change.

For Michelle and Meadow, who work within academia, consistent with the Principle IV value of *Development of knowledge*, we will strive to improve the training of graduate students. Although many Canadian universities have sought to change their curricula and have attempted to hire Indigenous faculty, there is still a limited number of Indigenous scholars of psychology in Canada (CPA & PFC, 2018). We are relying on a small pool of young, pre-tenured faculty members to lead change (Schmidt, 2019) and we have personally witnessed the emotional toll this has taken on them. Those of us who are not Indigenous have a responsibility to be non-Indigenous allies. Not only should students understand the history of Indigenous peoples, but they also need to take a critical stance on mainstream assessment, intervention, and consultation practices. There is also a need to attract and retain more Indigenous students in programs. This is a difficult task because there are numerous barriers for Indigenous students to access and complete post-secondary training (Louie et al., 2017). Our goal is to identify Indigenous students early on who are interested in pursuing degrees in psychology, including graduate school. By collaborating with communities and removing barriers, we want to provide mentorship that promotes student success. Once students are in our programs, we need to ensure they feel they are not alone in their views or subject to subtle racism. Furthermore, they will need help integrating both worlds (Indigenous and non-Indigenous) so that they are not continuing to perpetuate harmful psychology practices.

Importantly, we can join the national conversation about access to reliable funding for education and quality psychology services. We can work to change graduate training and practice in communities, especially our approach to assessment. We believe changes to the latter will only be effective if we include the perspectives of community members, Indigenous graduate students, and Indigenous scholars. The system that perpetuates insufficient services will be difficult to change. Together, we can take a stance on these issues by publishing chapters like this one that highlight the problems with our systems as well as lending our voices to minority Indigenous voices seeking to make change and be a part of the decision-making discussions at a federal level.

Concluding Thoughts

This chapter exposes some of the challenges school psychologists may face when working with Indigenous students. Keeping in mind the great diversity that exists within and among Indigenous communities, clinicians must be mindful of cultural considerations specific to each community, family, and individual with whom they are invited to work. We situated this ethical dilemma within a First Nation community school. Although there are unique aspects to serving Indigenous populations living in First Nation communities, much of what has been discussed in this chapter also can be applied to serving Indigenous students living off-community. Some general areas to consider are an individual's degree of acculturation, English language proficiency, historical trauma, and a shared understanding of the education system and psychology. It is our hope that anyone reading this chapter will carefully contemplate their roles and responsibilities should they find themselves working with Indigenous communities and Indigenous people; they should also work toward building relationships and trust with such communities over time.

School psychologists function within the larger social institution of schools—a system that may not be always congruent with the standards and practices of psychology. This is highlighted in our scenario, including in the principal's strong push for a diagnosis in order to access much-needed funds to better support Jonathan's learning and social-emotional needs. School psychologists can and should work to advocate for the adoption of practices that are culturally appropriate and aligned with contemporary thinking; however, such work takes time. In the meantime, school psychologists are left to make difficult and seemingly imperfect decisions. In such instances, the conscientious application of existing ethical principles, values, and standards can provide school psychologists with guidance to make the most ethical decisions possible in the circumstances.

Questions for Reflection

1. When considering Principles I and II, how would you apply the principles, values, and standards in your work with Indigenous students? Identify barriers to upholding them fully.
2. In a graduate psychology program, one faculty member has opposed a decision to accept an Indigenous student because of the student's lower grade point average and lesser research experience. Considering the colonial and educational history of Indigenous people, draft an argument outlining the CPA ethical principles and associated values that counter the faculty member's opinion.
3. The psychologists in this chapter decided to work with a First Nation community despite limitations to their cultural competence. Were they justified in doing this?
4. With a growing Indigenous population, school psychologists are faced with how best to serve them. Read CPA and PFC's (2018) response to the Truth and Reconciliation Commission of Canada report. Consider ways psychology might uphold Principle IV.

NOTES

1 The referral presented in this chapter is fictional. It is based on the type of referrals seen in First Nations communities and is representative of the tensions that exist between psychology, the education system, and Indigenous culture.

2 An exact number is difficult to calculate. Funding differs for multiple reasons, including location and community access.

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18

Charting New Territory: Reflections on Accompanying a Client who has Chosen Medical Assistance in Dying (MAiD)

Kimberly A. Thomas, Ivana Djuraskovic

This chapter provides two reflections related to an ethical dilemma involving medical assistance in dying (MAiD). The first reflection describes the journey that a provisional psychologist (Kim) underwent in deciding to support her client, John (a pseudonym), in pursuing MAiD and by being present at the time of his death. Kim deconstructs her ethical decision-making process regarding John's wish to have her present at his death. She also discusses the roots of her reflection, obstacles she encountered in making her decision to be with John when he passed away, and tips for clinicians dealing with difficult ethical dilemmas. The second reflection describes her supervisor's (Ivana's) experience in helping Kim to make a decision that was in John's best interests. The chapter ends with a postscript from both authors, offering thoughts about their journey and honouring John's memory.

Kim's Reflection: A Provisional Psychologist's Tale

My eyes and ears were opened when I saw, heard, and felt the plight of a terminally ill individual in pursuit of MAiD. I did not expect to embark on such a therapeutic journey in my career as a psychologist, let alone encounter it in the first several months of my placement as a provisional psychologist providing therapy in a community health clinic that served some of my city's most vulnerable populations. Many of those served are survivors of pervasive and systemic trauma spanning the course of their lifetime. Their struggles often are rooted in historically unmet needs to be seen, heard, and believed by those who are tasked to provide care and protection, namely, social and health service providers.

These providers are also tasked with promoting and protecting client autonomy, self-determination, and choice in their clients' wellness journey. This includes securing dignified and humane care throughout their lives, including the dying experience.

Part of this chapter speaks to the reflections and ethical challenges I encountered as both a clinician and a human being working alongside a client on his journey of choosing and planning for his death through MAiD. MAiD refers to "what is commonly called voluntary euthanasia (i.e., the administration by a medical practitioner or nurse practitioner of medication that will cause a person's death at their request) and assisted suicide (i.e., the prescription or provision by a medical practitioner or nurse practitioner of medication that a person could self-administer to cause their own death)" (Government of Canada Department of Justice, 2018). I also include tips and learnings that I hope others may find useful as a source for reflection and consideration. Through this experience, I came to realize first-hand some of the challenges clients and clinicians may face in navigating a client's choice of MAiD—a choice that is becoming more frequent in our society. The experience opened my eyes to the need for the discipline of psychology to acknowledge the unique position it holds in the lives of vulnerable clients, especially when invited to be part of their dying experience.

The Roots of My Reflection

Upon completion of my master's degree, I accepted a job placement at a community health clinic. The physician who referred John to me informed me that working with him might be challenging given that John did not trust clinicians. Many survivors of complex trauma report invalidating experiences within the health care system. I understood and sympathized with his distrust and let the physician know I was up for the challenge. I readily welcomed John into my practice for what would turn out to be an unexpectedly life-changing journey.

When we started treatment, John let me know that he was pursuing MAiD for when his body could no longer support his quality of life. As such, the narratives of life and death were common guests in our sessions. I also came to learn that John was estranged from all members of his family, and that he had no friends who he considered able to provide safe emotional supports for him. John shared with me the complicated nature of his relational past and said that there were many wounds he did not expect to be healed in his lifetime. In the two years we worked together, there were many ruptures and repairs relating to his mistrust of the medical system, and a fair amount of waxing and waning regarding being able to step two feet into the therapeutic relationship with me—in part, no doubt, due to his relational trauma history. Furthermore, though John was committed to pursuing MAiD, securing this was never a sure thing as there were medical practitioners along the way who had raised questions about his psychological fitness to make such a choice. These challenges could have been barriers to his securing MAiD, yet John's fight compelled him to move forward to pursue his right to a dignified death through MAiD. Amid all the hurdles and hoops, I invited John to keep returning to the therapeutic process with me. In his own time, every time, he came back—something that humbles me to this day.

Seasons passed and his body continued to deteriorate. The cruel course of his health diagnoses was unrelenting, and his body became increasingly weak. John and his treatment team had navigated the challenging process of securing MAiD in the next few months. Eventually, he called me to say he could no longer get himself on transportation safely due to the deterioration in his body. He said he was ready to have me come to meet him at home. I recall how hard it was for him to accept my previous offers to meet with him in his home. Where we once walked the halls of the community clinic together, we found ourselves sitting in his living room or taking a couple steps onto the patio. We spent the last several months of sessions in the safe place of his home, where he would play rock and roll on the stereo, all the while playing air guitar. He set out a pair of slippers for me by the door to use every week I visited and greeted me with a smile time and time again.

One day as he sat across from me on the sofa, his demeanour changed. He appeared nervous as he let me know he had something important he wanted to ask me. In that moment, my heart jumped into my throat as I knew what he was going to say. The words came out and felt suspended in the air for a moment: "Would you be there to hold my hand as I die, Kim?" Immediately, I heard an internal voice that spoke with clarity and a sense of knowing "Yes, I would be honoured. I am here with you every step of the way." However, I did not say it out loud. I paused.

Finding My Compass: Reliance on The Discipline and Self-Reflection

When confronted with the ethical dilemma of whether to accept John's request to be present at his time of death, I was a neophyte provisional psychologist. I can recall that the moment he asked me to be with him during his passage through death, the weight of his request struck me deeply in my human heart, yet it also kindled immediate uncertainty in my clinical brain. I felt both honoured and speechless. My heart yearned to say yes. It felt profound that John had lived his life feeling abandoned and, at times, choosing to be alone in the belief that this could keep him safe. However, he had stepped bravely into trust and a sense of attachment with me. It seemed unimaginable that he could be denied the ability to leave this world with his chosen support person. I was jarred out of this emotional reflection by the rational thoughts that reminded me this was a request I did not have an answer for at this time. I never had been asked this by a client, nor had I ever read or heard of any clinician being asked. I did not know what my ethical obligations were.

At the time John first asked me, I validated his immense courage in making his needs known. I also reflected what a great honour and privilege it was to be asked. In this moment of John's vulnerability, I looked at him and admitted that because I cared for him, and because my role was to ensure my decisions are in the service of enhancing benefit and decreasing harm, I would have to engage in consultation and personal reflection before I could come to an answer.

Tip 1

To the green clinicians out there, I want to let you know the value of practicing taking a deep breath and saying, "I don't have an answer for that right now, and I will be sure to do what it takes to come to a possible answer we can discuss." *There will be lots of these moments.*

During this moment, I could sense my not answering him fed into his uncertainty regarding the medical system and his hope to have my support throughout his MAiD journey. However, he told me he respected my commitment to navigate this uncharted territory. He was tongue-in-cheek in his response, winking as he told me, "Just don't take too long deciding." Hearing him say this struck me like a ton of bricks. The gravity of the sentiment was palpable—John's life was to end whether I accepted his invitation or not. I felt relief for him, and sadness that our journey was to close so very soon.

As a provisional psychologist, I was used to asking questions—lots of questions—of my supervisors, interdisciplinary colleagues, and mental health peers. My first point of contact was to my compass, my provisional supervisor, Dr. Ivana Djuraskovic. I vividly recall her reflecting to me that she was not surprised John asked me to be present, given his life circumstances and the therapeutic alliance she had witnessed us build. In supervision, she had supported my work with John over the previous two years and knew how hard-fought this relationship was for both him and me. John's ability to connect with me after having survived so much wounding and suffering within relationships was humbling. Yet, at that time, it also meant I was the sole support person in his life, and he had asked me to be present at his death.

Tip 2
You can never ask too many questions.

Ivana too reflected uncertainty regarding precedent for this type of request. She encouraged me to start out by consulting with the professional guidance department of the College of Alberta Psychologists and let me know she would be seeking consultation from the discipline as well. I felt a sense of duty to commit to an ethical course of exploration, both to minimize possible harm to John and to ensure I was protected professionally. I felt my humanity and my role as a provisional psychologist hung in the balance. This was an anxious space to hold for some time. Having Ivana in my corner providing supportive supervision filled me with a sense of reassurance. We were in this together, and we were both committed to ethical decision making and personal reflective practice. Without competent supervision, I am not confident that continuous due diligence could be upheld—the risk of harm to John and me could have been great.

Tip 3
The importance of finding the right supervisor for your provisional psychologist journey is one of the most significant lessons I learned throughout this ethical decision-making process. It is crucial to do the work needed to find someone who has the capacity to help you navigate the many firsts you will experience during your provisional process and who will ensure you have a secure base to collaborate with.

When I proceeded to call the College of Alberta Psychologists (CAP), I was prepared not to be handed an explicit road map for navigating this dilemma due to the intersection of personal and professional factors impacting any one professional. However, what I was not expecting was for the consulting members to tell me that they had never received this ethical dilemma before. I engaged in separate consultations with two members of the professional guidance department and was reminded that the CAP guidelines do not provide explicit dos and don'ts for psychologist's involvement in MAiD. Rather, I was encouraged to reflect on how to say yes or no to John's request in a manner consistent with the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association [CPA], 2017).

My fear increased upon receiving this feedback. Though reliance on the discipline was my starting point, this ethical decision-making process taught me that ultimately it is also my own process of critical reflection that I must come to trust. This ethical dilemma had me reflect that my neophyte position led me to seek reassurance and answers from consultation. However, the result of these discussions was also encouragement for me to engage in a process of critical self-reflection, and in doing so, find my own inner compass and nurture a deeper trust in myself. Consulting with the professional guidance department and my provisional supervisor also compelled me to reflect on my acceptance of the art and science of ethical decision making—sitting with the uncomfortable reality that there is no formulaic answer to many of the dilemmas we will come to face in this work.

Pathfinding: Forks in the Road

In having identified both reliance on the discipline and my personal conscience as parts of the compass guiding me through my ethical decision-making process, I considered John's moral right to request my presence at the time of his death. Informed from a palliative care perspective, I believe that end-of-life and bereavement care is a human right. Therefore, I knew that I needed to endeavour to support John in his self-knowledge, agency, and decision-making process to control his death experience. John's vulnerability (economic, lack of social supports) and the *Code*'s value of *Protection for vulnerable persons* were also of significant considerations. John had limited options to access other counselling services or social supports for his MAiD procedure. I informed him of alternative palliative counselling supports should he be interested. However, after some communication with such possible service providers, he decided against pursuing these options.

Given John's hope that I be present, I invited him to consider possible risks of my being in the room, and whether we would be able to troubleshoot safety planning if I had to leave the room. John said he would respect whatever decision I made about being with him. I felt the weight of this responsibility in my gut—there would be no opportunity for do-overs or rupture repairs. My presence or lack thereof would be part of his final passage. Involving him in the ethical decision-making process was the most important thing I did in my clinical journey with him. John reflected that inviting him to be an active participant in the process gave him choice regarding ongoing consent, and voice in directing his dying process. This contributed to his sense of dignity. This time, the medical system was not doing things to him, or leaving him to feel abandoned and alone. His voice mattered.

I also considered the problems of possibly establishing a dual relationship and invited John to discuss his rationale for my being present for the MAiD procedure. He stated that his request was twofold—for me to be present both as his therapist and his support person. Through consultation with two members of the CAP Professional Guidance Committee, my provisional supervisor, CAP members and colleagues, I came to the decision that to be present both as his support person and therapist would be complementary and inseparable in the situation and, thus, not conflicting in nature.

People I have known and loved have died alone. My experience of this spurred a deep sense of wanting to accept John's request of me, so that he too did not have to die in isolation. However, the anxious part of me was nervous given the gravity of his request and the realization that the intersection of MAiD and the role of psychologists throughout the process was a relatively new topic.

Tip 4
Commit to consistent personal and clinical self-reflection to enhance your confidence in the ethical decision-making process.

Building upon my reflective process, I brought my insights of possible personal biases, stressors, and self-interest to ongoing consultation and supervision with members of the discipline of psychology, as well as consultation with members of other disciplines. For example, I consulted with John's physician of record regarding what I could expect if I were present for a MAiD procedure. I also received ongoing consultation with my fellow mental health colleagues at my community health clinic, presenting my ethical decision-making process as part of case conferences and clinical rounds to panels of psychologists and social workers. This process highlighted the duty I have to look after my needs, especially given my work with clients with trauma histories navigating the end of their lives. To supplement my self-care activities, I took it upon myself to attend formal counselling with a grief/palliative therapist as I navigated this ethical dilemma. Placing importance upon myself as the clinician reminded me that, as therapists, we sweep the path for our clients along their journeys.

Tip 5
Form meaningful and collaborative relationships with other professionals within psychology and the fields of nursing, social work, and medicine. These individuals can provide a rich diversity of perspectives and wisdom, which both support and challenge your personal stance and help ensure you are considering as many factors as possible in your ethical decision making.

The Forest Through the Trees: Forging a Route Forward

Navigating my way through this ethical dilemma elucidated for me the need for our discipline to create signposts for those who may find themselves working with clients journeying through the MAiD process. Prior to John's death, he relayed his hope for a future in which psychologists would be more active participants for clients pursuing MAiD. He spoke of how his work with me had brought about a sense of feeling seen, heard, understood, and validated in his determination to live with dignity no matter how much he struggled. He shared with me how having a therapist working with him through his MAiD process fostered generativity and a belief that his legacy would have meaning. He spoke about how our work helped him uncover the strength and wisdom within himself to "know the great things I have done and how successful I was every day; which I do not think I would have got to without having the reflection opportunities with you." What was most profound for me was his reflection on my eventual decision to accept his request for me to be present during his death. He stated, "You reached out to me. You came and found me time and time again—nobody ever came looking for me or stayed with me in my life. Thank you for finding me, for holding on—you did not let me go."

John lamented that although waiting for my answer was challenging, he hoped that his request and my decision-making process could help encourage open dialogue in the field of psychology regarding considerations of MAiD for our clients, our discipline, and ourselves as clinicians. Taken in concert with the feedback from the College that I was the first person to present the dilemma of being asked to be present during a client's MAiD procedure has motivated me to advocate for much more interdisciplinary discussion, consultation, research, conference engagement, and the writing of reflective pieces regarding client experiences as they journey through MAiD, as well as clinician experiences as they help to navigate that journey.

Upon reflecting now, I could not feel more privileged and grateful for the opportunity to be with John in his final moments. John's request changed me both as a person and as a clinician, and I would not take back any of the process. The anxieties, the second-guessing myself, the discomfort with not having a straightforward answer, the what-ifs, the facing of my personal biases, the painful process of turning inwards and of looking outwards to receive critical feedback, and the tears of frustration, joy, and gratitude for the help and collegiality of others who supported me—these experiences revealed to me much about the art and science of ethical decision-making and contributed to the human being and clinician I am today.

Ivana’s Reflection: A Supervisor’s Tale

I still remember it clearly. I was in the living room sitting on my couch when the telephone rang. It was late afternoon, and I was in no mood for a conversation. However, when I saw Kim’s number on the telephone display, I knew that it was something important. Kim never calls out of the blue unless it is important. I answered, and I heard Kim’s voice say, “John wants me to be by his bedside when he dies.” Initially, I did not say anything. I just released a long sigh. Frankly, I did not know what to say. John had been Kim’s client for quite some time, and I was very familiar with his situation. I had never met John personally, but I knew his story. In my mind, he was someone who was set in his ways. It is true that he was struggling with mental health concerns. However, most of all, he was struggling with debilitating illness and he was sure that when his body started to fail him, he wanted to die on his own terms, on the date he chose, with people he chose to be by his side. I related to John’s struggle with physical illness, and I have said on more than one occasion that I would make the same decision if I were in his shoes—to die on my own terms. However, in this particular situation, I did not know how to respond to Kim’s statement that John wanted her with him when he died. In situations that have no clear answer, I always become curious. I invited Kim to tell me more. She gave me a quick rundown of the most recent experiences she had with John and informed me that John had picked a date on which he would die, and it was coming soon. My initial gut reaction was “I don’t think it is within your scope of practice to sit with John while he is exiting this world. You are his psychologist. You have worked with him. You processed his thoughts and feelings, and now is probably a good time to start closing your work with him.” I knew instinctively that what I was saying to Kim was coming from fear and not from an informed place. As I was laying out all the reasons why I thought that Kim should not attend John’s death, I kept hearing myself somewhere in the background, saying, “Come on Ivana! You did not consider all the factors at play here. What you are really telling Kim right now is that you do not want to bother with another complicated situation, and that you are afraid. But you are her supervisor and the least you could do is support her in figuring out the best thing to do for John and for her. This is your job, whether you like it or not. Besides, you love complex situations.” In response to that inner voice, I said, “Ok mind, I will step back and start again.”

At the time, medically assisted dying was relatively new across Canada, including Alberta. Up until John, I had never met or known anybody either personally or professionally who wanted to die through MAiD. I had heard about an occasional circumstance that made the news, but it was not in my backyard, so I did not pay attention. At least, not until Kim called me and told me that John requested her to be present at his MAiD. After some pondering, and conversing back and forth, I still stood by my decision and told Kim that it was likely not her job to be by John's side during his last moments. I rationalized that being there would represent a role confusion and dual relationship, and possibly cause harm to John and Kim, respectively. Kim understood my reasoning; however, she still noted that she could not quite see why the mere act of holding John's hand while he was exiting this world was so problematic. She provided all the reasons why being with John in his last moments would be the most appropriate decision. She talked about John's social isolation, the depth of their therapeutic relationship, and John's willingness to present his wishes to Kim and share the written notes and journals he kept over the years. John kept detailed notes of his process of deciding to die through MAiD, including reasons why it would be relevant for his psychologist to be present at his death. He was a loner type of person. He did not have many friends, and his family did not want to have any contact with him. John was also extremely intelligent and set in his ways. He knew the gravity of the question he had posed to Kim, but he also knew the reasons why he wanted Kim to be part of his death journey. He felt that Kim could support him, and he also felt that Kim could tell his story. John wanted his story to be heard because he did not want to be just a statistic. He wanted the world to know that there is beauty and dignity in making such a decision. In all reality, John was a difficult individual, with a complex mind and needs; yet being willing to connect to one random psychologist allowed him to find self-compassion, self-confidence, and willingness to live his journey in an authentic way. John felt that it was his responsibility to pave the way for other clients who felt the lack of voice in their own lives. John had experienced many obstacles in having his decision finalized. On his journey, he met with professionals who did not support his decision to die through MAiD and who questioned his ability to make an informed decision to die. In the process, John even underwent a psychiatric assessment, the results of which put his wish to die in question.

Kim and I did not make a definitive decision at the end of our first conversation. I was not sure whether she should be present during John's passing or not. And Kim was worried she would abandon John if she decided to not attend his MAiD. Like I always do when a situation is not an emergency, I asked Kim to take a break, sleep on it, and review the ethical decision-making model. We scheduled another conversation, and I promised her that I would consult with a couple of senior colleagues to pick their brains about this medically assisted dying process. That night I could not sleep. I tossed and turned and kept asking myself "What would John want me to do?" Then again, I knew that what clients may think is best for them is sometimes not the best for them. "How did I get myself in this mess? How is it that these complicated situations end up in my backyard? Why?" My mind kept running its commentary until the wee morning hours; yet, when sun came out, I still did not have any answers. I rose slowly, my body aching, and my head pounding. And then I called my former supervisor and asked him what he thought about John's situation. My hope was that he would perhaps support my decision of saying no. However, he did not do that. He simply asked me a question: "If we do not honour such important client wishes, are we abandoning them?" Well, that was indeed a question to ponder. Are we abandoning our clients? Are we contributing to a larger systemic barrier when it comes to people freely choosing MAiD? I called Kim later that day and said, "I am more confused now than yesterday, and I do not know what the best answer is, but today I am no longer prepared to say no. I think we need to explore this more." I sensed a relief in Kim's voice when she noted that she shared my thoughts. We agreed that the best way to go about this is to work through the ethical decision-making model in the *Canadian Code of Ethics for Psychologists* (2017) and see what decisions could come from that. I also suggested that Kim consult with the College of Alberta Psychologists and explore possible courses of action for her and John with its Professional Guidance Committee.

Deciding to work through the ethical decision-making model was just the beginning of a much more complex journey for both Kim and me. In theory, it seems simple enough just to follow the model and make a decision. However, in this circumstance, no decision was straightforward or easy. I wondered about many things as I considered the ethical decision-making steps. I wondered about John's family. Did they know what he was planning? How would they be affected? How would the event of John's passing affect Kim? What does it really mean to be a party to someone's death? I worried increasingly about John and whether he would feel completely abandoned if Kim said no to his request. I also worried about Kim because a couple of years earlier, she had experienced a grief and loss that could be triggered by simply attending John's passing. Would she have any support to help her process her thoughts and feelings? How would I support her adequately? I had so many questions that I thought my brain would burst. I had been in practice long enough to know that the ethical dilemma Kim and I faced was not easy. We were constrained by time limits and needed to decide sooner rather than later whether Kim would be present at John's passing. We also had to consider how Kim would deliver her decision to John and still be consistent with the *Canadian Code of Ethics for Psychologists* and the College of Alberta Psychologists *Standards of Practice*. I quickly learned that the decision that Kim and I had to make involved our personal conscience, especially when the code of ethics and standards of practice did not give clear answers when applied to John's situation.

Kim and I frequently discussed the multiple contexts that were relevant to John's life. In making our decision, we had to consider the level of personal support that was available to him. That was a clear but tough consideration. John noted often that he was somewhat of a social recluse, and that he did not maintain relationships with family and friends. He said he was estranged from his primary family, including his son, and that he did not want any of his family present at his passing. John said he saw Kim's presence at his passing as complementary and not in any way conflicting with anyone else's role. In fact, we realized that, due to his social isolation, Kim's presence at his passing could be a catalyst for, rather than a hindrance to, a healthy transition into death. John's wishes for Kim to be present at his passing involved his belief that Kim was a trusted, compassionate, and empathetic person and psychologist. From his perspective, Kim bore witness to his journey and his fight to gain the right to decide when to die. She understood his traumas and was aware that he often described her "as the only person who ever really looked out for me." John also seemed prepared to accept Kim's potential decision not to be present at his passing, noting that "I have died alone once, I can do it again." John was referring to the experience he had when he died, but after several minutes of life-saving interventions regained consciousness. He had reflected on how lonely and difficult this experience was for him. Could Kim and I live with ourselves if we left John to die alone? This was the question that stretched us beyond the moral constraints of this circumstance.

It soon became clear to me that if Kim decided not to be present at John's passing, she would in a way be abdicating her responsibility towards him. Nevertheless, was that enough to say yes to John's request? I conversed frequently with Kim about the meaning of her decision-making process and how she would be able to justify it if asked. Kim always stood her ground and said that she would document every step in detail, and that she would consider the ethical decision-making model carefully. She also mentioned the bigger value questions in psychology; for instance, what service do we provide to our clients if we decline their wishes without due consideration? I always respected Kim's concern and love for all human beings. I had never seen her be judgemental, and her empathy for clients was "a dance in the making." In the past, when I observed Kim's sessions, I often found myself longing to be as non-judgemental as she is. However, concerning John's situation, I was not yet fully convinced that by saying yes to his request, we were making a right decision. As a supervisor, I wanted to make sure that Kim was not engaging in something that was outside of her competence.

In one of our conversations, I asked Kim whether she felt she had enough competence to support John in his transition from life to death. She was really honest and told me, "Well I never have sat with someone during their last moments. However, I have counselled clients who were in palliative care. So, I think I know enough about what to expect." She also said something that affected me deeply. She noted that when involved in continuity-of-care activities, psychologists often need to advocate for clients. She felt strongly about this advocacy and reiterated many times that if we are to put social justice into practice, such advocacy would be a responsibility. For example, at John's request, Kim worked closely with John's physician of record, who was also the practitioner John chose to complete his MAiD procedure, and attended many appointments with John to provide emotional and psychological support as he navigated the steps of the MAiD assessment process. John informed Kim that, with someone whom he trusted to journey alongside him, he felt less alone in the process.

Kim also advocated for John's choice to explore the possibility of having her be present to hold his hand when he died. She took the additional step of consulting with two senior counselling psychology supervisors. Both supported her decision about not abandoning John, advocating for him, and providing care in the last moments of his life. For Kim, a decision to be present at John's passing was not philosophical or moral. It was human. She often mentioned that the first thing that came to mind whenever she thought about her decision was the ethical principle of Respect for the Dignity of Persons and Peoples. From Kim's perspective as a psychologist, she felt that her professional judgement was of the outmost importance given the complexity of John's situation. Kim did not in any way direct or impact John's decision to engage in medically assisted dying, and she knew she was not obligated to be with him at the time of his death. However, she understood the meaning of the process of informed consent and engaged in conversations with John regularly to explore his decision to die through MAiD. As we moved through the process of solving the ethical dilemma, Kim and I recognized John's right to self-determination and personal liberty to make his own decisions. As we came closer to saying yes to John's request to have Kim present at his passing, we began wondering about how the process should evolve to protect both John and Kim. We had to consider how vulnerable John felt within the mental health system, the multiple oppressions he experienced over the years, and the difficulty he had in exercising his right to engage in medically assisted dying. John had been in the mental health system for a long time, and he had come across counsellors and physicians who did not understand either his emotional or physical pain. Many did not want to entertain the idea that a person like him could make a valid decision to die at their own volition.

Through a careful and detailed process of ethical decision-making, Kim and I learned important lessons. Initially, it was intimidating even to think that psychologists could be present at their clients' last moments. After all, we work in a profession where our work often consists of keeping our clients alive. However, in John's situation, being able to have Kim at his passing was giving him his life back in a way. He was able to exit his world of suffering and pain with someone at his side whom he trusted and knew would support him as he was taking his last breath. For Kim, I think the process was both painful and rewarding because she had advocated for John and understood him in the way he needed to be understood. Many people participated in our decision making. In the process, we consulted with at least ten professionals about whether Kim should be present at

John's passing or not. The most beautiful outcome was that all of us agreed that saying no would have had far more negative consequences than positive ones.

Postscript

John chose to pass away on his birthday. He decided to have his favourite meal, a view towards the mountains, and music playing in the background. He had been able to tie up loose ends with one of his family members whom John decided to invite to his passing after all. This family member accepted his invitation to be present and sat on the edge of his bed. John also asked for his physician's dog to be present to lay at his feet. He had Kim by his side holding his hand. We had a telephone conversation shortly after John passed away. When Ivana asked Kim how she felt, Kim replied "It was beautiful, Ivana. It was a celebration of life and choice. As John exited this world, I even thought I heard him giggle in the background . . . and he said he was sorry he did not get to meet you." Kim and Ivana also discussed at length Kim's self-care plan and how she would be kind to herself in the days following John's death.

John impacted us in significant ways. He fought for his right to freely choose to die with the assistance of MAiD, and how important such freedom can be in a person's life. We think about him often and imagine that John's spirit lingers in our lives. Occasionally, we are reminded how challenging and difficult, but rewarding and meaningful our work really is. We learned that supervision is not always straightforward and that supervisors need to remember they still do work behind the curtains. Supervisors' decisions impact students' clients. In addition, students come to supervisors for guidance and support and expect them to share their wisdom. Supervisors and students both need to recognize their fears and discomfort with certain situations and need to open up space for that discomfort. When we can sit with that discomfort, we are more able to make sound ethical decisions.

We reminisce about John often when we see each other. We imagine he is still there somewhere to guide us in decisions to come, and we are grateful to him for deepening our understanding of ethics. Fly freely John! You deserve it. And thank you.

Questions for Reflection

1. Identify some of the beliefs and biases you have about MAiD. How might they influence your work with clients considering MAiD?

2. What role do you think the following would play in developing your competencies related to MAiD? Knowledge of relevant legislation? Knowledge of practice guidelines (e.g., *CPA MAiD Task Force Report & Practice Guidelines for Psychologist Involved in End-of-Life Decisions*)? Consultation? Supervision? Formal training?
3. Imagine you decide to seek MAiD for yourself. What thoughts and feelings might you experience? What kind of psychological support would you want to have?
4. Your client requests your presence at the time of their death through MAiD. The client's daughter asks you not to be present, as she considers it to be their family's private journey. Using the CPA ethical decision-making model as a framework, what do you think would be the best course of action?

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PART F

International Ethics

19

From Parenting Training to Collaborating with Parents

Inés Sametband, Joaquín Gaete-Silva

Introduction

We work at the Centro de Estudios y Atención a las Personas (CEAP; Centre for Studies and Counselling Persons) in Viña del Mar, Chile, where we provide counselling and family therapy services at low-cost for individuals and families. Families come to see us for a variety of concerns, among which are children's disruptive behaviours such as oppositional-defiance, aggression, and attention-deficit/hyperactivity disorder (ADHD). The CEAP is associated with the School of Psychology from the Universidad Adolfo Ibáñez, and is a training facility for students in the master's in psychology program. Our family therapy team meets with a family once a week to offer a consultation to a family that is working with one of the counsellors at the centre. Following the consultation, members of our team provide a reflection to the client-family, a practice known in family therapy as the *reflective team* (Anderson, 1991). This final reflection offered to the family is intended to generate different perspectives and ideas on the presenting concern for the family to take with them once the consultation has concluded.

Inés: My training as a family therapist has taken place in different parts of the world. I am originally from Argentina and completed my undergraduate and part of my graduate education in Buenos Aires. I moved to Canada as an adult, where I completed my master's and Ph.D. degrees, and my training as a family therapist at the Calgary Family Therapy Centre with Karl Tomm and his colleagues. Later on, I moved to Chile with my family. As a result of my international living, I had the opportunity to learn from and work with families who understood and practiced parenting in a variety of ways. I will always remember a family I worked with in Buenos Aires, Argentina, when I was part of a family therapy team trained in the Milan family therapy model (e.g., Palazzoli et al., 1989). The parents were struggling to manage their four-year-old son's behaviour, who was hitting and biting other children at school. At the time, I remember feeling uneasy about the way the team (including me) were working with this family. We were quite directive and probably a bit confusing for them. My sense was that somehow we were missing the point, even if the family kept coming back. I had the nagging feeling that we were deciding for them what we considered to be the right steps to follow.

Some years later, during my training in Canada, my view of counselling families changed. I was exposed to a multicultural world that I had not been exposed to in Argentina in the late 1990s. Training in a multicultural society made me realize that there are different ways to understand and be part of a family, or to be parents. Recognizing and integrating this diversity into my work made sense to me. It allowed me to be curious and learn about a multiplicity of ways of living life. It also required me to balance what families wanted with what I had learned was "good for them." Although such balancing may sound simple, it has not been that way for me. Trying to balance between my knowledge as a psychologist and clients' understanding of how to solve difficult situations (e.g., what parents should do when their child starts acting up) has become a guiding concept for me, and I continue to learn every day how to achieve this in my practice.

Having the opportunity to study and practice counselling psychology in Argentina, Chile, and in Canada has been truly life-changing. This is not only because I had the opportunity to live and learn about different ways of living, but because I had to learn to become flexible yet persistent in my profession. I needed to learn a new language, new customs, and many times face the same bureaucratic obstacles many immigrant professionals encounter when trying to get their credentials recognized. My international experience made me aware of the importance of considering and recognizing that different perspectives are valid and explanatory for many situations. For me, being able to recognize others' voices is part of ethical practice; a stance that requires reflection and openness to what is not familiar to oneself. The image of a kaleidoscope comes to mind. Depending on the position, the light, and the movement, you achieve a different, breathtaking, and sometimes challenging image. However, it is up to the person looking through the kaleidoscope to achieve these effects; for instance, to stay with some images that are challenging and to find ways to connect with them. Training and working internationally enriched my experience and, similar to a kaleidoscope, added colours and movement.

Joaquín: My training as a clinical psychologist also has been in different places in the world. I studied psychology at the Pontificia Universidad Católica de Chile for six years to become a professional psychologist. I then completed a three-year M.Sc. to become a registered psychotherapist in Chile. Finally, I did my Ph. D. in Canada at the University of Calgary. Throughout the years, decisions I made about my career were influenced by a sense that scientific, psychological, or professional knowledge could sometimes be treated as some kind of "capital T" truth to be imposed on people. It felt like something was wrong with the professional habit—not excepting myself—of replacing people's own ways of understanding themselves (e.g., "It's hard for me to be far from my husband") with more seemingly legitimate, canonical, professionally acceptable ways (e.g., "You are dependent"). Fortunately, I now have language to render my experience of witnessing this mix of distortion and silencing practices as a form of undue discrimination (i.e., epistemic injustice). On the one hand, testimonial injustice: how some people's preferred language to understand themselves was sometimes dismissed simply because of their alleged identities, like being casted as a "patient," a "borderline/dependent woman." On the other hand, hermeneutical injustice: how some people's preferred self-understandings have been dismissed because the concept of "resistant patient" was (and still is) more popular or available than the concept of "resistant professional." Lay people seemed to be less conceptually equipped to resist narratives about themselves when the narratives were told in an expert/scientific/professional language. At the time I was a psychology undergraduate, such professional language was presented as scientific, reliable, necessary—almost analogous to how the language of physics would be needed to build a ship at NASA. Fortunately, during my later years as a psychology student in Chile, I also learned a good deal of philosophy, particularly epistemology, which I think helped me develop a critical stance toward the often taken-for-granted "truths" within the field. I felt freer to be more curious about the local knowledge that my clients brought to counselling as potential resources for therapeutic change (such as those we refer to later in this chapter when discussing parents' parenting preferences). I believe this background ended up influencing my inclination towards what the psychology establishment at the time would see as "rebellious" postmodern models. I became more sensitive to the ways in which psychology can become a modern form of power; that is, when psychology is used for the purposes of social control, domination, and misrecognition (e.g., Foucault, 1995; Gaete et al., 2018). These purposes prescribe what is considered abnormal and needs correction, impose how life issues should be understood and addressed (e.g., medically/pharmacologically), or situate problems inside individuals instead of considering that those problems might be a response to unjust social conditions. I think the emphasis Inés and I place on giving parents an authoritative voice when collaborating with them speaks to this postmodern influence.

My masters' degree in Chile was quite different from the training I received in Canada. In Chile, instead of learning about many theoretical approaches, but not in any particular depth, I had the opportunity to learn about one particular approach to therapy (systemic) for two full years. In addition, since psychology students in Chile have 12 semesters of theory in their undergraduate programs, master's degrees in Chile at the time were very focused on developing clinical competencies and on learning by doing (i.e., with an emphasis on clinical work and supervision rather than having classes, as it is common in the Canadian context). My conviction about epistemic justice, or the importance of bringing forth, legitimizing, and relying on (rather than supplanting) my clients' local knowledge brought me to pursue my doctoral studies in Canada, where I had the opportunity to learn from Karl Tomm and his colleagues at the Calgary Family Therapy Centre. Their unique approach to family therapy invited me to further develop a critical stance towards psychological/expert knowledge and develop a tremendous respect and admiration for clients' resourceful histories and ways of relating to one another. This emphasis on epistemic justice embraces, in my view, what both Chilean and Canadian psychologists regard as the most important ethical principle in our profession. It is what inspired this chapter, namely: respect for the dignity of persons and peoples.

In this chapter, we share with readers our work with families in Chile. We focus on relational patterns, and how these can open up conversations on parenting practices that respect parents' preferences in raising their children. We provide a clinical example, and show how, by exploring different interpersonal patterns, we highlight possible alternative parenting practices, used by clients, and that fit better for who they are.

The Pull to Be the Best

Meet Sonia, a 42-year-old woman who consulted our team at the CEAP in Chile about her 10-year-old son, Darío, who had been showing disruptive behaviours for at least six years. Sonia explained that Darío had always been "a peculiar child." She described him as creative, intelligent, and having to get his way for everything. Sonia said Darío had very strong and recurrent temper tantrums or "rage outbursts" (*ataques de rabia* in Spanish) in which he became aggressive, broke things, and hit others (including Sonia). Concerned about this behaviour, Sonia and Pedro (Darío's father) had taken Darío to see a psychiatrist, who prescribed some medication that helped decrease the intensity and frequency of the rage episodes. However, Sonia described feeling exhausted and not knowing what else to do. She said that Darío's father had almost "given up on him." Sonia explained that Darío also had been seen by a psychologist in a community clinic, who had diagnosed him with autism spectrum disorder and recommended psychotherapy as well as psycho-education for the parents. Sonia indicated that, although the psychologist's assessment made sense to her, she also hoped Darío could learn self-control over his aggression so that eventually he could stop taking medication. Sonia also mentioned that she and Pedro needed to learn to deal with the situation better and described ways in which they tried to stop Darío's behaviour in the past. She qualified these approaches as "wrong."

Now take a step back. How would you approach this consultation? How do you make sense of what is going on for Sonia and her family? What would you prioritize in your work with this family, and why? Who would you include in the therapeutic process? In our experience working in Chile, we have seen a dominant trend in how psychologists and other health professionals tend to approach their work with families like Sonia's. Professionals seem to start by answering the questions posed above—deciding beforehand how to approach the situation, guided by their own ideas of what should be prioritized and done. Although we also ask ourselves these questions, we strongly believe that we need to know how the families we work with would answer them. This is why we prefer to begin by asking *them* how they would answer questions such as: In your experience as a parent so far, what would you say has worked best for you in dealing with your son's disruptive behaviour? What is your preferred way of responding to his behaviour? What are some of the values you want your son to learn when you respond in that way? In doing so, we are trying to keep in mind an overarching ethical question that guides our practice: *How do we ensure that our expertise does not blind us to what clients want to do with their lives, and how they want to resolve and deal with the situations about which they are consulting us?* We hope to answer this question by providing a reflection on how we practice, and why we practice that way. That is, by respecting clients' preferences when collaborating with them to change and resolve difficult situations in their lives in ways that are beneficial and oriented toward wellness for all participants. (We discuss this further later in the chapter.)

Whose Knowledge Is It?

The *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association [CPA], 2017) recommends in its Principle II (Responsible Caring) that psychologists use their knowledge and skills to promote and protect the welfare of any individual, family, group or community with whom they relate (CPA, 2017) in their work as psychologists. Said differently, we (psychologists) use knowledge (e.g., about parenting skills) to avoid harm and provide services that will benefit clients, such as providing useful information to optimize children's development. On the other hand, clients develop a sense of what is *the* good life—their "ends" as parents, so to speak—in relation to their cultural backgrounds. Their parenting preferences rise from a diversity of moral backgrounds or horizons, to use Gadamer's (2004) metaphor. In the context of the local communities in which they live, the "horizon" of values and preferred practices within which parents respond to their children (e.g., with empathy, with guidance, with love) is the repertoire of "good reasons" parents rely on or may invoke when challenged to account for their actual responses. For us, parenting preferences are situated in socio-cultural practices for raising children that are meaningful and acceptable to the parents who engage in them (see Sutherland, Sametband, Gaete, Couture, & Strong, 2013). We assume parents "do parenting" *always* within such social horizons—hence we see parenting preferences never as completely belonging to just the parents or just the communities, but to both.

Benefiting clients is thus a matter of means (e.g., offering expert knowledge on parenting) *and* a matter of ends (e.g., attending to parents' preferences). This is a key aspect of Principle I (Respect for the Dignity of Persons and Peoples) (CPA, 2017), which includes respecting parents' preferences in how they parent children. As stipulated in the *Code*, we "strive to develop and maintain constructive and collaborative relationships that reflect the fundamental principle of respect for dignity" (CPA, 2017, Principle I, Values Statement, para 2). Our overall goal is to help parents optimize their agency—that is, their capacity to define priorities and choose the type of parenting style they value (and which also reflect the moral values of what is considered good by their local communities). In the next section, we describe one of the ways we understand and approach this dilemma.

On Parenting

In Western societies, parenting has become an extenuating, complex, all-encompassing task in which parents are expected to raise children to become model citizens. However, what parents actually do to achieve this goal has been given little attention (Hartas, 2014). Instead, parents are overloaded with information from "experts" on how to raise their children. In Chile (as well as all other parts of the world) for example, it is quite common for parents to receive most of their information about what they should do with their children through suggestions and advice from health professionals, teachers, judges, family, and friends (among others)—how they should dress them, feed them, talk to them, discipline them, when they should put them to bed, and how much TV they should allow their children to watch.

Suggestions and advice for parents is also available readily in the popular Western media. A simple Google search on parenting tips shows 52,000,000 results. Workshops for parents, teachers, and professionals, as well as self-help information (e.g., the popular TV program *The Nanny*, the US bestsellers *The Whole-Brain Child*, *Raising your Spirited Child* and *The Happiest Toddler on the Block*, to name a few). Many of these TV programs and bestsellers have been imported by, and have become popular in, Spanish-speaking countries, including Chile. In addition, within the Western mental health field, parenting training has become one of the most recommended interventions to approach children's disruptive behaviour (e.g., Dishion & Stormshak, 2007; National Collaborating Centre for Mental Health [NCCMH], 2008/2013; Weisz & Kazdin, 2010). Some models of parenting training draw from attachment theory and social learning concepts and offer models of what is called "authoritative parenting" (Zizzer & Eyberg, 2010). Others focus on empowering and enhancing parents' knowledge, skills, and confidence as a way to improve parenting by teaching parents what to do in particular situations (e.g., Forgatch & Patterson, 2010; Sanders, 1999).

Although these models of parenting training can be very beneficial to families, we believe that they potentially can disempower the persons involved. Imagine if Sonia went back home after her session believing that the main problem was that she needed training on how to address her son's outbursts (i.e., that she as a parent is "lacking a skill"; see Paré 2014). How would she feel as a parent, and how might this feeling influence how she approaches problematic situations with Darío?

Most parenting training models emphasize behaviour as a separate construct, rather than viewing it as a response in a relationship (e.g., Forgatch & Patterson, 2010). Based mostly on traditional theories of behaviour conditioning, these models conceptualize children as learning through reinforcement, rewards, or by modelling behaviours. Parenting is proposed as a one-way process, in which children's disruptive behaviours are seen as the result of parents' coercive practices (Kuczyinski & Mol, 2015). There is little attention, for example, to how children's behaviours shape parents' effectiveness in responding to them.

Without question, most Chilean parents want their children to have a "good life," to use a common expression in ethics. Paraphrasing philosopher Sen (1999), we all want to optimize our children's capabilities or freedoms to live lives they can both enjoy and appreciate. Parenting training models may be a great contribution to parents who embrace this belief. However, we also have seen how an emphasis on "training" can compromise the parents' right[1] to define how they want to parent their children in the first place. As Hartas (2014) suggests, parents can be objectified and treated as incapable of exercising their responsibilities, "justifying micromanagement and therapeutic interventions at a family level" (p. 172) from professionals. Further, Principle II of the *Code* recommends that psychologists recognize and respect the ability of individuals and groups "to make decisions for themselves and to care for themselves and each other" (CPA, 2017, Principle II, Values Statement, para 2).

On Preference

Parents show preferences regarding their children's development. Typically, these preferences are not explicit—rather, they are implicit in how parents respond to children when children shift away from something the parents value

(Garfinkel, 1967). As we mentioned, we view preferences as the situated, local practical knowledge (Geertz, 1983) on raising children that is meaningful to the parents, acceptable to them, and customary in the community in which they live. For example, it may seem odd for a parent to leave their young child playing on his or her own outside of their home in Calgary, because it would be considered a parent's individual responsibility to supervise his or her child. However, this parenting practice is not common for some families in Chile, where children are seen as a responsibility of their local community. In many cases, families live in small houses, so it also makes sense for children to play outside. This is the case in particular for families living in the hills surrounding the city of Viña del Mar who cannot afford a home of their own and tend to live with extended family members in the same land or house. Living with 16 other people in the same house, for example, means that parents, grandparents, uncles, aunts, and even common law family members raise and look out for the children.

Dominant, mainstream ideas on parenting practice can overshadow and limit local practices. Nowadays, communication technologies make it easier for some ideas or beliefs to proliferate (e.g., through the internet). Some examples are the recent North American anti-vaccination movement based on the belief that vaccinations cause autism. This movement has extended to South America. An opposite example is the change in the view of breastfeeding as a positive practice compared to how it was viewed in the 1950s. Even the recent increase in *babywearing*—carrying a baby in a sling or in another form of carrier—has become an international practice, though it was seen as eccentric before. The tensions between these different ways of understanding and practicing parenting can generate confusion or even uncertainty for parents who do not see their preferences represented in these practices.

Tensions over differences in parenting preferences are not only cultural, but also can arise within families. For example, mothers and fathers may differ on how to practice "good manners." These differences could become confusing for their children, who may not have a full understanding of what "good manners" mean in the cultural context in which they live. In order to provide a coherent understanding of this practice, parents need to negotiate and co-ordinate ways in which "good manners" are practiced in their family. Likewise, how to understand a person's development will always be part of a delicate negotiation process between the preferences of the different parties involved in children's socialization, including the children themselves, their families, and other persons and social institutions relevant to the children's lives. We consider this a moral negotiation, because it pertains to the values and preferred practices within which parents respond to their children. Much contemporary moral philosophy interprets a person's view of morality in a narrow sense, insofar as it "has tended to focus on what it is right to do rather than on what it is good to be, on defining the content of obligation rather than the nature of the good life" (Taylor, 1989, p.3). To the extent that "good parenting" is part of the nature of the good life, good parenting is related to the moral realm.

When we work with families who describe their child's behaviour as disruptive, we see them (and us) fluctuate between two positions at odds with each other. On the one hand, parents want to raise children so they develop as independent persons. On the other hand, an emphasis on parenting training can limit the parents' creativity and sense of authority. For us, the tension between these two positions represents an ethical dilemma we face in our work with families. We use our expertise to help families deal with problems in their lives, yet we need to ensure our expertise does not overpower parents' preferences in how to raise their children. As a result of this experience, we have come to believe that there are alternative ways to help parents articulate and practice parenting in ways that are meaningful for them.

We consider that an emphasis on teaching parenting skills may have a negative influence on parent-child relationships and work against an ethics of care (Hartas, 2014). At the same time, we acknowledge our privilege as professionals regarding access to information about parenting and would consider it negligent not to use this information to benefit clients. We also acknowledge our privilege of being aware that there are probably more ways in which clients' experiences can be understood, other than those championed by experts or professionals (e.g., Paré, 2014). We believe that Sen's (1999) concept of *adaptive preferences* can be enlightening—namely, there are things or goods people may not recognize right away as preferred, since historically they have not had access to such goods (e.g., claiming equal rights as a woman). However, we believe that exploring "what else" or "how else" clients might prefer to deal with the concerns that bring them to counselling is worthwhile. To do so, we use an approach that we call *collaborating with* (rather than *training*) parents.

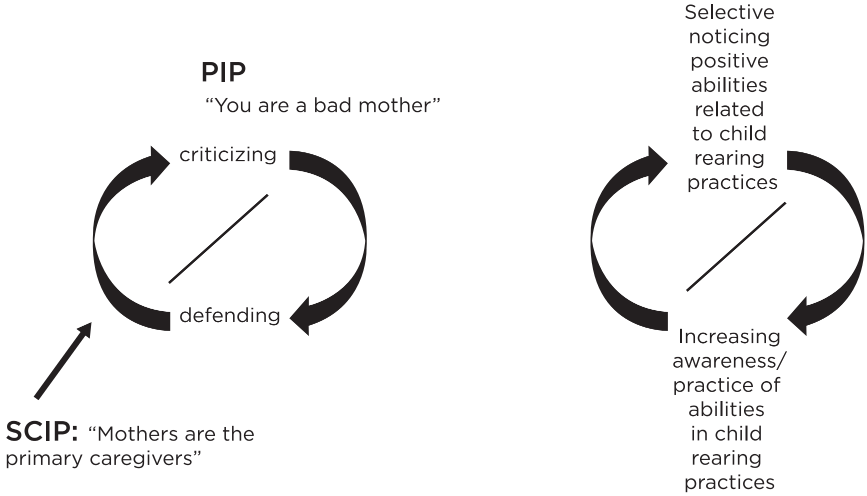
Collaborating with Parents

At the CEAP, we use a relational approach called the IPscope (Tomm et al., 2014) in our work with families to deal with disruptive behaviours from one of their members. The IPscope is a collaborative family therapy approach focused on interpersonal patterns of relationships. The approach focuses on preferred relationships (i.e., ways of relating that are meaningful and oriented to a person's wellness), through a joint exploration of social practices and discourses; ways of doing and saying that are morally charged (i.e., preferred and non-preferred). It is an approach we learned in Canada, but which we have found very helpful in working with families who live in a different culture.

Using this approach, we understand disruptive behaviours as resulting from *pathologizing interpersonal patterns* (PIPs; Tomm, 1991, 2014) between children and parents. PIPs are interpersonal patterns that invite or increase negativity and/or suffering in at least one of the persons interacting, or within the relationship. For example, a father may criticize his son's performance at school, which in turn could invite the boy to defend himself, which may in turn invite further criticism from his father and so on (see figure 1). PIPs can be counteracted with HIPs, or *Healing Interpersonal Patterns* (HIPs; Tomm, 1991, 2014). HIPs bring forth positive behaviours that serve as antidotes to PIPs. For example, a father may notice that his son has mastered a specific ability, such as collaborating with his peers. The father noticing this ability will in turn help his son to be more aware of this capacity to collaborate with peers and increase his practicing of it. This, in turn, could invite more notice from his father, and so on (see figure 1). These kinds of interactions are supported by cultural ideas on what is appropriate in a parent-child relationship. When the cultural ideas supporting interactions become prevalent in family relationships, we call them *socio-cultural interpersonal patterns* (SCIPs; St. George & Wulff, 2014). For example, a common SCIP is the idea that women should do most of the parenting compared to men. This SCIP may support PIPs such as a father criticizing a mother for a child's behaviour due to a belief that mothers are the primary caregivers or have sole responsible for parenting. In turn, this may invite the mother to defend herself, which again invites more criticism from the father, and so forth.

The IPscope, in our experience, is a useful tool to help parents prevent what they define as disruptive behaviours (e.g., PIPs; impulsivity, opposition, hyperactivity, stealing, and lying) and promote preferred ones (e.g., HIPs; respecting invites co-operation; asking respectfully invites compliance). This is not to say that we take parents' definitions ("X is disruptive") at face value. We invite parents to reflect on how their definitions may hinder what they prefer to see in their relationships with their children. How they define a child as disruptive may have unintended consequences and obscure the relationship they would prefer to have with their child. We think that part of our ethical responsibility is to help the parents become aware of cultural ideas on parenting, and what parenting "should" look like. We believe that by making these ideas visible, clients have the opportunity to examine how these ideas influence their family relationships. However, in our conversations with clients, we need to take special care and responsibility regarding our privileged position as professionals and avoid imposing our own ideas. For example, we may ask parents, how does calling your son's behaviour "manipulative" influence your relationship with him? What may your son learn from having a reputation of being "aggressive"? How may focusing on the problem influence your child's future?

Figure 19.1: PIPs, HIPs, and SCIPs



Our hope is that by examining these understandings and ideas, we avoid imposing our standards of what good parenting is. This does not mean that our professional knowledge is useless; rather, we propose that it is one possible way of understanding among many. Families often report that focusing on the relational aspect of their problems and using the PIPs and HIPs language as a starting point, is useful. Our conversations aim to help them find wording that fits better for what they envision as wellness in their relationships. In addition, we found that sharing families' relational preferences using the PIPs and HIPs language has become a helpful repository of options for other families that come to see us. In our experience, it has been useful to have, at least conceptually, relational alternatives or prototype descriptions that we frequently hear about in our sessions with families, such as nagging coupled with ignoring, which tends to invite further nagging and so on (common between parents and adolescents), or criticizing coupled with defending (common in co-parenting situations).

Let us go back now to Sonia and her family's situation. Sonia described Darío's behaviours as rage outbursts, in which he would either throw objects to the floor or walls, or hit, scratch, or pull hair from his younger brother or Sonia. In our first meeting, Sonia mentioned that she and Pedro needed to learn alternative ways of dealing with their son's behaviour. When we explored with her what kinds of responses from her and Pedro she was referring to, she described that they tried “everything”—from ignoring the behaviour, trying to reason with Darío, and finally resorting to yelling at him and even trying to control his behaviour physically (e.g., restraining him). In relational terms, we conceptualized this interaction as a PIP of hitting (by child) coupled with ignoring (by parents), which invited more hitting or more intense aggression (by child), which in turn invited yelling (by parents) and so forth, to the point of parents resorting to physical restraint.

Disruptive Behaviours as Responses in Interpersonal Patterns

Historically, disruptive behaviours have been described by focusing on deficits in the child (e.g., aggressiveness, attention deficit, delinquency, disobedience; Achenbach et al., 1987). From this perspective, Darío’s behaviour could be seen as the result of impulsivity or as a deficit in impulse control. Although this perspective could be a useful way to understand his problematic behaviour, for us it is both unjust and limited. It is unjust, insofar as the child’s perspective and context are typically ignored (e.g., Sutherland et al., 2016); and limited, in the sense that it does not attend to how the behaviour impacts his relationships with others, and how change could be sought through those relationships.

Alternatively, children’s disruptive behaviours can be described relationally, as obstacles to their *affiliative capacity*, to their ability to live and show concern for others, to be treated as a dignified being (Nussbaum, 2000). Looking at disruptive behaviours as obstacles to a child’s relational potential is to put the emphasis on what is preventing the child from transforming opportunity into actual development. Likewise, going beyond the disruptive behaviours themselves can contribute to highlighting the parents’ preferred developmental course for their children according to their culturally embedded standards. In our view, disruptive behaviours need to be understood in a less abstract and more specific manner, to include more complex, *rich descriptions* (Geertz, 1973) in which children and parents’ preferences, hopes, and behavioural expectations are taken into account from within their socio-cultural relational context.

In our practice, we find conceptualizing disruptive behaviours as responses in interpersonal patterns to be useful in two ways. First, it is our experience that parents appreciate being able to understand disruptive behaviours as habits that have become recurrent within a PIP. Being able to understand disruptive behaviours as *responses* to others help parents to view them as something that can be changed. Rather than inviting blame and mutual accusations between family members, this conceptualization helps generate hope and collaboration among the parties involved. Second, this approach allows us to use our expertise while respecting and helping parents (and children) follow their preferences in how they want to relate to one another. These relational conceptualizations are tentative classifications of disruptive behaviours—a first approximation to the relational world we inhabit, not a "standard" to be followed. We view them as a method to map interactions, useful in a particular relationship, place, and time. Finding the right wording for these patterns often gets a "we have always known this!" kind of response. We offer these prototype examples as one possible way to conceptualize relationships, not as the "right" version of interpersonal patterns or the only one that psychologists should use. More so, we invite psychologists to explore what may be examples of interpersonal patterns more prevalent in their practice.

Most of us are unaware of our own contributions to forming and maintaining relational habits or patterns. It is easier to notice what bothers us, or what others are doing. For example, it could be easy to focus solely on Darío's behaviour. We are more likely to notice that a child is ignoring a parent than we are to notice that the parent's tone of voice, or the way in which we are communicating may be inviting the child's behaviour/response. However, zooming out of the child's behaviour to include how others respond, and how the child responds to their responses, allows us to have a different perspective. For example, when the therapist working with Sonia explored the different kinds of interactions in which she engaged with Darío, the understanding of the situation shifted. We provide next an example of how we explored the interpersonal patterns in this family. This example is based on actual therapy conversations but details have been changed to protect clients' privacy. The conversations originally took place in Spanish and have been translated into English by the authors:

Clinical Example

1	T:	So when Darío reacts throwing things, what do you do?
2	S:	Lately, I've had to restrain him . . . like I go behind him and restrain him with my arms, but it is hard
3		because he fights back and sometimes, he hurts me. I know he does not want to be this way,
4		he even says to me sorry when he is in the middle of it. He just gets into these moods and he
5		can't stop.
6	T:	So what were you hoping would happen by restraining him?
7	S:	That he learns to control himself . . . that he realizes what he is doing.
8	T:	You would like him to learn to control himself, so that the restraining is not necessary.
9	S:	Yeah, I don't like it either!
10	T:	Have there been times when your hopes for him to learn to control himself had a different result?
11	S:	Well . . . there was this time not too long ago—we were at the mall buying some stuff with Pedro
12		and him, and he began yelling because I said I would not buy him some toy he wanted. I told him
13		that I didn't like that he was yelling and asked him to calm down and he did.
14	T:	Oh wow! What do you think helped him respond to you by calming down instead of yelling and
15		hitting?
16	S:	I don't know . . . maybe that I was calm? I didn't yell at him. . .
17	T:	Well, that could be one thing for sure . . . what else?
18	S:	. . . I didn't wait till things got out of hand, I knew what was coming and I didn't want him to have
19		another temper tantrum in the mall.
20	T:	Okay, so you were clear about what you didn't want to see happening and you were calm . . . if
21		Pedro was here, what do you think he would say about how you responded that day?
22	S:	He would probably say the same, that I was calm and firm.
23	T:	Interesting. And what do you think Darío would say if I asked him?
24	S:	I don't know . . . probably the same. That I didn't yell at him.
25	T:	I see. So if I ask you which way do you prefer to respond to Darío, what would you say?
26	S:	This way, of course.
27	T:	Why?

28	S:	Well . . . I don’t like yelling at my kids (tears up) . . . I love them, and I want the best for them. I just
29		want Darío to learn not to be like this . . . I don’t want him to be a *mamón*.*
30	T:	I see. Tell me a bit more Sonia, how do you see his behaviour connected to being a mamón?
31	S:	Well . . . sometimes I am afraid of what his reaction will be, so I give him what he wants and he
32		knows it . . . so he has become very attached to me but not in a good way. He wants to be around
33		me because he knows I will probably give in . . .

* Chilean expression that denotes a very closed or enmeshed relationship between a mother and her male child.

By orienting the questions toward interpersonal patterns, we (therapist and team) were able to understand Sonia’s concern in a different way. We learned, for example, that Sonia’s hope by restraining Darío was that he would learn to control himself. However, according to Sonia, the more she tried to control Darío’s behaviour, the less he learned how to control himself (PIP; externally controlling behaviour invites less self-control). In addition, we learned that Sonia attempted to deal with the situation by “giving in” when she felt the behaviour would escalate. This interaction could be seen as a variation of the previous PIP: The more insistent Darío became to get something, the more Sonia felt she had to give in to avoid an outburst (i.e., threatening with behaviour invites giving into demands). In addition, we learned that Sonia was concerned that her interactions with Darío would make others label him a *mamón*, which has a negative connotation in Chile.

Exploring interpersonal patterns provided the team and Sonia the opportunity to understand Darío’s behaviour as a *response* to certain relational invitations. It also allowed us to work with Sonia toward generating alternative invitations to Darío to help him change his responses as well. Indeed, exploring *unique outcomes* (White & Epston, 1990) helped us work with Sonia in exploring her preferences about how to deal with Darío’s behaviour. For example, in lines 14–16, the therapist’s question (“What do you think helped him respond to you by calming down instead of yelling and hitting?”) seemed to help Sonia consider how her behaviour may have generated a different response from Darío (“I don’t know . . . maybe that I was calm? I didn’t yell at him. . . ”). Being able to recognize a different response (being calm) to her child could be a starting point for a new interpersonal pattern; one in which Sonia calmly asks Darío to do something, which invites him to respond in a calm manner (as he did).

Conclusion

One possible way of practicing respect for others is by being curious and trying to understand the language they use to create and recognize relationships within their own relational world. Rather than trying to translate their language into our language, we take the position that there are several languages of expression (Taylor, 1994): languages with which clients live and interpret their *ethos*: what the good life is for them (e.g., "being a good parent"). In this chapter, we call them parenting preferences. We believe we can severely harm others by not recognizing their language, their form of life. This is what Principle I (Respect for the Dignity of Persons and Peoples) of the *Code* is all about for us; to respect our clients' dignity and acknowledge that persons (in this case the parents we work with) are "worthy of equal moral consideration" (CPA, 2017, Principle I, Values Statement, para 3). To enhance their capacity to transform opportunities into actual human development, parents search for help and support from the environment, including professional knowledge (e.g., mental health services). They may find ways to understand parenting skills as ways to transform opportunities into actual development in their children in accordance with their culturally embedded standards. This is how we interpret the gist of Principle II (Responsible Caring) in the *Code*. Rather than substituting or ignoring parents' preferences, we acknowledge their ability to make decisions about the well-being and best interests of their children (CPA, 2017). Hence, far from being contradictory, and despite whatever tension we may feel between Principle I and Principle II, we believe it is useful for us as professionals to remind ourselves that these two Principles are intended to go hand in hand. Ultimately, our hope is always that our knowledge will help bring forth (rather than ignore, misrecognize, dismiss) parents' knowledge, and help them generate and develop long-lasting parenting competencies to raise their children according to their preferences and culturally embedded standards. We view this exploration as opening possibilities for change while respecting the dignity of those involved. In sum, our international experience provided us with the opportunity of experiencing and recognizing multiple perspectives in our work, and we hope to continue infusing our work with what we have learned elsewhere—not by imposing it, but by bringing it forth as another possibility. Rather than defining ourselves and our work depending on the cultural context we learned in, we try to contribute our international experience to our current professional location.

Questions for Reflection

1. Connect with a psychology practitioner who received part of their training in a country other than Canada. Explore the

differences (between Canada and the other country) regarding psychology training and the provision of mental health services. What stands out for you?

2. Do you think training and/or professional experience in a country other than Canada would be an advantage or a disadvantage in working in a multicultural country like Canada? In what way(s)?
3. Do you think that training in psychology can be transferred between different cultural contexts? For example, professionals trained in Canada who go to practice in other countries—what may be some advantages or a disadvantages they face? In what way(s)?
4. Think of a situation in which you believe that a client's cultural perspectives and values could interfere with achieving a good outcome in therapy. How would you deal with this in a way that balances achieving a good outcome with respecting the client's dignity?

NOTE

1 The Chilean constitution (and probably many others) designates the family as the primary socialization agent; that is, the institution in which a child develops and learns what constitutes a "good" life. That is why the State needs to support that each child develops his or her abilities, exercising his or her right to live with a family (UNICEF, 1991).

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20

Ethical Challenges for Psychologists Conducting Humanitarian Work[1]

Nicole Aubé

Is it possible to maintain ethical standards while working on humanitarian missions?

Humanitarian work for psychologists, although personally fulfilling, is also full of professional challenges. While working with Médecins Sans Frontières on a number of missions, I was confronted regularly with ethical dilemmas that at times allowed for adaptive solutions but at other times remained persistent and unresolved. The key objective of this article is to review the types of ethical challenges that psychologists face when they are involved in humanitarian work on a mission. These challenges are presented in light of the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association [CPA], 2000).[2] To achieve this objective, the article offers real-life examples to illustrate some of the dilemmas the humanitarian worker has to face. The examples include how certain solutions were attempted, which might have been quite different if applied in the Canadian context at home.

Recently, a vast number of humanitarian crises have engaged the energies of international aid organizations, also referred to as non-governmental organizations (NGOs). These NGOs provide health care and support for physical and psychological needs to populations suffering from human-made or natural disasters. Little research has been done on the ethical challenges encountered by medical and nursing professionals participating in humanitarian aid work, and even less is available on the specific challenges faced by psychologists on a mission.

The involvement of psychologists in humanitarian missions is a fairly new concept. Médecins Sans Frontières was founded in 1971 after the Biafran famine by a group of French physicians and journalists; however, it was only in the late nineties that mental health workers were systematically recruited as well. A main target of mental health worker assignments was dealing with the sequelae of rape.

Rape tragically has become a weapon of war; an attempt to create disequilibrium. In recent years, this has applied to African countries such as the Congo, Sudan, and even more close to home, now in Haiti. Such a situation creates a role for mental health workers that goes beyond mere medical crisis management.

Psychologists' work on a mission can be quite varied. To provide a context for understanding the inherent ethical challenges, below is a list of the types of work I was engaged in; namely, when working one-on-one with patients:

- Identify target groups needing psychological services.
- Set up a triage system to assess and respond to needs.
- Assess available psychological resources and prepare intervention strategies.
- Provide psychological treatment and support to survivors.
- Co-ordinate outreach to the identified target group.
- Identify and maintain a local referral network.
- Provide psycho-education and social-education material.
- When working in hospitals or clinics:
    - assist and support the medical and paramedical staff of the hospital;
    - develop a culturally adapted training curriculum consisting of psycho-educational topics and counselling skills for local counsellors;
    - put programs and research in place.
- When working in a more administrative role:
    - help to strengthen collaboration with other NGOs by identifying any contextual issues or stressors that impact upon problems in service delivery;
    - help to find short- or long-term solutions;
    - record and evaluate clinical work.

When Canadian psychologists work outside of their country, they are likely to be guided by the *Code*'s ethical principles. However, these broad principles need interpretation and contextualization to be of use. The Canadian Psychological Association's *Code* is structured around four major principles:

I: Respect for the Dignity of Persons
II: Responsible Caring
III: Integrity in Relationships
IV: Responsibility to Society.

It is easy to agree with and commit to the values expressed in these four overarching principles. They reflect the philosophy and training that Canadian psychologists were raised with and are comfortable with. Yet, while doing humanitarian work with the best of intentions, these large principles and the specific concepts described within each can seem to take a beating. The humanitarian worker has to learn to live with some very flexible interpretations of what is much clearer and easier to apply at home. Below you will find descriptions of the many situations in which I or my colleagues experienced major challenges, organized around eight major themes.

Severe Limitation of Resources

On humanitarian missions, psychologists are confronted regularly with situations where the resources are utterly insufficient to meet the quantity of need. In addition, the level of service quality is also often greatly insufficient. The fact that resources are so scarce is not a surprise, but it is a recurrent source of ethical struggle for psychologists on a mission (Schwartz et al., 2010).

As psychologists are at times responsible for selecting which patients will receive health care and which will not (Hunt, 2010; Sinding et al., 2010), they need to learn the elements of triage. This role often results in an ethical dilemma insofar as we need to assure that triage thinking does not open the door to the kind of discrimination our ethical principles are trying to prevent. In Principle 1 (Respect for the Dignity of Persons), it is stated that:

> psychologists acknowledge that all persons have a right to have their innate worth as human beings appreciated and that this innate worth is not dependent on their culture, nationality, ethnicity, colour, race, religion, sex, gender, marital status, sexual orientation, physical or mental abilities, age, socioeconomic status, or any other preference or personal characteristic, condition or status (CPA, 2000, Principle I, Values Statement, para 2).

Psychologists should actively avoid and not support unjust discrimination based on any of these factors. Given that triage can open the door to discrimination, how can triage be appropriate?

In some situations, patient A may be chosen to the detriment of patient B, with a fair amount of time spent immediately with patient A because she may never come back. For instance, if a mobile clinic reaches the patient once, it does not mean that the patient will be seen a second time. The patient's inability to return may be due to: (a) the fact that the patient lives in the jungle or in a remote area that has no road access; (b) the inability of the patient to return to treatment or to comply with the treatment; (c) the length of treatment required (e.g., for patients suffering from posttraumatic stress disorder) competes with the patient's other pressing needs, such as food, work, or shelter; (d) lack of an adequate support system, especially for victims of physical and sexual violence (e.g., when a woman victim of rape is not supported by her husband in her wish to be seen, she will not return because her visits to our clinic will be seen as a defiant gesture). Triage as a way of minimizing the impact of limited resources can be challenging for the psychologists on a mission. In helping those who are easier to reach and /or who have a better chance of survival, we may be neglecting those with even greater need who may be more of a priority to local government, but who are not easily accessible.

Another ethical challenge related to limited resources is Ethical Standard II.21 in Principle II (Responsible Caring) of the *Code*, which states that psychologists "strive to provide and/or obtain the best possible service for those needing and seeking psychological services." Often in a humanitarian work setting, there are no alternative services, no other forms of support or help. Once the NGOs go away, the patient is left to him or herself. Also, in Standard II.33, it is stated that psychologists "maintain appropriate contact, support, and responsibility for caring until a colleague or other professional begins service." The situation usually does not allow us to follow through with the intent of this Standard and we are stuck with the following ethically troubling thoughts and concerns:

- What happens to people when there is no one to help?
- What happens when the local resources are inadequate or incompetent?
- Should we provide humanitarian assistance if we cannot monitor or evaluate the quality or our services (Human Accountability Partnership [HAP] & World Health Organization [WHO], 2002)?
- Is it ethical to start treatment when we know that we will be long gone before the treatment can assist the patient? (By virtue of their role, psychologists set in place programs or hire people to carry on, knowing that they will not be able to supervise or evaluate the services because they will be returning to their home country.)

Local Political Pressure on NGO

Ethical challenges also can relate to social and governmental injustices. Local government may permit the humanitarian worker only to work with the government's chosen population, which often is based on ethnic, social, and/or gender inequalities (Schwartz et al., 2010). Such situations almost force the practitioner to engage in or contribute to discrimination. For instance, a psychologist working in a refugee camp may be directed by the local authorities to favour one group. If you don't comply, you are not allowed to work any longer in the camp. Sadly, in many countries of the third world, women's health is either disregarded or a low priority. The bias to favour men and limit the treatment of women is a regular challenge in many countries (e.g., east-central Africa). Despite such pressures, the psychologist is expected ethically to advocate for the vulnerable. If authorities do not respond to such advocacy efforts, they may need to be reminded that it is important to consider the needs of everyone and to value equality.

Local Cultural and Social Realities

The tension between respecting local customs and imposing values can be a great dilemma for humanitarian workers, especially when the local cultural values endorse unjust discrimination and the limitation of information for the purpose of political or gender control (Hunt, 2009; HAP & WHO, 2010). Family planning and abortion are sensitive topics on a mission, even more sensitive than they can be at home in Canada. There are situations that exacerbate tension between respecting the local customs and imposing our values (Hunt, 2010). The following examples delineate situations that exacerbate such tensions and describe some of the multiple, interwoven challenges to the way we interpret our ethical principles when in Canada:

1. In Congo, abortion is illegal. It is also socially and religiously condemned. What should a psychologist do when a victim of rape is asking for help to get an abortion, knowing that if she disclosed to her husband that she is pregnant as a result of gang rape by the militia, he will chase her out of the family and the village? She then would become a total outcast and very vulnerable for more victimization. With the agreement of the woman, the psychologist could negotiate with the medical staff another label for the medical procedure, such as calling it a "D&C" without further specification or "internal complication surgery." The value of finding ways to minimize harm takes on special importance in this type of situation.

2. How does the psychologist respond to a local staff member in a Burundi clinic who refuses to provide information to young mothers about family planning because of her personal views? In this case, a new staff member with more open and modern views on family planning was hired as a receptionist for the program. A new administrative system (including some personnel changes) was also put in place to monitor everyone's reason for referral to the clinic.
3. Is it ethical to teach a wife who is a victim of spousal abuse to speak her mind and not to accept the violence from her husband when one knows that if she confronts her aggressor she will be chased out, abandoned, and cast away? In reality, when thinking of providing such advice, a psychologist needs to be aware of the physical and emotional resources and supports available in the local culture for a woman who stands up for herself. There are no women's shelters in the bush. If the local support system is precarious, the psychologist instead needs to offer psychological support and suggest nonprovocative coping strategies. Most humanitarian work is carried out in countries where the rights of women are not only ignored but abused. For any humanitarian worker who meets this injustice every day, the ethical challenge is huge. The inability to effectively reduce such abuses becomes a source of much personal stress given that we value the individual's right to safety but cannot guarantee its implementation.

Challenges to Protecting Confidentiality

At home, we treat confidentiality as sacrosanct. In Principle I (Respect for the Dignity of Persons) of our *Code*, we are advised to ensure that the person who receives assistance is treated in privacy and that the information transmitted is kept confidential. However, in a crowded refugee camp consisting of a tent city, confidentiality is often an unfulfillable dream. On humanitarian missions, there often is one tent that is called "the mental health tent." Everyone knows who comes to ask for mental health support. What does a psychologist tell a husband who insists on an explanation for why his wife came to see a counsellor in the mental health tent, knowing that if the answer provided does not satisfy the husband, his wife won't be permitted to return to get services? This type of situation is even more difficult in a culture where health care workers are expected to obtain permission from the husband before his wife can receive services (Schwartz et al., 2010). I faced this situation in a refugee camp filled with Somalis in South

Africa. I chose to tell the husband a generic and non-threatening reason (a white lie) why his wife had come to counselling, saying that she was wondering about her children and wanted some simple advice about child development.

Keeping information confidential is similarly challenged when patients are unwittingly labelled while waiting for services. Many governmental and non-governmental organizations in Africa offer help to victims of sexual violence. The program is called "Sexual Gender Bias Victim" services and is announced with this title. For instance, when a young woman waits in a line-up at the clinic, everyone is cognizant that she is at the clinic for victims of sexual violence. Similar concerns pertain for HIV patients who are identified as such while waiting for service. This aspect has raised a great deal of ethical angst for psychologists, who are especially aware of the stigmatization of these two vulnerable groups.

When dealing with sexual violence, other challenges to protecting confidentiality include the regular lack of availability of female translators and the lack of translators who understand and are willing to commit to confidentiality. They also include the difficulty of providing private space when wards are so overcrowded that patients sleep on the floor between beds. Additionally, in our modern computerized world, psychologists need to remember that the ease of dissemination of information can readily lead to loss of control over information. This happens even in remote areas (HAP & WHO, 2002). Again, the role of the psychologist becomes one of advocating for ways to protect the patient's dignity.

Patient Consent

Under Principle I (Respect for the Dignity of Persons), obtaining informed consent includes telling people about the procedures, the benefits, and the risks. It also implies that the mental health worker will explain to patients that they have the right to decline. This process is very complicated for persons who are in movement and/or in war zones.

Humanitarian work often does not occur in a setting where one has time to ask and obtain truly informed consent from the patient/ client. The arena of work is often very spontaneous and brief. Psychologists need to recognize when truly informed consent is possible and when it can be waived in crisis situations when speed is paramount (HAP & WHO, 2002).

Many of the populations being assisted are illiterate or have limited reading abilities. In these cases, written consent cannot be sought and sharing a copy of a signed consent form is pointless. Alternatively, one could seek verbal consent, but then there is no written evidence of it from the patient, and bringing in a witness to the consent process is a threat to confidentiality.

Everyone knows that a picture is worth a thousand words. Despite the fact that a photo can serve to witness injustice and inequality, or is useful for fundraising, taking pictures of the victims of natural disasters or war can challenge the values of consent, privacy, and confidentiality. For example, essential for fund-raising after the earthquake in Haiti on 12 January 2010, many pictures and videos of victims were transmitted all over the planet. Is it more important to obtain individual consent for the taking and use of photographs, or is it more important to have the ability to raise funds to help victims? This is another ethical dilemma faced by psychologists on a mission.

Colonialism and the "Superior Role"

Even in western health care there is an asymmetrical power relationship between healer and patient. This differential is amplified in the context of health care practice in crisis settings. The imbalance of power can be seen in humanitarian work, but it is amplified by a blatant racial issue. It is frequently observed in the third world that locals automatically grant special power to the White professional over the opinion, experience, and knowledge of the local non-White health care professional. In humanitarian work, mental health professionals need to be cognizant of this reality and need to consciously strive for respect of local expertise.

Individual Interests Versus Population Interests

Psychologists have a responsibility to care for the most vulnerable person(s). In humanitarian work, we at times close our eyes to the single vulnerable person in front of us, and instead focus our energy on tasks that may lead to greater long-term benefit for a larger group of vulnerable persons. For instance, pushing for constructive long-term policy change might ultimately benefit more persons than doing one-on-one psychological band-aid work.

Tolerance for Differences in Standards

In supporting Principle IV (Responsibility to Society), psychologists often struggle with deciding how little may have to be good enough. Trying to provide adequate supervision and training reflects such a challenge. To some degree, Principle IV is particularly relevant to the process of clinical supervision in humanitarian work. The foreign psychologist knows that his or her stay will be time-limited and she wants to leave a cadre of helpers who continue to honour this principle. In supervision, the psychologist will try to instill a sense of responsibility to the societies in which the supervisees live and work to ensure psychological knowledge will be used for beneficial purposes, to encourage the supervisees to convey respect for social structures, to encourage achieving consensus within societies through democratic means, and to speak out against structures or policies that ignore or oppose the principles of respect for the dignity of persons, responsible caring, integrity in relationships, or responsibility to society (CPA, 2000, Principle IV, Values Statement).

Supervision and training can be a great challenge in precarious environments such as refugee camps. Due to lack of time, adequate facilities, and privacy, it can be quite demanding for the psychologist to provide proper supervision to his or her staff. This situation occurred in South Africa and in Chechnya, where it was at times impossible due to time pressures, an excessive number of supervisees, and geographical access constraints.

For some missions, the job description of the supervisor includes the administrative power to hire and fire staff. The duality of this role can be difficult. Firing somebody for lack of competence can make sense if a replacement resource can be found. In Chechnya/Ingushetia, there were no alternative resources available at all. I felt I had to stretch my own views of what were minimally acceptable clinical abilities for some of the counsellors. I justified this to myself by considering the local reality. After over 10 years of war, there were no other psychological resources left and even embarrassingly modest support might be better than no support.

Conclusion

Many ethical problems are universal. At home in Canada, psychologists can encounter similar difficulties in crisis situations, such as triage, quality of resource allocation, challenges to obtaining informed consent, and needing to cope with professional hierarchies. Nevertheless there is something acutely different and more cumbersome when the ethical challenges arise within the context of humanitarian aid work (Schwartz et al., 2010). The challenges are different because of the extreme precariousness of the population's situation, the political situation, and the extreme scarcity of resources. The utterance "My God, they have nothing . . . where do I start?" is often expressed by humanitarian workers.

There are a great many ethical challenges and dilemmas for psychologists overseas on a mission. One has to keep in mind that our *Code* was developed within and for a democratic society with equality, resources, and professional standards. The *Code* is not always applicable in the same way in a society torn by wars and longstanding inequalities. Given these limitations and the constant challenges, psychologists on a mission need to be even more flexible than at home. They will be pushed to the limits of their skills and tolerance, and many times they will perform activities that they never carried out before, all under a great deal of pressure.

The four major ethical principles of our *Code* are a valuable point of reference that we need to keep in mind wherever we work. Using those principles as a guide, psychologists on a mission may need to adapt the operationalization of the principles to the contextual reality, using discretion and swift judgements. On a mission, our ethical principles help guide our professional work but often need to be seen as aspirational. They must be interpreted within a broader practical context of what is possible. My advice is clear: do not leave home without the guidance of your ethical principles, but please remain flexible. Do not look just at the tree in front of you but remember the forest that is surrounding you.

Sadly, there is no specific training for humanitarian workers in respect to the application of one's code of ethics. It is clear that NGOs rely on the workers themselves to decide how to do it. Further challenges occur as a result of psychologists working not only with other mental health professionals but also with local and international staff from around the world who may have divergent standards.

It is imperative that I end this article by explaining to the reader that although the challenging aspects of humanitarian work are plentiful for psychologists, the professional and personal rewards often exceed expectation. The solidarity psychologists can feel with the human race while on a mission often becomes one of the most invigorating experiences of a career. It is distinctively rewarding work as it forces one to retrieve and use one's full clinical, personal, and ethical resources. Sometimes this includes going well beyond the boundaries and the scope of our regular routine.

Questions for Reflection[3]

1. Do you think psychologists should be involved in humanitarian work? Why or why not?
2. Is humanitarian work as a psychologist something you would consider doing yourself? Why or why not?
3. You have just arrived on site as a humanitarian aid psychologist and have been asked to support a five-year-old child who was raped and is about to undergo surgical repairs of the physical damage that was done. She will be awake during the surgery and you are asked to go directly to the surgery room. What ethical issues do you see? What would you do? Why?
4. What do you think "choosing the best course of action" means? Is it making sure that you follow the ethical standards of the *Code*? Is it more a matter of doing the best you can ethically under the circumstances? Other? Explain.

NOTES

1 Aubé, N (2011). Ethical challenges for psychologists conducting humanitarian work. *Canadian Psychology, 52*(3), 225–239. Copyright ©2011 by the Canadian Psychological Association Inc. Reprinted by permission of the Canadian Psychological Association Inc.

2 Please note that, as this article was originally published in 2011, it is based on the third edition of the *Code* (CPA, 2000), not on the current fourth edition (CPA, 2017).

3 Please note that these Questions for Reflection were not included in the original article, but have been added here by the author.

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21

International Psychological Ethics: The Story of the *Universal Declaration of Ethical Principles for Psychologists*

Janel Gauthier

From a global perspective, the development of the *Universal Declaration of Ethical Principles for Psychologists* (2008; hereinafter also referred to as the "*Declaration*" or the "UDEPP") is "arguably, the single most important development in the history of psychological ethics" (Prentice et al., 2017, p. 247). The *Declaration* was adopted unanimously in 2008 by both the General Assembly of the International Union of Psychological Science (IUPsyS) and the Board of Directors of the International Association of Applied Psychology (IAAP).[1] It was the product of a six-year process involving a widely representative working group, original research, broad international consultation, and numerous revisions in response to feedback and suggestions from the international psychology community (Gauthier, 2008a, 2008b; Gauthier & Pettifor, 2011, 2012; Gauthier & Sinclair, 2020; Leach & Gauthier, 2012; Prentice et al., 2017).

The purpose of the present chapter is to describe how the idea of developing a universal declaration of ethical principles for psychologists came about, how the *Declaration* was developed, and how it has influenced global ethical thinking and contributed to the international advancement of psychological ethics. In this chapter, I will provide some of the backstory, drawing from my notes and memory of the events.

How it All Began

In a chance encounter, separate chains of events have their own causal determinants (e.g., entry skills, values, emotional ties), but their intersection occurs fortuitously. According to Bandura (1982, 1998), the science of psychology cannot shed much light on the occurrence of chance encounters, but it can provide the basis for predicting their impact. Personal resources help them to make the most of opportunities that arise unexpectedly. But what has this to do with the *Declaration*? Let's go to the beginning of the story.

My personal involvement in international psychological ethics began in the year 2001 and occurred somewhat by chance. In the mid-90s, I was the chair of a working group created in Quebec City by a friend and myself outside the auspices or sanctioning of any organization or other group to obtain the release of a Canadian Vietnamese businessman (Trần Triệu Quân) who had been unjustly arrested and condemned to life imprisonment in Vietnam following the failure of a business deal. The deal involved a company owned by the Vietnamese government and a businessman of the United States for whom the Canadian was acting as an intermediary. In 1998, and against all odds, the working group was successful in obtaining the Canadian's release from prison and his safe return from Vietnam to Canada on humanitarian grounds. However, this was only after three-and-a-half years of intense and continuous representations in several arenas (political, legal, business, and religious organizations; human rights associations; labour unions; chambers of commerce; schools and colleges; the Supreme Court of Canada, etc.) at the local, regional, national, and international levels. Through this experience, I learned first-hand that human rights should never be taken for granted, be it at home or elsewhere in the world, and that the struggle and maintenance of hope can be long and challenging.

In 2001, I received an invitation from Jean Pettifor (to whom this book is dedicated) to speak about ethics at an invited symposium she was convening for the International Congress of Applied Psychology to be held in Singapore in July 2002. The invitation was unexpected because I had never presented or published any paper on ethics. However, Jean was aware of my interest and work in human rights, including my involvement in the case of Trần Triệu Quân (it had been the focus of my second address as president of the Canadian Psychological Association [CPA] in 1998 [Gauthier, 1998]). In addition, the situation had been widely publicized throughout Canada. I wrote to Jean to let her know that I would be happy to accept her invitation if I could: (a) discuss the moral values promoted in codes of ethics in the context of connecting them to the values promoted in the *Universal Declaration of Human Rights* (UDHR) (United Nations, 1948); and (b) argue for the development of a universal declaration of ethical principles for psychologists that would be to psychology what the UDHR is to the world. Her reply was brief: "Send me an abstract and I will let you know." She must have liked the idea because she accepted my abstract "as is" right away. At the time, I did not know how much Jean had been involved in fighting for human rights (particularly, women's rights) throughout her personal and professional life. I came to realize later that she had connected human rights and ethics long before I did. For her (as well as for me today), ethics and the concept of human rights strengthened and complemented each other.[2] Opportunities existed in both to make contributions to the struggle for justice, peace, freedom, and respect for human dignity. Contributions to ethics could make contributions to the promotion of human rights, and vice versa.

With respect to my planned presentation, one problem was that the world of ethics and the world of human rights were perceived by most at the time as two different worlds, not to say two solitudes. The former is a world of human values (aspirational and inspirational in nature); the latter is a world of defined human entitlements (specific and prescriptive in nature).[3] They appeared so distinct that it was difficult to imagine a human rights activist becoming interested in ethics or an ethicist becoming a human right activist. However, another problem was that there was much skepticism in the international psychology community about whether the goal of developing a universal declaration of ethical principles for psychologists could be achieved. Both the International Union of Psychological Science and the International Association for Cross-Cultural Psychology (another organization that provided support in the development of the *Declaration*) had tried and been unsuccessful in developing a code of ethics that would be applied worldwide.

D-Day and the Following Days

I was somewhat apprehensive about my presentation at the Congress in Singapore. I was worried both about how my proposal would be received and what could happen to me after speaking about human rights at the conference. At the time, Singapore was a highly developed nation with a thriving economy. However, freedom of speech and peaceful assembly were restricted by the government in the belief that they could undermine national security as well as religious and racial harmony. For example, before 2004, public speakers needed police permits to express themselves inside buildings (Hays, 2008). The political rights and civil liberties of people in Singapore were limited. There were reports of harassment, intimidation, unfounded charges, arbitrary detention, judicial caning, and the death penalty being used as methods of maintaining social order. In other words, in the view of many, human rights in Singapore had a long way to go, and promoting the universal recognition of human rights in Singapore involved some personal risks (I had not forgotten what had happened to Trần Triệu Quân just a few years earlier). In any case, the day on which my presentation on connecting ethics and human rights arrived, and things began to unfold quickly—far more quickly than I had anticipated.

On Monday, 8 July 2002, on the very first day of the conference, I presented my paper "Ethics and Human Rights: Toward a Universal Declaration of Ethical Principles for Psychologists." It was part of the symposium convened by Jean, which was entitled "Professional Codes of Ethics across National Boundaries:

Seeking Common Ground" (ICAP, 2002, p. 53). The aim of my paper (Gauthier, 2002) was to present evidence demonstrating that developing a universal declaration of ethical principles for psychologists that would be to psychology what the UDHR (United Nations, 1948) is to the world was something doable and desirable for the advancement of international psychological ethics. I did this by showing that: (a) there are commonalities in the ethical principles used to develop national codes of ethics for psychologists around the world; and (b) the ethical principles most frequently used to develop national ethics codes for psychology are closely connected to the moral imperatives underlying the UDHR (United Nations, 1948). To my surprise, the presentation and its proposal were so well received that, in a manner of speaking, it instantly became the "talk of the town."

On Wednesday, 10 July 2002, parallel to the Congress, IAAP was hosting the World Forum of International Psychological Associations in Singapore. One of the topics discussed at the Forum was ethics and how international psychological associations could work together in promoting psychological ethics around the world. No specific project was discussed, but some participants in the Forum knew about my paper and the proposal of a universal declaration of ethical principles for psychologists. They came to me after the Forum to encourage me to submit the proposal to both IAAP and IUPsyS for consideration. At the time, I was a Canadian delegate to the IUPsyS General Assembly and had just been elected member-at-large of the IAAP Board of Directors. Coincidentally, the IUPsyS General Assembly was meeting the next day in Singapore.

On Thursday, 11 July 2002, at the beginning of the IUPsyS meeting, I moved to add one item to the proposed agenda; namely, to present my proposal for the development of a universal declaration of ethical principles for psychologists. A 2/3 vote was required to adopt the motion. My request was a challenge considering that the agenda was already full. To my surprise, the motion was approved unanimously, and I was given a maximum of five minutes to make my presentation. The chair of the General Assembly called the question immediately after my presentation. Again, to my surprise, the proposal was unanimously approved. No one abstained from voting. It also was agreed that it would be a joint project between IUPsyS and IAAP, that I would be the chair of the "Joint Ad Hoc Committee" responsible for developing the declaration, and that I would have the freedom to select all its members.

Jean and I were excited and looking forward to working on the development of the *Declaration* with other colleagues. However, there was no road map to do this. We needed to reflect on what we had heard and seen during the week, and what it meant for the next move.

Development of the *Declaration*

One of the lessons learned from the week in Singapore was the importance of developing a declaration that had maximum generalizability, applicability, and acceptance. As mentioned above, there was no available road map for doing this. In the end, though, following much discussion and consultation, an agreement was reached on how to proceed. The process involved: (a) creating a working group for the development of the *Declaration* (2002–2003); (b) conducting research designed to develop and validate a moral framework for the *Declaration* (2003–2004); (c) writing and revising drafts of the *Declaration* (2005–2008) for review and feedback; and (d) consulting the international psychology community throughout the development process (2002–2008). Each of these is discussed in turn below, along with some of the backstory explaining directions taken and decisions made.

Establishing a Working Group

The creation of a working group (also referred to as the "Joint Ad Hoc Committee") to oversee the development of a universal declaration of ethical principles for psychologists was quite challenging. It was important that it be representative and inclusive, and that it reflect the different worldviews in the international psychology community. It was equally important to have a group whose members had relevant expertise and genuine interest in contributing to the development of an ethics document that would enjoy worldwide generalizability, applicability, and acceptance. It took over a year to recruit the members of the Committee. Jean Pettifor, who had attended numerous sessions about ethics at international psychology conferences every year over the previous 15 years, was helpful in identifying individuals to invite.

Responding to concerns that previous ethical frameworks and codes had come primarily from Western philosophy and worldviews, care was taken to ensure that members of the Joint Ad Hoc Committee were drawn from the major cultures and regions of the world. It included individuals whose heritage was Eastern, Western, and Indigenous. Members were from (in alphabetical order): Canada (Janel Gauthier, chair), China (Kan Zhang), Colombia (Rubén Ardila), Finland (Tuomo Tikkanen), Germany (Lutz Eckensberger), Iran (Nasrin Jazani), New Zealand (Catherine Love), Singapore (Elizabeth Nair), South Africa (Ann D. Watts), the United States (Paul B. Pederson), Yemen (Hassan Kassim Khan), and Zimbabwe (Kwadzi Nyanungo) (Gauthier, 2005, 2008a).

No attempt was made to have on the Committee a member from every country in the world, as it was thought that a small group would be more effective than a large group for the task at hand. However, that said, it is important to note that the Committee was working under the auspices of IUPsyS and IAAP, and that both these organizations had the opportunity to review ongoing progress reports and to comment on the drafts of the *Declaration* before it was considered for adoption. At the time, national organizations from over 80 different countries had IUPsyS membership (one per country), and psychologists from over 40 countries were members on the IAAP Board of Directors.

Conducting Research Designed to Identify a Universal Moral Framework

A moral framework that reflected the most universally agreed-upon ethical principles and values in psychological ethics was needed to draft the *Declaration*. One could have relied on the beliefs, thoughts, opinions, viewpoints, perspectives, and the like of the Joint Ad Hoc Committee members and the international psychology community to identify what those principles and values might be. This approach had been successfully used in the development of regional ethics documents such as the *Meta-code of Ethics* of the European Federation of Psychologists' Associations and the *Etiske prinsipper for Nordiske psykologer* [*Ethical Principles for Nordic Psychologists*] (Gauthier & Pettifor, 2011). However, there was some uncertainty about whether a similar consensus could be achieved among psychologists worldwide as well as some concerns about how much time would be required to reach it if it could ever be achieved. Reliance on research explicitly designed to identify a universal moral framework for drafting of the *Declaration* seemed more promising. After all, the scientific approach is commonly used in psychology to address complex, and sometimes highly sensitive, questions or issues. This is not to say that there would be no challenge. At the time, there was no established methodology available to develop and validate a moral framework for drafting a universal declaration of ethical principles. We had to create one, one that would be credible, effective, and low budget.[4]

To identify commonalities in ethical principles, we started by examining existing codes of ethics for psychologists from around the world (Gauthier, 2002, 2003, 2004, 2005). All codes in which ethical principles were clearly identified were included in the review. The ethical principles having the strongest commonality across national and continental boundaries in psychology were found to be: (a) respect for the dignity and rights of persons; (b) caring for others and concerns for their welfare; (c) competence; (d) integrity; and (e) professional and scientific responsibilities to society. However, as codes of ethics were more prevalent in Western cultures than in non-Western or Indigenous cultures, one could not rule out the possibility that ethical principles based on non-Western worldviews, including Indigenous worldviews, were underrepresented in the sample and, therefore, that the principles identified above were not truly "universal." Further research was needed to test their "universality."

To assess universality, three avenues of research were pursued: (a) review of codes of ethics of other disciplines (e.g., social work, medicine, sports coaching), including disciplines as far from psychology as martial arts, to identify the ethical principles and values espoused by other disciplines (Gauthier, 2005); (b) review of internationally accepted documents such as the UDHR (United Nations, 1948) and the *Declaration Toward a Global Ethic* (Parliament of the World's Religions, 1993) to delineate their underlying moral principles (Gauthier, 2002, 2003, 2004); and (c) review of historical documents from both Eastern and Western countries and cultures (e.g., Babylon, China, Egypt, Greece, India, Japan, Persia) to determine the extent to which the ethical principles and values being considered for inclusion in the *Declaration* had roots in ancient cultures and civilizations (Gauthier, 2006; Sinclair, 2005a, 2005b, 2005c, 2012). These documents varied from formal oaths taken by new physicians to sets of instructions for physicians to, in one case, a physician's prayer. They ranged chronologically from circa 500–300 B.C.E. to 1770 C.E. Carole Sinclair carried out this research. At the time, Carole was interested in identifying the roots of ethical principles and values in modern codes of ethics for psychologists. I asked her to extend her research to test the universality of the five ethical principles identified above, which she kindly agreed to do. Her research provided critical evidence for the universality of the ethical principles being considered for inclusion in the *Declaration* (Sinclair, 2012).

Together, the three avenues of research showed that the ethical principles used most commonly to articulate codes of ethics in psychology were based on human values shared throughout human history, as well as across communities, disciplines, cultures, and civilizations. Even where there were differences in emphasis (e.g., on individualism versus collectivism, science versus traditional healing, secular versus religious authority, and authoritarian versus democratic governance), there was a meeting ground in terms of respect, caring and competence, integrity in human relations, and the collective well-being of society.

Drafting of the Declaration

CREATING THE FIRST DRAFT

By late 2004, the ethical principles of the moral framework for the *Declaration* had been identified, and feedback from the international psychology community indicated that these principles enjoyed the support needed to be used for drafting a universal declaration of ethical principles. We, therefore, began to shift our attention to the drafting of the document.

As challenging as it was to develop a moral framework for a universal declaration of ethical principles for psychologists, the drafting of the document itself represented an even greater challenge. As they say, "The devil is in the details."

Issues about language and meaning emerge in the context of almost all cross-cultural work. There are commonalities in basic human values across cultures. However, there also are obstacles to mutual understanding, and differences in how people believe life should be lived.

The very first attempt to have a crack at drafting the *Declaration* occurred on 19 October 2004 when Jean e-mailed me some ideas to consider for the drafting of the *Declaration*. She made suggestions about how to structure the document and what to include in each section. She also made preliminary attempts to word some paragraphs. Those who knew Jean know that this was her way of pressing people to move forward and get things done.

After reviewing her suggestions, I asked Jean if she would be willing to meet with me in Calgary (Jean's hometown) for a few days to work on the *Declaration*. My goal was to develop a draft that would be good enough to present to the members of the international Joint Ad Hoc Committee for comments and suggestions by June 2005. I was aware that the required work could not be accomplished by email or teleconference alone. The task was too complex. There was a need to ensure that the perspectives of the Joint Ad Hoc Committee members and consultations carried out to date were incorporated into the draft document. Also, there was a need to describe the ethical principles in such a way that they could be operationalized differently depending on culture and needs, but still honoured.

We agreed to meet in person in May 2005. We were unable to meet earlier because of my duties as full-time university faculty and my frequent travels as president of IAAP. I arrived in Calgary on 16 May, and we were at work by the following day. We started off by revising the working document that Jean had produced in October. In a matter of days, we produced several versions (no less than eight according to my records). Versions sometimes evolved quite quickly throughout a working session. At the end of each working day, we had a new version of the *Declaration* that we critically reviewed the next working day. This unavoidably led to further revisions. We had our last working session on 21 May. I remember that day quite clearly. Like the first day, it was long and gruelling. Jean wanted to take me to Drumheller on 22 May to show me the Royal Tyrrell Museum of Palaeontology, Canada's only museum dedicated exclusively to the study of ancient life, and I was scheduled to fly back to Quebec City (my hometown) in the morning of 23 May. We had agreed to work on the draft document until we ran out of ideas to improve its quality, and 21 May represented our last chance to achieve our objective. Jean allowed almost no breaks on that last day. I think that she enjoyed helping me work on the *Declaration* so much that her excitement could not give way to fatigue.

One week later, I visited Carole Sinclair at her office in Toronto to work on the document with her. She had been given a copy of the last version that Jean and I had worked on. On 28 May, she sent it back with comments, questions, and proposed edits. We had two working sessions during my visit: one on 30 May 2005 and another on 1 June 2005. The revised version was submitted for review to Jean who had only minor edits to suggest. Following minor editing in the light of Jean's suggestions, this version was submitted to the members of the international Joint Ad Hoc Committee for review and approval in early June 2005. The feedback from the Committee was overwhelmingly positive. Within about two weeks, the draft document was approved unanimously by the Committee for release as the official first draft for review and feedback. This draft (for complete text, see Gauthier, 2006) included a Preamble and four sections corresponding to four different ethical principles, namely: (a) Respect for the Dignity of All Human Beings (Principle I); (b) Competent Caring for the Well-Being of Others (Principle II); (c) Integrity (Principle III); and (d) Professional and Scientific Responsibilities to Society (Principle IV).

REVISING DRAFTS

The official first draft of the *Declaration* was sent to the leadership of IUPsyS and IAAP at the end of June 2005, with a request for feedback. In addition, as of June 2005 and as part of the broad international consultation process, it was presented, reviewed, and discussed in the context of symposia, focus groups, and panel discussions at international and regional conferences (for further details, see next section of this chapter).

Overall, the first draft of the *Declaration* was well received,[5] and the broad international consultations that occurred in the following two years yielded several helpful suggestions for improving it. It was revised in June 2007 in light of the feedback received, and an official second draft was approved by the Joint Ad Hoc Committee for release and international consultation in July 2007 (for complete text, see Gauthier 2008a). The structure of the second draft was the same as in the first draft. Once more, the draft was well received. The international consultations for the second draft continued through 2007–2008 and yielded additional helpful suggestions to improve the document even further.

Taking into account all feedback received, the second draft of the *Declaration* was revised in March and April 2008. After this third draft was reviewed and approved by the Joint Ad Hoc Committee, it was submitted as the "final draft" to the leadership of IUPsyS and IAAP in May 2008 for consideration for adoption by the IUPsyS General Assembly and the IAAP Board of Directors at their respective meetings in Berlin, Germany in July 2008. It was unanimously adopted by both organizations. The structure of the final draft (for complete text, see Gauthier, 2008b) was the same as in the previous two drafts.

LESSONS LEARNED

Drafting an international ethics document such as the *Declaration* involves cross-cultural work. One of the major lessons to be learned in working cross-culturally is that the meaning of language is not constant across cultures and wide consultation is essential to be sensitive to the differences in meaning. Such differences are not always visible, nor is how to cope with them always obvious. The importance of the meaning of language in a global society, without a global language, cannot be over emphasized. For example, Principle I, which had been labelled "Respect for the Dignity of All Human Beings" in the first draft, was relabelled "Respect for the Dignity of Persons and Peoples" in the second draft because some psychologists had reported that the term "All Human Beings" did not capture the concept of the collective versus the individual well enough to be accepted in their cultures. Likewise, in the final draft, Principle II, which had been labelled "Competent Caring for the Well-Being of Others" in the first and second drafts, was relabelled "Competent Caring for the Well-Being of Persons and Peoples." This change was made because it was reported that the term "others," used 11 times in the draft *Declaration* but never defined, had a negative connotation in some countries (e.g., South Africa[6]). Still another example, is that the statements dealing with informed consent and confidentiality under Principle I were revised in the final draft to better reflect the role of cultural factors in defining what is relevant.

Other issues related to language involved the identification and clarification of unclear, difficult, or unfamiliar aspects of the text. These aspects included awkward sentences or passage structures, unfamiliar vocabulary, or obscure concepts. For example, the wording and the ranking of the objectives of the *Declaration*, as stated in the Preamble, were revised to clarify the intent of the *Declaration*. Likewise, some sentences were modified because they were thought to contain unrealistic expectations. For instance, in the last paragraph of the Preamble as worded in the final draft of the *Declaration*, psychology organizations were no longer being *asked* to keep the *Declaration* in mind *constantly*. Instead, they were *encouraged* to keep it in mind; that is, the word "asked" was replaced by "encouraged," and the word "constantly" was deleted.

Finally, as drafting the *Declaration* involved articulating principles and related values that are aspirational rather than prescriptive, the wording of several statements was revised to remove any word or term that might be perceived as prescriptive (e.g., "must,", "shall," "should", "are obliged to," "are required to"), and replace each of them with a word or a term that was more aspirational (e.g., "may," "strive for").

International Consultations

Essential to ensuring the generalizability, applicability, and acceptability of the *Declaration* were the numerous international consultations carried out between 2002 and 2008. Both the research-based moral framework to be used for developing the *Universal Declaration of Ethical Principles for Psychologists* and all drafts of the document were presented for review and discussion at many international and regional conferences in many parts of the world. They formed the basis of many symposia, focus groups, and panel discussions.

I need to highlight here the role that Jean played in organizing these activities. As soon as a session was over, she would get us together to reflect on it and plan the next one. I have fond memories of these debriefing and planning sessions with her at conferences. We were constantly tossing around ideas and topics for the next conference and considering names of individuals to invite to present. Sometimes, contacts were made for the next conference right on site. Jean always insisted on organizing sessions that would have broad international appeal and representation. Above all, she wanted sessions to be as inclusive as possible of different worldviews. This meant striving to reach out to psychologists who live and work in different cultural settings in different parts of the world. On a few occasions, Jean and I went as far as subsidizing the travel of psychologists from low-income countries to attend an international conference because it was our belief that it was essential for the world to hear what they had to say. Jean was never short on energy, drive, or commitment.

The main conferences and places where the proposed moral framework and the drafts of the *Declaration* were presented for review and discussion between 2002 and 2008 included: (1) the International Congress of Applied Psychology, Singapore, July 2002; (2) the European Congress of Psychology, Vienna, Austria, July 2003; (3) the International Congress on Licensure, Certification and Credentialing of Psychologists, Montreal, Canada, April 2004; (4) the International Congress of Psychology, Beijing, China, July 2004; (5) the Interamerican Congress of Psychology, Buenos Aires, Argentina, June 2005; (6) the European Congress of Psychology, Granada, Spain, July 2005; (7) the International Congress of Cross-Cultural Psychology, Isle of Spetses, Greece, July 2006; (8) the International Congress of Applied Psychology, Athens, Greece, July 2006; (9) the Second Middle East and North Africa Regional Conference of Psychology, Amman, Jordan, April 2007; (10) the European Congress of Psychology, Prague, Czech Republic, July 2007; and (11) the International and National Conference of Indian Academy of Applied Psychology, Kolkata, India, February 2008. Each consultation yielded important and useful feedback that was seriously considered by the Joint Ad Hoc Committee to address or clarify issues, and to revise the moral framework and the working document.

It is important to note that biennial progress reports submitted to the IAAP Board of Directors and the IUPsyS General Assembly provided further opportunities for consultation and feedback. When one considers the number of countries represented through these two governing bodies at the time (over 40 in the case of IAAP, and over 80 in the case of IUPsyS), the feedback was truly diverse, broad, and international.

Structure and Content of the *Declaration* as Adopted in 2008

How the Declaration is Organized

The *Universal Declaration of Ethical Principles for Psychologists* (2008), as adopted by IUPsyS and IAAP in 2008 (see Appendix B of this book for complete text), includes a Preamble followed by four sections. Each section relates to one of the four ethical principles, which are formally labelled: (a) Respect for the Dignity of Persons and Peoples (Principle I); (b) Competent Caring for the Well-Being of Persons and Peoples (Principle II); (c) Integrity (Principle III); and (d) Professional and Scientific Responsibilities to Society (Principle IV). Each section includes a statement defining the principle and listing ethical values associated with the principle. In accepting the principle, one also accepts the values associated with that principle.

The ethical principles and values contained in the *Declaration* are presented in Table 21.1. The ordering of the principles from I to IV is meant to facilitate reference to various parts of the content of the *Declaration*. Although there is no hierarchy implied in the numbering of the principles, it is important to note that Principle I (Respect for the Dignity of Persons and Peoples) is described as "the most fundamental and universally found ethical principle across geographical and cultural boundaries, and across professional disciplines" (UDEPP, 2008, Principle I, para. 1). In addition, it should be noted that the principles are interrelated and need to be considered together.

Objectives of the Declaration

The objectives of the *Universal Declaration of Ethical Principles for Psychologists* (2008) are defined in the second paragraph of the Preamble of the *Declaration*. They are to provide a moral framework and generic set of ethical principles for psychology organizations worldwide: (a) to evaluate the ethical and moral relevance of their codes of ethics; (b) to use as a template to guide the development or evolution of their codes of ethics; (c) to encourage global thinking about ethics, while also encouraging action that is sensitive and responsive to local needs and values; and (d) to speak with a collective voice on matters of ethical concern.

It is important to note that the *Universal Declaration of Ethical Principles for Psychologists* (2008) has no mechanism of enforcement. Compliance with the ethical principles and related values articulated in the *Declaration* is voluntary. Does this matter? The *Declaration* is intended to influence the local and global ethical discourse and the development of ethics codes. How can these objectives be achieved in the absence of any mechanism of enforcement? This question was asked repeatedly when drafts of the *Declaration* were released for consultation.

Table 21.1: Ethical Principles and Related Values Contained in the *Universal Declaration of Ethical Principles for Psychologists (2008).*

Principle I ***Respect for the Dignity of Persons and Peoples***	**Principle II** ***Competent Caring for the Well-Being of Persons and Peoples***	**Principle III** ***Integrity***	**Principle IV** ***Professional and Scientific Responsibilities to Society***
Values • Respect for worth and dignity of all human beings • Respect for diversity among persons and peoples • Respect for customs and beliefs of cultures • Free and informed consent • Privacy • Protection of confidentiality • Fairness and justice in the treatment of persons and peoples	*Values* • Active concern for well-being • Take care not to harm • Maximize benefits and minimize harm • Offset or correct harmful effects • Develop and maintain competence • Self-knowledge • Respect for ability of persons and peoples to care for themselves and others	*Values* • Honesty, truthfulness, openness, and accuracy in communications • Avoid incomplete disclosure of information • Maximize impartiality and minimize biases • No exploitation of persons or peoples for personal, professional, or financial gain • Avoid conflicts of interest and declare those that cannot be avoided	*Values* • Increase scientific and professional knowledge for well-being of society • Use knowledge for benefits of society and protect knowledge from being misused, used incompetently, or made useless • Conduct affairs of discipline in ways that are ethical and consistent with well-being of society • Promote highest ethical ideals • Adequately train its members in their ethical responsibilities and required competencies • Develop discipline's ethical awareness and sensitivity

Although the *Declaration* cannot be enforced, it has the potential to influence local and global ethical discourse through expectation, promotion, dissemination, teaching, education, adoption, endorsement, ratification, application, and so on. The mechanism whereby it can exercise this influence is described in the last paragraph of the *Declaration*'s Preamble (UDEPP, 2008, Preamble, para. 5), which reads as follows:

> The significance of the Universal Declaration depends on its recognition and promotion by psychology organizations at national, regional and international levels. Every psychology organization is encouraged to keep this Declaration in mind and, through teaching, education, and other measures, to promote respect for, and observance of, the Declaration's principles and related values in the various activities of its members.

This mechanism is the same as the one whereby the UDHR (United Nations, 1948) has influenced the worldwide development of laws, rules, and regulations since it was adopted by the United Nations in 1948. Strictly speaking, the UDHR is not a legally binding document and, therefore, cannot be enforced. That said, the UDHR has acquired the status of "customary international law" (Donnelly, 2013) because most states have come to treat it over the years as though it were binding. It has been a powerful instrument for the promotion and implementation of inalienable rights for all people, and it has left an abiding legacy for humankind.

Important Characteristics of the Content of the Declaration

The *Universal Declaration of Ethical Principles for Psychologists* (2008) has several important characteristics that distinguish it from many other ethics documents. Let me highlight five of them (please note that the order of presentation does not imply any ordinal position in importance):

- As demonstrated through original research and broad international consultations, the *Declaration* describes ethical principles based on shared human values across cultures (see UDEPP, 2008, Preamble, para. 3) and therefore provides a universally acceptable moral framework to support and guide psychologists in conducting their professional and scientific activities anywhere in the world.
- The *Declaration* is about ethical principles and values, rather than ethical standards. It articulates principles that are general and aspirational rather than specific and prescriptive behavioural

expectations or rules. On the other hand, it acknowledges the need for the development of ethical standards or rules that are more specific and prescriptive (see UDEPP, 2008, Preamble, para. 3).

- The *Declaration* emphasizes respect and competent caring for *peoples* as well as persons. The aim of this is to address the balance between the individual and the communal (e.g., families, groups, communities, peoples), and allow for appropriate differences in the interpretation of such ethical concerns as informed consent, confidentiality, privacy, professional boundaries, and ethical decision-making across cultures. First incorporated into the New Zealand code of ethics for psychologists in 2002 (New Zealand Psychological Society, 2002), the concept of respect for the dignity of peoples as well as persons became part of the *Declaration* primarily due to the contribution of a member of the working group who was a Maori psychologist from New Zealand. However, unlike the New Zealand code, the concept of "peoples" in the *Declaration* was extended to include both Indigenous *and* non-Indigenous peoples.
- The *Declaration* recognizes that differences exist in the way professional and scientific responsibilities to society are interpreted by psychologists in different cultures. It states, however, that these interpretations need to be considered in a way that is both culturally appropriate and consistent with the ethical principles and related values of the *Declaration* (UDEPP, 2008, Principle IV, para. 2).
- The *Declaration* reaffirms the "commitment of the psychology community to help build a better world where peace, freedom, responsibility, justice, humanity, and morality prevail" (UDEPP, 2008, Preamble, para. 3). It does so by providing: (a) a global consensus on the fundamental attitude toward right and wrong, good and bad; (b) a generic set of ethical principles based on shared human values to identify harmful aspects of societal changes; (c) a moral framework to speak with a collective voice; (d) a tool to focus on ethics from both a global and a local perspective; and (e) a common moral framework to guide and inspire psychologists around the world toward the highest ethical ideals.

The Question of Human Rights

Considering my very first presentation in Singapore and my personal involvement in human rights activities, it may be surprising to know that the term "human rights" does not appear in the *Declaration*. This is not an oversight. The term was deliberately avoided because, although similarity in the expression of values exists, the term "human rights" has a negative connotation in some countries. In some parts of the world, human rights as defined in the UDHR (United Nations, 1948) are perceived as a political tool for harassing or controlling other nations or as a lack of understanding and respect for different cultures, religions, or political systems. The concept of human rights is neither a unitary nor a universal construct (Allan, 2013; Gauthier, 2018), and lack of full acceptance of the UDHR has led to the development of alternative and complementary regional declarations of human rights (Gauthier & Sinclair, 2020). The use of the term "human rights" in the *Universal Declaration of Ethical Principles for Psychologists* (2008) would have made it difficult, if not impossible, for psychologists in some countries to use the *Declaration*, not to mention adopt, endorse, or ratify the document.

Impact of the *Universal Declaration of Ethical Principles*

The impact of the *Universal Declaration of Ethical Principles for Psychologists* (2008) is growing. Since its adoption by the IUPsyS and the IAAP in 2008, there have been several developments, eight of which are highlighted here (once again, please note that the order in which they are listed does not reflect any ordinal position in importance):

- The *Declaration* has been endorsed, ratified, or adopted by several psychology organizations in addition to IUPsyS and IAAP. In 2008, for example, it was adopted by the Psychological Society of South Africa and ratified by the CPA. It also was adopted in 2008 by the Interamerican Society of Psychology, which took the extra step in 2009 to amend its Constitution to require its members to comply with the *Declaration*. The International Association for Cross-Cultural Psychology adopted the *Declaration* in 2010. So did the International Council of Psychologists in 2017.
- A "culture-sensitive" model has been developed to assist psychology organizations that wish to use the *Declaration* as a template for creating or reviewing a code of ethics (Gauthier et al., 2010). The first recommended step is to consider the reasons the psychology organization has for creating a code of ethics (e.g.,

for whom it is intended, why it is needed, how it will be used, whether there are unique or cultural aspects to be addressed). The second step is to consider what each of the four ethical principles means within the given culture and context. The third step is to define culture-specific standards or behaviours that are relevant to local objectives but that also reflect proposed universal ethical principles. Throughout the process, consultation with those individuals whose work will be most affected by the code of ethics is strongly encouraged. Their input is invaluable to creating a relevant document, and their support is key to the ultimate acceptance of the code of ethics.

- National psychology organizations are using the *Declaration* to develop or revise their codes of ethics. For example, the College of Psychologists of Guatemala used it to develop its very first code of ethics in 2008–2010 (Colegio de Psicológos de Guatemala, 2011). Actually, Guatemala was the first country in the world to use the *Declaration* as a template to create an ethical code and the model proposed by Gauthier et al. (2010) as a guide to do so. The Australian Psychological Society used drafts of the *Declaration* to revise its code of ethics between 2005 and 2007 (Australian Psychological Society, 2007). The Psychological Association of the Philippines revised its code in 2008–2009. The revised code, now called *Code of Ethics for Philippine Psychologists* (Psychological Association of the Philippines, 2009), includes the full text of the *Universal Declaration of Ethical Principles for Psychologists* (2008) in a section entitled "Declaration of Principles." Furthermore, psychologists in the Philippines are required by their code to adhere to the *Declaration*. The International School Psychology Association consulted the *Declaration* as part of revising its existing code in 2009–2011 and used it to inform the revision process (International School Psychology Association, 2011). It was used by the CPA to help revise the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association, 2017) in 2012–2017. The *Declaration* is currently used by the Mexican Society of Psychology to revise its code (Sociedad Mexicana de Psicología, 2010). In 2018, American Psychological Association (APA) created a task force to evaluate its ethics code (APA, 2017) and recommend revisions as needed. Recently, the Ethics Code Task Force was consulting the *Declaration* and asking me questions about how it was developed.

- The *Declaration* is influencing the development and revision of psychology ethics codes with respect to the way they recognize cultural diversity. For example, after consulting the *Declaration*, some codes have explicitly incorporated the concept of respect for the dignity of persons *and peoples* to reflect the importance of balancing respect for the individual and the collective (e.g., families, groups, communities, peoples). First incorporated into the New Zealand code of ethics for psychologists in 2002 (New Zealand Psychological Society, 2002), the codes from the following countries also have incorporated the concept: Australia (Australian Psychological Society, 2007), Canada (CPA, 2017), Guatemala (Colegio de Psicológos de Guatemala, 2011), the Philippines (Psychological Association of the Philippines, 2009), and the United Kingdom (British Psychological Society, 2018). Two of these codes provide a definition of the concept of "peoples," namely, the Australian and the Canadian codes. It is worth noting that these definitions both include Indigenous and non-Indigenous peoples, in that "peoples" is used to refer to any group of persons who are distinctly linked by a common identity, culture, history, and collective interest.
- Researchers and practitioners are using the *Declaration* as a framework to discuss ethical issues from an international perspective and to offer recommendations of global value. For example, Fitzgerald et al. (2010) examined ethical issues relating to the growing practice of internet-based psychotherapy, using the lens of the *Declaration*. Based on their review and discussion, they make recommendations intended to guide mental health practitioners who are considering involvement in the provision of internet-based services. Furthermore, psychologists around the world are faced daily with ethical questions and dilemmas, and Sinclair (2012) demonstrated how the *Declaration* can be used as a resource in ethical decision-making. Ferrero (2014) also used the *Declaration* to develop a guide specifically designed to provide ethical guidance and promote ethical thinking among university students and supervisors who are involved in "pre-professional" training, and who have not yet studied professional ethics. More recently, Sinclair (2020) used the *Declaration* as an ethical framework for identifying the ethical issues facing psychologists in end-of-life decision-making and active

euthanasia, reflecting on psychology's ethical responsibilities to society in that area.

- The *Declaration* has been used as a moral framework by other disciplines to develop ethical guidelines for research. For example, the International Commission on Illumination has consulted the *Declaration* to develop ethical standards for applied lighting research (Veitch, 2018; Veitch et al., 2019).
- The *Declaration* is now included in the professional psychology ethics curriculum in countries in many parts of the world (e.g., Africa, Asia, Central America, Europe, North America, Oceania, South America) to help understand ethics from an international perspective. It is also used as a guideline for psychologists working internationally (e.g., Leach & Oakland, 2010).
- The *Declaration* has been the focus of review and discussion in several articles and book chapters. Examples include Allan (2013), Ferrero (2014), Gauthier (2020), Gauthier & Pettifor (2011, 2012), Gauthier & Sinclair (2020), Pettifor & Ferrero (2012), Prentice et al. (2017), and Stevens (2010, 2012). In addition, a book chapter on internationalizing the professional ethics curriculum in the United States dedicated several pages to the *Declaration* (Leach & Gauthier, 2012).

In summary, the *Universal Declaration of Ethical Principles for Psychologists* (2008) is still relatively new. However, the above uses indicate that it holds much promise for continuing to shape the development of global thinking about ethics in a way that is sensitive and responsive to local needs and values, as well as promotes adherence to the highest ethical ideals in psychology.

Epilogue

Reflecting on the story of the *Universal Declaration of Ethical Principles for Psychologists*, I am struck by what a unique, amazing, and inspiring story it is. It is a remarkable success story, involving psychologists from around the world, and shows how a vision that seemed impossible to achieve was embraced and turned into reality.

Important to understanding the successful development of the *Declaration* is the fact that the international initiative was launched at a time when global consensus on what constitutes "good" was urgently needed to ensure a better future for us all (Gauthier & Pettifor, 2012; Gauthier & Sinclair, 2020). With the rapid globalization of the world in the 21st century, psychologists were being faced with expansion of their scope of practice and competencies to work multiculturally within their own country and culture, as well as to work internationally or globally. Having a declaration that recognized and addressed culture-specific differences while inspiring the global psychology community toward the highest ethical ideals was an idea whose time had come. There was widespread openness to developing the *Declaration*. It really was the right idea at the right time.

Important to understanding the growing impact of the *Declaration* is the relevance of ethical principles and values in today's globalizing world. Globalization can be "unilateral" or "enlightened" (Kim & Park, 2007). Enlightened globalization is based on understanding, dialogue, and respect for cultural differences. It recognizes that each culture has its own set of values, beliefs, and practices. Unilateral globalization is based on the belief that one's own culture and values are superior to others, and on the imposition of one's own culture and values on others. It violates all concepts of virtue, ethics, and human rights, and constitutes a form of oppression. Enlightened globalization may lead to greater harmony, while unilateral globalization by dominant cultures will not (Pettifor & Ferrero, 2012).

There are no maps showing the way to enlightened globalization. However, the *Universal Declaration of Ethical Principles for Psychologists* (2008) provides a moral framework for psychologists, based on shared human values across cultures. It contains a generic set of ethical principles and values that can help psychologists around the world to behave and make decisions in accordance with the highest ethical standards, while also honouring and understanding culture-specific differences.

Acknowledgements, Appreciation, and Gratitude

This book is dedicated to Jean Pettifor, and this chapter would not be complete without expressing my warmest gratitude to her for her kind encouragement, advice, suggestions, and numerous contributions to the development of the *Universal Declaration of Ethical Principles for Psychologists*. Without her support, guidance, and wisdom, this declaration would not be what it is. I will be for ever grateful to Jean for agreeing to join me as my closest companion and senior advisor on this journey. As always, Jean was keenly committed and dedicated to the task. Before embarking on the journey, she had spent the last 15 years working internationally on bringing psychologists from different countries together to find the commonalities in values across cultures. I think that it is fair to say that she paved the way for the development of the *Declaration*.

I also wish to express my appreciation to Carole Sinclair. Her research played a key role in demonstrating the universality of the ethical principles used for drafting the *Declaration*. In addition, Carole kindly agreed to act as a sounding board at various points in time, whenever needed. I could always rely on her for informed, objective, and expert opinions, not to mention her thoughtful suggestions.

Finally, I would like to use this opportunity to thank the International Union of Psychological Science and the IAAP for sponsoring the development of the *Declaration*. I also would like to thank the many psychologists around the world who provided feedback and support for this very important and unique project, as well as each and every member of the Joint Ad Hoc Committee for helping to develop a declaration that is truly based on shared human values.

Questions for Reflection

1. The *Declaration* emphasizes respect and competent caring for both persons and peoples. Think of one or two situations where you think there may be a conflict between the individual and the collective. How would you achieve a balance between them?
2. Think of a situation in which you found it difficult to reconcile the need to make an ethical decision in accordance with the highest ethical standards and being respectful of cultural differences. What made it difficult? How did you resolve the issue? What did you learn?
3. Respect for the dignity of persons and peoples is expressed in different ways in different communities and cultures. Can you think of some examples of this? What are the implications for psychologists working across cultures?
4. How can you ensure that respect for the local culture does not become a pretext for bypassing ethical guidelines?

NOTES

1 The International Union of Psychological Science is the largest and oldest psychological organization based on national membership—one per country. The International Association of Applied Psychology is the largest and oldest international association of psychologists based on individual membership.

2 For further details, see Gauthier & Pettifor (2012).

3 For further details, see Gauthier & Sinclair (2020).

4 The *Declaration* was developed without any financial support from any source.

5 One international psychology organization thought that the first draft of the *Declaration* seemed too detailed and too prescriptive. Its concerns were addressed in subsequent drafts.

6 One of the biggest long-term effects of apartheid, a government system of institutionalised racial segregation and discrimination against the non-White population that existed in South Africa from 1948 until the early 1990s, was inter-racial mistrust. Combined with the effects of colonialism, it brought a culture of "Us vs. Them" (i.e., "Us vs the Others"). Hence the negative connotation of the word "others" in South Africa.

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Appendices

APPENDIX A

Canadian Code of Ethics for Psychologists, Fourth Edition[1]

Preamble

INTRODUCTION AND APPLICABILITY

Every discipline that has relatively autonomous control over its entry requirements, training, development of knowledge, standards, methods, and practices does so only within the context of a contract with the society in which it functions. This social contract is based on attitudes of mutual respect and trust, with society granting support for the autonomy of a discipline in exchange for a commitment by the discipline to do everything it can to assure that its members act ethically in conducting the affairs of the discipline within society; in particular, a commitment to try to assure that each member will place the welfare of society and individual members of society above the welfare of the discipline and its own members. By virtue of this social contract, psychologists have a higher duty of care to members of society than the general duty of care that all members of society have to each other.

The Canadian Psychological Association recognizes its responsibility to help assure ethical behaviour and ethical attitudes on the part of psychologists. Attempts to assure ethical behaviour and ethical attitudes include: (a) articulating ethical principles, values, and standards; (b) promoting those principles, values, and standards through formative and continuing education, supervision, peer modelling, and consultation; (c) developing and implementing methods to help psychologists monitor the ethics of their behaviour and attitudes; (d) adjudicating complaints of unethical behaviour; and (e) taking corrective action when warranted.

This *Code* articulates ethical principles, values, and standards to guide all members of the Canadian Psychological Association, whether scientists, practitioners, or scientist-practitioners. Although some of its ethical standards are specific to particular activities or contexts, its ethical principles and values are applicable whether members are acting in a research, direct service, teaching, supervision, administrative, management, employer, employee, student, trainee, consultative, peer review, editorial, expert witness, social policy, or any other role related to the discipline of psychology. The ethical principles and values also are applicable regardless of the communication modality used (e.g., spoken, written, or printed; in person, or remotely through telephone, text, audio, video, online communication or other means).

STRUCTURE OF THE *CODE*

The *Code* begins with this Preamble, which introduces the underlying philosophy of the *Code,* including its nature, purposes, an explanation of ethical decision making, and a definition of terms. Following the Preamble, the *Code* is organized around four ethical principles to be considered and balanced in ethical decision making. Each principle section begins with a statement of those values that are included in and give definition to the principle. Each values statement is then followed by a list of ethical standards that illustrate the application of the specific principle and values to the activities of psychologists. The standards range from minimal behavioural expectations (e.g., Standards I.28, II.29, III.30, IV.26) to more idealized, but achievable, attitudinal and behavioural expectations (e.g., Standards I.12, II.12, III.9, IV.6). In the margin, to the left of the standards, key words are placed to guide the reader through the standards and to illustrate the relationship of the specific standards to the values statement. Some standards are specific to particular types of psychology activity (e.g., direct service, research, teaching, supervision); however, the majority of standards are applicable to all types of psychology activities.

ETHICAL DECISION MAKING

Ethical choices need to be made when ethical questions, issues, or dilemmas arise. Such choices involve ethical decision making.

The ethical decision-making process might occur very rapidly, leading to an easy resolution of an ethical question or issue. This is particularly true of questions or issues for which clear-cut guidelines or standards exist and for which there is no conflict between principles, values, or the best interests of parties involved. On the other hand, some ethical issues (particularly those in which ethical principles, values, or best interests conflict) are not easily resolved, might be emotionally distressful, and might require time-consuming deliberation.

All four principles are to be taken into account and balanced in ethical decision making. However, in circumstances in which the ethical principles themselves conflict, it might not be possible to give each principle equal weight. The complexity of many conflicts precludes a firm ordering of the principles. However, the four principles have been ordered according to the weight each generally should be given when they conflict, namely:

Principle I: Respect for the Dignity of Persons and Peoples. This principle, with its emphasis on inherent worth, non-discrimination, moral rights, distributive, social and natural justice, generally should be given the highest weight, except in circumstances in which there is a clear and imminent danger of bodily harm to someone.

Principle II: Responsible Caring. This principle generally should be given the second highest weight. Responsible caring requires competence, maximization of benefit, and minimization of harm, and should be carried out only in ways that respect the dignity of persons and peoples.

Principle III: Integrity in Relationships. This principle generally should be given the third highest weight. Psychologists are expected to demonstrate the highest integrity in all of their relationships. However, in some circumstances, Principle III values (e.g., openness, straightforwardness) might need to be subordinated to the values contained in the Principles of Respect for the Dignity of Persons and Peoples, and Responsible Caring.

Principle IV: Responsibility to Society. This principle generally should be given the fourth highest weight of the four principles when it conflicts with one or more of them. Although it is necessary and important to consider responsibility to society in every ethical decision, adherence to this principle needs to be subject to and guided by Respect for the Dignity of Persons and Peoples, Responsible Caring, and Integrity in Relationships. When the welfare of an individual or group appears to conflict with benefits to society, it is often possible to find ways of working for the benefit of society that do not violate respect for dignity, responsible caring or integrity. However, if this is not possible, the dignity, well-being and best interests of persons and peoples, and integrity in relationships should not be sacrificed to a vision of the greater good of society.

Although the above ordering of principles can be helpful in resolving some ethical questions, issues, or dilemmas, the complexity of many situations requires consideration of other factors and engagement in a creative, self-reflective, and deliberative ethical decision-making process that includes consideration of many other factors. The following basic steps typify approaches to such a process:

1. Identification of the individuals and groups potentially affected by the decision.
2. Identification of ethically relevant issues and practices, including the moral rights, values, well-being, best interests, and any other relevant characteristics of the individuals and groups involved, as well as the cultural, social, historical, economic, institutional, legal or political context or other circumstances in which the ethical problem arose.
3. Consideration of how one's own biases, external pressures, personal needs, self-interest, or cultural, social, historical, economic, institutional, legal, or political context and background, might influence the development of or choice between courses of action.
4. Development of alternative courses of action.
5. Analysis of likely short-term, ongoing, and long-term risks and benefits of each course of action on the individuals and groups involved or likely to be affected, taking into account relevant individual and cultural, social, historical, economic, institutional, legal, and political contextual factors.
6. Choice of course of action after conscientious application of existing principles, values, and standards (which includes but would not be limited to relevant laws and regulations).
7. Action, with a commitment to assume responsibility for the consequences of the action.
8. Evaluation of the results of the course of action.
9. Assumption of responsibility for consequences of action, including correction of negative consequences, if any, or re-engaging in the decision-making process if the ethical issue is not resolved.
10. Appropriate action, as warranted and feasible, to prevent future occurrences of the dilemma (e.g., communication and problem solving with colleagues and team members or other collaborators; changes in procedures and practices).

Psychologists engaged in time-consuming deliberation are encouraged and expected to consult with the individuals and groups affected by the ethical problem when appropriate. In addition, they are encouraged and expected to consult with colleagues or relevant others, including advisory bodies, when such individuals or groups can add knowledge or objectivity to the decision-making process. Although the decision for action remains with the individual psychologist, the seeking and consideration of such assistance reflects an ethical approach to ethical decision making.

Even with all of the above, psychologists may be faced with ethical dilemmas that are still difficult to resolve. In these circumstances, psychologists are encouraged and expected to engage in an ethical decision-making process that is explicit enough to bear public scrutiny. In some of these cases, resolution might be a matter of personal conscience. However, decisions of personal conscience are also expected to be the result of a decision-making process that is based on a reasonably coherent set of ethical principles and that can bear public scrutiny. If the psychologist can demonstrate that every reasonable effort was made to apply the ethical principles of this *Code* and resolution of the conflict has had to depend on the personal conscience of the psychologist, such a psychologist would be deemed to have followed this *Code*.

USES OF THE *CODE*

This *Code* is intended to guide psychologists in their everyday conduct, thinking, and planning, and in the resolution of ethical questions, issues, and dilemmas; that is, it advocates the practice of both proactive and reactive ethics.

The *Code* also is intended to serve as an umbrella document for the development of codes of conduct or other more specific codes. For example, the *Code* could be used as an ethical framework for the identification of behaviours that would be considered enforceable in a jurisdiction, the violation of which would constitute misconduct; or jurisdictions could identify those standards in the *Code* that would be considered of a more serious nature and, therefore, reportable and subject to possible discipline. In addition, the principles and values could be used to help specialty areas develop standards that are specific to those areas. Some work in this direction has already occurred within CPA (e.g., *Guidelines for Non-Discriminatory Practice; Guidelines for Ethical Psychological Practice with Women; Ethical Guidelines for Supervision in Psychology: Teaching, Research, Practice, and Administration*). The principles and values incorporated into this *Code*, insofar as they come to be reflected in other documents guiding the behaviour of psychologists, will reduce inconsistency and conflict between documents.

A third use of the *Code* is to assist in the adjudication of complaints against psychologists. A body charged with this responsibility is required to investigate allegations, judge whether unacceptable behaviour has occurred, and determine what corrective action should be taken. In judging whether unacceptable conduct has occurred, many jurisdictions refer to a code of conduct. Some complaints, however, are about conduct that is not addressed directly in a code of conduct. The *Code* provides an ethical framework for determining whether the complaint is of enough concern, either at the level of the individual psychologist or at the level of the profession as a whole, to warrant corrective action (e.g., discipline of the individual psychologist; general educational activities for members; incorporation into the code of conduct). In determining corrective action for an individual psychologist, one of the judgments the adjudicating body needs to make is whether an individual psychologist conscientiously engaged in an ethical decision-making process and acted in good faith, or whether there was a negligent or willful disregard of ethical principles. The articulation of the ethical decision-making process contained in this *Code* provides guidance for making such judgments.

RESPONSIBILITY OF THE INDIVIDUAL PSYCHOLOGIST

The discipline's contract with society commits the discipline and its members to act as a moral community that develops its ethical awareness and sensitivity, educates new members in the ethics of the discipline, manages its affairs and its members in an ethical manner, is as self-correcting as possible, and is accountable both internally and externally.

However, responsibility for ethical action depends foremost on the integrity of each individual psychologist; that is, on each psychologist's commitment to behave as ethically as possible in every situation. Acceptance to membership in the Canadian Psychological Association commits members to:

1. Adhere to the Association's *Code* in all current activities as a psychologist.
2. Apply conscientiously the ethical principles and values of the *Code* to new or emerging areas of activity.
3. Engage in ongoing development and maintenance of their ethical sensitivity and commitment, ethical knowledge, and ethical decision-making skills.
4. Assess and discuss ethical issues and practices with colleagues and appropriate others on a regular basis.
5. Bring to the attention of the Association ethical issues that require clarification or the development of new guidelines or standards.
6. Bring concerns about possible unethical actions by a psychologist directly to the psychologist when the action appears to be primarily a lack of sensitivity, knowledge, or experience, and attempt to reach an agreement on the issue and, if needed, on the appropriate action to be taken.

7. Bring concerns about possible unethical actions of a more serious nature (e.g., actions that have caused or could cause serious harm; actions that are considered misconduct in the jurisdiction) to the person(s) or body(ies) best suited to investigating the situation and to stopping or offsetting the harm.
8. Consider seriously others' concerns about one's own possibly unethical actions or unrecognized biases and attempt to reach an agreement on the issue and, if needed, take appropriate action.
9. Not be vexatious or malicious if bringing or responding to concerns about possible unethical actions.
10. Cooperate with duly constituted committees of the Association that are concerned with ethics and ethical conduct.

RELATIONSHIP OF THE *CODE* TO PERSONAL BEHAVIOUR

This *Code* is intended to guide and regulate only those activities a psychologist engages in by virtue of being a psychologist. There is no intention to guide or regulate a psychologist's activities outside of this context, although an individual psychologist might make a personal decision to be guided by the *Code*'s principles and values outside of this context. Personal behaviour becomes a concern of the discipline only if it is of such a nature that it undermines public trust in the discipline as a whole or if it raises questions about the psychologist's ability to carry out appropriately his/her responsibilities as a psychologist.

RELATIONSHIP OF THE *CODE* TO PROVINCIAL REGULATORY BODIES

In exercising its responsibility to articulate ethical principles, values, and standards for those who wish to become and remain members in good standing, the Canadian Psychological Association recognizes the multiple memberships that some psychologists have (both regulatory and voluntary). The *Code* has attempted to encompass and incorporate those ethical principles most prevalent in the discipline as a whole, thereby minimizing the possibility of variance with provincial/territorial regulations and guidelines. Psychologists are expected to respect the requirements of their provincial/territorial regulatory bodies. Such requirements might define particular behaviours that constitute misconduct, are reportable to the regulatory body, and/or are subject to discipline.

RELATIONSHIP OF THE *CODE* TO THE *UNIVERSAL DECLARATION OF ETHICAL PRINCIPLES FOR PSYCHOLOGISTS*

One of the events that occurred after release of the third edition of the *Code* (2000) is the 2008 endorsement by the Canadian Psychological Association of the *Universal Declaration of Ethical Principles for Psychologists*. This *Declaration* was developed under the auspices of two major international psychology organizations (the International Union of Psychological Science and the International Association of Applied Psychology), by a working group of psychologists representing different continents, cultures and worldviews. The *Declaration* is not a code of ethics; rather, it is intended to provide a template or ethical framework to guide the development and evolution of psychology ethics codes around the world. The *Declaration* was used in this way in the development of this fourth edition.

DEFINITION OF TERMS FOR THE PURPOSES OF THIS *CODE*

A. Terms related to persons and peoples.

"Primary client" means an *individual*[2] or *group* (e.g., couples, families, *organizations*, *communities*, *peoples*) that has contracted for and/or is receiving services that are intended to help with the *individual*'s or *group*'s own issues, responsibilities, questions, or problems. Primary clients may be *independent*, *partially dependent*, or *fully dependent* in terms of their decision making regarding their involvement. This means that *individuals* or *groups* mandated to receive such services (e.g., by a court) and *individuals* who require a substitute decision maker (e.g., young children) to receive such services are considered primary clients. More than one *individual* or *group* can be primary clients in a single service contract.

"Community" means a *group* of *individuals* of any size whose members are connected to each other by relatively durable social relations that extend beyond immediate family ties, and share a common sense of identity and interests. A community may or may not live in the same geographic area.

"Contract examinee" is an *individual* or *group* that is the subject of a psychological assessment at the request of a *retaining party*, for the purpose of assisting an external decision maker (e.g., court, insurance company, or employer) to make a decision. Contract examinees may be *independent*, *partially dependent*, or *fully dependent* in terms of their decision making regarding their involvement.

"Group" refers to a number of human beings connected by a shared activity, interest, or quality. A group includes such entities as couples, families, *organizations*, *communities*, and *peoples*.

"Independent," "partially dependent," and **"fully dependent"** are terms that can apply to *primary clients*, *contract examinees*, research participants, students, trainees, and any other *individuals* or *groups* with whom *psychologist*s come in contact in the course of their work. Such *individuals* or *groups* are "independent" if they can independently contract or give informed consent, are "partially dependent" if the decision to contract or give informed consent is shared between two or more parties (e.g., parents and school boards; workers and Workers' Compensation Boards; *retaining party* and *contract examinee*; adult members of a family coming for service), and "fully dependent" if they have little or no choice about whether or not to receive a particular service or participate in a particular activity (e.g., patients who have been involuntarily committed to a psychiatric facility; very young children involved in a research project).

"Individual" refers to a human being as a separate entity, distinct from other human beings.

"Organization" means a *group* of *persons* or *peoples* organized for some end or work.

"Others" means any *individual* or *group* with whom *psychologists* come in contact in the course of their work. This may include, but is not limited to: *primary clients* seeking help with *individual*, family, *organizational*, industrial, or *community* issues; *contract examinees*; research participants; employees; students; trainees; supervisees; colleagues; *interdisciplinary* or intradisciplinary team members; other collaborators; employers; third party payers; and members of the general public.

"Peoples" means a distinct *group* of *persons* who are linked by a common identity, culture, history, and collective interests.

"Persons" means human beings both as *individuals* and as members of *groups*, including couples, families, *organizations*, *communities*, and *peoples*.

"Psychologist" is used in the *Code* in a distinctive way and means any *individual* who is a member or affiliate (including student affiliates) of the Canadian Psychological Association, or a member or affiliate of any psychology voluntary association or regulatory body that adopts, endorses, or ratifies this *Code*. Readers are reminded that provincial/territorial jurisdictions often restrict the legal use of the term psychologist in their jurisdiction and that such restrictions are to be honoured.

"Retaining Party" means the *individual* or *group* that has retained a *psychologist* to assess a *contract examinee* for the purpose of helping an external decision maker (e.g., court, insurance company, or employer) to make a decision.

"Society" means a structured system of human *organization* and relationships, which normally provides protection and continuity for its members. In the *Code*, it can refer to such systems on a small scale (e.g., neighbourhoods, *communities, peoples*), as well as to such systems on a larger scale (e.g., individual nations; the entire *community* of nations; the global *community*).

B. Other terms.

"Best available evidence" refers to the evidence that is the most trustworthy and valid according to a hierarchy of evidence (i.e., a hierarchy that ranks evidence from strongest to weakest), and which is appropriate to the services being delivered.

"Best interests" mean those interests that support the dignity and well-being of *individuals* and *groups*, and are morally justifiable.

"Critical inquiry studies" refers to research that uses critical thinking approaches to analyze the structures, policies, activities, and/or social impact of an institution, *organization*, or other social entity. Such studies are carried out for the benefit of ethical societal improvement. They do not normally involve the institution, *organization*, or other social entity as *primary clients*, although some institutions, *organizations*, or other social entities might commission such a study for their own benefit in addition to potential societal benefit.

The **"discipline of psychology"** refers to the scientific and applied methods and knowledge of psychology, and to the structures and procedures used by its members for conducting their work in relationship to *society*, members of the public, students or trainees, and each other.

"Ethical attitudes" refers to personal dispositions and ways of thinking and feeling about ethics and ethical issues. It includes such concepts as ethical sensitivity, moral perception, and moral intent and integrity, and is reflected in what an *individual* or *group* says or does.

"Interdisciplinary" refers to the involvement in an activity of the members of more than one discipline (e.g., psychology and medicine, psychology and law, psychology and computer science). It subsumes the term **"interprofessional,"** which is interdisciplinary in nature but generally limited to situations involving the provision of service.

"Just laws" means laws that are consistent with the *moral rights* of *persons* and *peoples*, and that are implemented in conformity with the principles of natural justice (e.g., fairness, impartiality, reasonableness, due process).

"Moral rights" means the fundamental and inalienable rights of persons and peoples. They apply to all human beings and are grounded in moral reasoning (e.g., reasoning that helps to identify and justify them). Some aspects of moral rights may be contained within and protected by international, regional, and national declarations, constitutions, laws, and statutes (e.g., human rights declarations; *just laws* defining the legal and civil rights of *persons* or *peoples* living in a country or region). However, other aspects may not be so contained or protected. Of particular significance to *psychologists* are moral rights to: developmentally appropriate privacy and confidentiality, self-determination, and liberty; cultural identity, cultural survival, and social participation; and distributive, social, and natural justice. Moral rights are not limited to those mentioned in this definition.

"Sexual harassment" includes either or both of the following: (i) the use of power or authority in an attempt to coerce another *individual* or *group* to engage in or tolerate sexual activity (e.g., explicit or implicit threats of reprisal for non-compliance; promises of reward for compliance); (ii) engaging in deliberate and/or repeated unsolicited sexually oriented comments, anecdotes, gestures, or touching, if such behaviours are offensive and unwelcome, create an offensive, hostile, or intimidating working, learning, or service environment, or can be expected to be harmful to the recipient.[3]

"Unjust discrimination" or "**unjustly discriminatory"** means activities that are prejudicial to or promote prejudice against *persons* or *peoples* because of their culture, nationality, ethnicity, colour, race, religion, sex, gender, marital status, sexual orientation, physical or mental abilities, age, socio-economic status, or any other preference or personal characteristic, condition, or status. The word "unjust" is used to differentiate such activities from the justifiable recognition and understanding of differences needed to determine, for instance, what might benefit or harm *persons* and *peoples*.

"Vulnerable" refers to *individuals* or *groups* whose dignity, well-being and *best interests* are more easily violated due to such factors as: (a) characteristics of the *individual* or *group* (e.g., level of cognitive and emotional functioning; history of oppression); (b) level of voluntary consent/assent (e.g., serious consequences threatened if consent not given); (c) interests of *individual* or *group* compete with interests of more powerful *individual*(s) or *group* (e.g., claimant and insurance company); and (d) high risk of harm (e.g., life-changing decision based on inadequate assessment).

Review Schedule

To maintain the relevance and responsiveness of this *Code*, it will be reviewed regularly, and revised as needed. You are invited to forward comments and suggestions, at any time, to the CPA office. In addition to psychologists, this invitation is extended to all readers, including members of the public and other disciplines.

Principle I: Respect for the Dignity of Persons and Peoples

VALUES STATEMENT

In the course of their work as scientists, practitioners, or scientist-practitioners, psychologists come into contact with many different individuals and groups, including but not limited to: research participants; primary clients seeking help with individual, family, organizational, industrial, or community issues or problems; contract examinees; students; trainees; supervisees; employees; business partners; business competitors; colleagues; interdisciplinary or intradisciplinary team members; other collaborators; employers; retaining parties; third party payers; and the general public.

In these contacts, psychologists strive to develop and maintain constructive and collaborative relationships that reflect the fundamental principle of respect for dignity. Respect for the dignity of persons is the most fundamental and universally found ethical principle across disciplines, and includes the concepts of equal inherent worth, non-discrimination, moral rights, and distributive, social, and natural justice.

In respecting dignity, psychologists acknowledge that each human being should be treated primarily as a person or an end in him/herself, not as an object or a means to an end, and is worthy of equal moral consideration. In doing so, psychologists acknowledge that all human beings have a moral right to have their innate worth as human beings appreciated and that this inherent worth is not dependent on a human being's culture, nationality, ethnicity, colour, race, religion, sex, gender, marital status, sexual orientation, physical or mental abilities, age, socio-economic status, or any other preference or personal characteristic, condition, or status. As such, psychologists do not engage in unjust discrimination based on such factors and promote non-discrimination in all of their activities.

Psychologists also acknowledge that all human beings, in addition to being individuals, are interdependent social beings who are born into, live in, and are a part of the history and evolution of social groupings (e.g., couples, families, organizations, communities, peoples). The different cultures, ethnicities, religions, histories, social structures, and other such characteristics of social groupings are often integral to the identity of the individuals who belong to them and give meaning to their lives. As such, respect for the dignity of human beings includes respect and moral consideration for social groupings such as couples, families, organizations, communities, and peoples. In their work, psychologists acknowledge, respect, and take into account the uniqueness, diversity, and role structures involved.

Adherence to the concept of moral rights is an essential component of respect for the dignity of persons and peoples. Of particular importance to psychologists in their work are moral rights to: developmentally appropriate privacy and confidentiality, self-determination, and liberty; cultural identity, cultural survival, and social participation; and distributive, social, and natural justice. Psychologists have a responsibility to protect and promote these rights in all of their activities. This includes developing and following procedures for informed consent, protection of privacy and confidentiality, non-discrimination, fair treatment, and due process that are consistent with those rights.

Psychologists recognize that, although all persons and peoples possess moral rights, the manner in which such rights are promoted, protected, and exercised varies across communities and cultures. For instance, definitions of what is considered private vary, as does the role of families, other community members, and community leaders in personal decision making. In their work, psychologists acknowledge and respect such differences, while guarding against clear violations of moral rights.

As the moral rights of any individual or group exist within the context of the moral rights of other individuals and groups, and of responsible caring (see Principle II), psychologists have a responsibility to balance these rights in their decision making. There might be circumstances in which the possibility of serious detrimental consequences to themselves or others, a diminished capacity to be autonomous, or a court order, would disallow aspects of some rights (e.g., privacy and confidentiality, self-determination, liberty). Indeed, such circumstances might be serious enough to create a duty to warn or protect others (see Standards I.45 and II.42). However, psychologists still have a responsibility to respect the moral rights of the persons and peoples involved to the greatest extent possible under such circumstances, and to do what is necessary and reasonable to reduce the need for future disallowances.

Although psychologists have a responsibility to respect the dignity of all persons and peoples with whom they come in contact in their role as psychologists, the nature of their contract with society demands that their greatest responsibility be to persons and peoples in the most vulnerable position. Vulnerability can be permanent or temporary, and can be increased by such factors as limited capacity to consent, reduced voluntariness to their consent or their involvement, difficulties in cognitive or emotional functioning, economic disadvantage, history of discrimination or oppression due to culture or other factors, or urgency of a situation. Normally, the individuals and groups directly receiving or involved in the psychologist's activities (e.g., research participants, primary clients, contract examinees, students, trainees) are in a more vulnerable position than those indirectly involved (e.g., employers, colleagues, interdisciplinary or intradisciplinary team members, other collaborators, organizational or community leaders, government, retaining parties, third party payers, the general public). Psychologists recognize that as the vulnerabilities of individuals and groups (e.g., couples, families, organizations, communities, peoples) increase, or their power to control their environment or their lives decreases, psychologists have an increasing responsibility to seek ethical advice and to establish safeguards to protect the moral rights of the persons and peoples involved. For this reason, psychologists consider it their responsibility to increase safeguards to protect and promote the moral rights of the persons and peoples involved in their activities proportionate to their vulnerability.

Respect for the dignity of persons and peoples also includes the concepts of distributive and social justice. With respect to psychologists, this concept implies that all persons and peoples are entitled to benefit equitably from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists, regardless of their characteristics, condition, or status. Although individual psychologists might specialize and direct their activities to particular populations or might decline to engage in activities based on the limits of their competence (cf. *Competence and self-knowledge* Standards in Principle II and *Objectivity/lack of bias* Standards in Principle III), psychologists do not exclude persons or peoples on a capricious or unjustly discriminatory basis.

By virtue of the social contract that the discipline has with society, psychologists have a higher duty of care to members of society than the general duty of care all members of society have to each other. However, psychologists are entitled to protect themselves from serious violations of their own moral rights (e.g., privacy and confidentiality, liberty) in carrying out their work as psychologists.

ETHICAL STANDARDS

In adhering to the Principle of Respect for the Dignity of Persons and Peoples, psychologists would:

General respect

I.1 Demonstrate appropriate respect for the knowledge, insight, experience, areas of expertise, and cultural perspectives and values of others, including those that are different from their own, limited only by those that seriously contravene the ethical principles of this *Code*.

I.2 Not engage publicly (e.g., in public statements, presentations, research reports, with primary clients or other contacts) in degrading comments about others, including demeaning jokes based on such characteristics as culture, nationality, ethnicity, colour, race, religion, sex, gender, or sexual orientation.

I.3 Strive to use language that conveys respect for the dignity of persons and peoples as much as possible in all spoken, written, electronic, or printed communication.

I.4 Abstain from all forms of harassment, including sexual harassment.

General rights

I.5 Avoid or refuse to participate in practices disrespectful of the moral rights of persons or peoples, including their human, legal and civil rights.

I.6 Refuse to advise, train, or supply information to anyone who, in the psychologist's judgment, will use the knowledge or skills to infringe on moral rights.

I.7 Make every reasonable effort to ensure that psychological knowledge is not misinterpreted or misused, intentionally or unintentionally, to infringe on moral rights.

I.8 Respect the moral right of research participants, primary clients, contract examinees, employees, supervisees, students, trainees, and others to safeguard their own dignity.

Non-discrimination

I.9 Not practice, condone, facilitate, or collaborate with any form of unjust discrimination.

I.10 Act to correct practices that are unjustly discriminatory.

I.11 Seek to design research, teaching, supervision, practice, and business activities in such a way that they contribute to the fair distribution of benefits to individuals and groups (e.g., couples, families, organizations, communities, peoples) and that they do not unfairly exclude those who are vulnerable or might be disadvantaged.

Fair treatment/due process

I.12 Work and act in a spirit of fair treatment to others.

I.13 Help to establish and abide by due process and other natural justice procedures for employment, evaluation, adjudication, editorial, and peer review activities.

I.14 Compensate others fairly for the use of their time, energy, and knowledge, unless such compensation is voluntarily refused.

I.15 Establish fees that are fair in light of the time, energy, and knowledge of the psychologist and any associates or employees, and in light of the market value of the product or service. (Also see Standard IV.12.)

Informed consent

I.16 Seek as full and active participation as possible from individuals and groups (e.g., couples, families, organizations, communities, peoples) in decisions that affect them, respecting and integrating as much as possible their opinions and wishes. This would include respect for written or clearly expressed unwritten advance directives. Also, when working in an organizational or community context, it would include seeking participation of relevant individuals and subgroups that may not be represented by or may not have a role in the formal leadership.

I.17 Recognize that obtaining informed consent is a process that involves taking time to establish an appropriate trusting relationship and to reach an agreement to work collaboratively, and may need to be obtained more than once (e.g., if significant new information becomes available).

I.18 Respect the expressed wishes of individuals to involve others (e.g., family members, community members, community leaders) in their decisions regarding informed consent.

I.19 Obtain informed consent from all independent and partially dependent individuals and groups (e.g., couples, families, organizations, communities, peoples) for any psychological services provided to them except in circumstances of urgent need (e.g., disaster or other crisis). In urgent circumstances, psychologists would proceed with the assent of such individuals and groups, but fully informed consent would be obtained as soon as possible. (Also see Standard I.29.)

I.20 Obtain informed consent for all research activities that involve obtrusive observation or measures, invasion of privacy, risk of harm, or any attempt to change the behaviour of research participants.

I.21 If signed consent forms are required by law or desired by the psychologist, the individuals or groups giving consent, or the organization for whom the psychologist works, establish and use signed consent forms that specify the dimensions of informed consent or that acknowledge that such dimensions have been explained and are understood.

I.22 Accept and document non-written consent (e.g., oral, a verbal agreement, a handshake or other culturally normative exchange) in situations in which signed consent forms are not acceptable culturally or in which there are other good reasons for accepting non-written consent.

I.23 Provide, in obtaining informed consent, as much information as reasonable or prudent individuals and groups (e.g., couples, families, organizations, communities, peoples) would want to know before making a decision or consenting to the activity. Typically, and as appropriate to the situation and context, this would include: purpose and nature of the activity; mutual responsibilities; whether a team or other collaborators are involved; privacy and confidentiality limitations, risks and protections; likely risks and benefits of the activity, including any particular risks or benefits of the methods or communication modalities used; alternatives available; likely consequences of non-action; the option to refuse or withdraw at any time, without prejudice; over what period of time the consent applies; and how to rescind consent if desired. (Also see Standards III.23–27.)

I.24 Relay the information given in obtaining informed consent in language that the individuals and groups involved understand (including providing translation into another language, if necessary), and take whatever reasonable steps are needed to ensure that the information is, in fact, understood.

I.25 Provide new information in a timely manner, whenever such information becomes available and is significant enough that it reasonably could be seen as relevant to the original or ongoing informed consent.

I.26 Clarify the nature of multiple relationships to all concerned parties, including collateral contacts, before obtaining consent, if providing services or conducting research at the request of or for the use of a retaining or other third party. This would include, but not be limited to clarifying: the purpose of the service or research; the role and responsibilities of the psychologist; the reasonably anticipated use that will be made of the information collected; access to records or the information contained therein; the limits of privacy and confidentiality; and any special legal requirements or limitations. Third parties may include schools, employers, community, or organizational leaders, third-party payers, courts, government, police, and research funding bodies.

Freedom of consent

I.27 Take all reasonable steps to ensure that consent is not given under conditions of coercion, undue pressure, or undue reward. (Also see Standard III.29.)

I.28 Not proceed with any research activity, if consent is given under any condition of coercion, undue pressure, or undue reward. (Also see Standard III.29.)

I.29 Take all reasonable steps to confirm or re-establish freedom of consent, if consent for service is given under conditions of duress or conditions of extreme need.

I.30 Respect the moral right of individuals and groups (e.g., couples, families, organizations, communities, peoples) to discontinue participation or service at any time, and be responsive to non-verbal indications of a desire to discontinue if the individuals or groups involved have difficulty with verbally communicating such a desire (e.g., young children, individuals with language disabilities) or, due to culture, are unlikely to communicate such a desire orally.

Protections for vulnerable individuals and groups

I.31 Seek an independent and adequate ethical review of moral rights issues and protections for any research involving vulnerable groups or individual members of vulnerable groups, including individuals of diminished capacity to give informed consent, before making a decision to proceed.

I.32 Not use vulnerable groups or individual members of vulnerable groups, including individuals of diminished capacity to give informed consent, in research studies, if the research involved may be carried out equally well with groups or individuals without such vulnerabilities.

I.33 Seek to use methods that maximize the understanding and ability to consent of vulnerable groups or members of vulnerable groups, including individuals of diminished capacity to give informed consent.

I.34 Carry out informed consent processes with those who are legally responsible or appointed to give informed consent on behalf of individuals not competent to consent on their own behalf, seeking to ensure respect for any previously expressed preferences of individuals not competent to consent, and clarifying protections and limitations regarding the privacy and confidentiality of such individuals.

I.35 Seek willing and adequately informed participation from any person of diminished capacity to give informed consent, and proceed without such assent only if the service or research activity is considered to be of direct benefit to that person.

I.36 Be particularly cautious in establishing the freedom of consent of any prospective research participant who is in a dependent relationship to the psychologist (e.g., student, trainee, employee). This may include, but is not limited to, offering that person an alternative activity to fulfill their educational or employment goals, or offering a range of research studies or experience opportunities from which the person can select, none of which is so onerous as to be coercive.

Privacy

I.37 Seek and collect only information that is germane to the purpose(s) for which consent has been obtained.

I.38 Respect the moral right of research participants, employees, supervisees, students, and trainees to reasonable personal privacy, and take care not to infringe, in research, teaching, supervision, or service activities, on the personally, developmentally, or culturally defined private space of individuals or groups (e.g., couples, families, organizations, communities, peoples), unless clear permission is granted to do so.

I.39 Collect and record only that private information necessary for the provision of continuous, coordinated or collaborative service, or for the goals of the particular research study being conducted, or that is required or justified by law. (Also see Standards IV.17 and IV.18.)

I.40 Respect the moral right of primary clients and contract examinees whose identifiable information is collected and recorded to access that information in the record (including obtaining copies) and to request corrections with regard to the accuracy or completeness of the information, except as otherwise required or justified by law (e.g., statutory law; court order; previous agreement; potential serious harm to the physical, emotional, or mental health of the individual or group; violation of the privacy or confidentiality of another individual or group).

I.41 Collect, record, store, handle, and transfer all private information, whether written or unwritten (e.g., paper or electronic records, e-mail or fax communications, computer files, recordings), in a way that attends to the needs for privacy, confidentiality, and security. This would include protection from loss or unauthorized access, appropriate education of staff or other agents, and having adequate plans in circumstances of one's own serious illness, termination of employment, or death.

I.42 Take all reasonable steps to ensure that records over which they have control remain personally identifiable only as long as necessary in the best interests of those to whom they refer and/or to the research project for which they were collected, or as required or justified by law (e.g., the possible need to defend oneself against future allegations), and render anonymous or destroy any records under their control that no longer need to be personally identifiable. (Also see Standards IV.17 and IV.18.)

Confidentiality

I.43 Be careful not to relay incidental information about colleagues, team members, other collaborators, the primary clients or contract examinees of others, team members, or other collaborators; research participants, employees, supervisees, students, or trainees gained in the process of their activities as psychologists, that the psychologist has reason to believe is considered confidential by those individuals or groups, except as required or justified by law. (Also see Standards IV.17 and IV.18.)

I.44 Clarify what measures will be taken to protect privacy and confidentiality, and what responsibilities group members (e.g., couples, families, organizations, communities, peoples) have for the protection of each other's privacy and confidentiality, when engaged in services to or research with groups.

I.45 Share confidential information with others only to the extent reasonably needed for the purpose of sharing, and only with the informed consent of those involved, or in a manner that the individuals and groups (e.g., couples, families, organizations, communities, peoples) involved cannot be identified, except as required or justified by law, or in circumstances of possible imminent serious bodily harm. (Also see Standards II.42, IV.17, and IV.18.)

Extended responsibility

I.46 Encourage others, in a manner consistent with this *Code*, to respect the dignity of persons and peoples, and to expect respect for their own dignity.

I.47 Assume overall responsibility for the scientific and professional activities of their assistants, employees, students, trainees, and supervisees with regard to Respect for the Dignity of Persons and Peoples, all of whom, however, incur similar obligations.

Principle II: Responsible Caring

VALUES STATEMENT

A basic ethical expectation of any discipline is that its activities will benefit members of society or, at least, do no harm. Therefore, psychologists demonstrate an active concern for the well-being and best interests of the individuals and groups (e.g., couples, families, groups, communities, peoples) with whom they relate in their role as psychologists. This concern includes both those directly involved and those indirectly involved in their activities.

As individuals and groups (e.g., couples, families, organizations, communities, peoples) usually consider their own well-being and best interests in their decision making, obtaining informed consent (see Principle I) is one of the best methods for ensuring that their well-being and best interests will be protected. However, it is only when such consent is combined with the responsible caring of the psychologist that there is considerable ethical protection of the well-being and best interests of the person(s) involved. Responsible caring recognizes and respects the ability of individuals and groups (e.g., couples, families, organizations, communities, peoples) to make decisions for themselves and to care for themselves and each other. It does not replace or undermine such ability, nor does it substitute one individual's or group's opinion about what promotes the well-being and best interests of another for that other individual's or group's competent decision making.

Psychologists define harm and benefit in terms of both physical and psychological dimensions. They are concerned about such factors as: social, family, and community relationships; personal and cultural identity; feelings of self-worth, fear, humiliation, interpersonal trust, and cynicism; self-knowledge and general knowledge; and such factors as physical safety, comfort, pain, and injury. They are concerned about immediate, short-term, and long-term effects.

Responsible caring leads psychologists to take care to discern and balance the potential harms and benefits to the individuals and groups involved, taking into account the degree and moral legitimacy of conflicting interests. It also leads psychologists to predict the likelihood of the occurrence of harms and benefits, to proceed only if the potential benefits outweigh the potential harms, to develop and use methods that will minimize harms and maximize benefits, and to take responsibility for correcting clearly harmful effects that have occurred as a direct result of their research, teaching, supervision, practice, or business activities.

In order to carry out these steps, psychologists recognize the need for competence and self-knowledge. They consider incompetent action to be unethical in itself, as it is unlikely to be of benefit and likely to be harmful. They engage only in those activities in which they have competence or for which they are receiving supervision, and they perform their activities as competently as possible.

They acquire, contribute to, and use the existing knowledge most relevant to the well-being and best interests of those concerned. They also engage in self-reflection regarding how their own values, attitudes, experiences, and social context (e.g., culture, ethnicity, colour, religion, sex, gender, sexual orientation, physical and mental abilities, age, socio-economic status) influence their actions, interpretations, choices, and recommendations. This is done with the intent of increasing the probability that their activities will benefit and not harm the individuals and groups (e.g., couples, families, organizations, communities, peoples) with whom they relate in their role as psychologists.

As with Principle I, psychologists have a responsibility to responsibly care for all individuals and groups with whom they come in contact in their role as psychologists[. However,] the nature of their contract with society demands that their greatest responsibility be to individuals and groups in the most vulnerable position. As mentioned in Principle I, vulnerability can be permanent or temporary, and can be increased by such factors as limited capacity to consent, reduced voluntariness to their consent or their involvement, difficulties in cognitive or emotional functioning, economic disadvantage, cultural discrimination or oppression, or urgency of a situation. Normally, the individuals and groups directly receiving or involved in the psychologist's activities (e.g., research participants, primary clients, contract examinees, students, trainees) are in a more vulnerable position than those indirectly involved (e.g., employers, colleagues, interdisciplinary or intradisciplinary team members, other collaborators, organizational or community leaders, government, retaining parties, third party payers, the general public). Psychologists recognize that as the vulnerabilities of individuals and groups (e.g., couples, families, organizations, communities, peoples) increase, or their power to control their environment or their lives decreases, psychologists have an increasing responsibility to seek ethical advice and to establish safeguards to protect the well-being and best interests of the individuals or groups involved. For this reason, psychologists consider it their responsibility to increase safeguards to protect and promote the well-being and best interests of the individuals and groups involved in their activities proportionate to the degree of vulnerability of these individuals and groups.

Psychologists' treatment and use of animals in their direct service, research, teaching, and supervision activities are also a component of responsible caring. Although animals do not have the same type of moral rights as human beings (e.g., to personal privacy), they do have a right to be treated humanely (i.e., with consideration and compassion) and not be exposed to unnecessary discomfort, pain, or disruption.

By virtue of the social contract that the discipline has with society, psychologists have a higher duty of care to members of society than the general duty of care all members of society have to each other. However, psychologists are entitled to protect their own basic well-being and best interests (e.g., physical safety, family relationships) in their work as psychologists.

ETHICAL STANDARDS

In adhering to the Principle of Responsible Caring, psychologists would:

General caring

II.1 Protect and promote the well-being and best interests of primary clients, contract examinees, research participants, employees, supervisees, students, trainees, colleagues, team members or other collaborators, and others.

II.2 Avoid doing harm to primary clients, contract examinees, research participants, employees, supervisees, students, trainees, colleagues, team members or other collaborators, and others.

II.3 Accept responsibility for the consequences of their actions.

II.4 Refuse to advise, train, or supply information to anyone who, in the psychologist's judgment, will use the knowledge or skills to harm others.

II.5 Make every reasonable effort to ensure that psychological knowledge is not misinterpreted or misused, intentionally or unintentionally, to harm others.

Competence and self-knowledge

II.6 Offer or carry out (without supervision) only those activities for which they have established their competence to carry them out to the benefit of others.

II.7 Not delegate activities to individuals or groups not competent to carry them out to the benefit of others.

II.8 Take immediate steps to obtain consultation or supervision, or to refer a primary client to a colleague or other appropriate professional, whichever is more likely to result in providing the primary client with competent service, if it becomes apparent that a primary client's issues or problems are beyond their competence.

II.9 Keep themselves up to date with a broad range of relevant knowledge, research methods, techniques, and technologies, and their impact on individuals and groups (e.g., couples, families, organizations, communities, and peoples), through the reading of relevant literature, peer consultation, and continuing education activities, in order that their practice, teaching, supervision, and research activities will benefit and not harm others.

II.10 Evaluate how their own experiences, attitudes, culture, beliefs, values, individual differences, specific training, external pressures, personal needs, and historical, economic, and political context might influence their interactions with and perceptions of others, and integrate this awareness into their efforts to benefit and not harm others.

II.11 Seek appropriate help and/or discontinue scientific, teaching, supervision, or practice activity for an appropriate period of time, if a physical or psychological condition reduces their ability to benefit and not harm others.

II.12 Engage in self-care activities that help to avoid conditions (e.g., burnout, addictions) that could result in impaired judgment and interfere with their ability to benefit and not harm others.

Risk/benefit analysis

II.13 Assess the individuals and groups (e.g., couples, families, organizations, communities, peoples) involved in their activities adequately enough to ensure that they will be able to discern what will benefit and not harm them, using assessment methods that are appropriate to the particular cultural and social contexts of the individuals and groups involved.

II.14 Be sufficiently sensitive to and knowledgeable about individual and group characteristics, culture, and vulnerabilities to discern what will benefit and not harm the individuals and groups (e.g., couples, families, organizations, communities, peoples) involved in their activities.

II.15 Carry out pilot studies to determine the effects of all new procedures and techniques before considering their use on a broader scale.

II.16 Seek independent and adequate ethical review(s), by individuals and groups with relevant expertise (e.g., other researchers in the area; research ethics boards or equivalent; relevant representatives of the population being studied) of the ethical protections and the balance of risks and benefits of all research and new interventions that involve procedures of unknown consequence, or where pain, discomfort, or harm are possible, before making a decision to proceed.

II.17 Not carry out any scientific or professional activity unless the probable benefit is proportionately greater than the risk involved.

Maximize benefit

II.18 Strive to provide and/or obtain the best reasonably accessible service for those seeking psychological services. This may include, but is not limited to, selecting assessment tools, methods, interventions, and communication modalities that are: (a) relevant and tailored to the needs, characteristics, and contexts of the primary client or contract examinee; and (b) based on the best available evidence in light of those needs, characteristics, and contexts. It also may include, but is not limited to: consulting or collaborating with service-providing organizations in the community, members of other disciplines, individuals and groups relevant to the culture or belief systems of those receiving or being subject to services; or advocating on behalf of a primary client when appropriate and needed.

II.19 Make themselves aware of the knowledge and skills of other disciplines (e.g., law, social work, medicine, business administration), and make referrals or advise the use of such knowledge and skills where relevant to the benefit of others.

II.20 Provide suitable information, unless declined or contraindicated (e.g., some critical inquiry studies, possibility of harm, legally disallowed), about the results of assessments, evaluations, or research findings to the individuals and groups (e.g., couples, families, organizations, communities, peoples) involved. This information would be communicated in ways that are developmentally, linguistically, and culturally appropriate, and that are meaningful and helpful.

II.21 Create and maintain records relating to their activities that are sufficient to support continuity and coordination over time and to manage risks.

II.22 Monitor and evaluate the effect of their activities, record their findings, and communicate new knowledge to relevant others.

II.23 Consult, unless declined or contraindicated (e.g., critical inquiry studies, possibility of harm, legally disallowed), with the individuals and groups (e.g., couples, families, organizations, communities, peoples) being studied, in order to increase the accuracy of interpretation of results, to enhance the benefit of the results to the individuals and groups, and to minimize risk of misinterpretation or misuse.

II.24 Debrief research participants in such a way that the participants' knowledge is enhanced and the participants have a sense of contribution to knowledge. (Also see Standard III.25.)

II.25 Perform their teaching duties on the basis of careful preparation, so that their instruction is current and scholarly.

II.26 Facilitate the professional and scientific development of their employees, supervisees, students, and trainees by ensuring that they understand the values and ethical prescriptions of the discipline, as well as the competencies needed for their areas of activity, and by providing or arranging for adequate working conditions, timely evaluations, and constructive supervision, consultation, and experience opportunities.

II.27 Encourage and assist students and trainees in their engagement in developmentally appropriate professional and scientific activities, including the publication of worthy student or trainee papers.

Minimize harm

II.28 Be acutely aware of the power relationship in therapy and, therefore, not encourage or engage in sexual intimacy with therapy clients, neither during therapy, nor for that period of time following therapy during which the power relationship reasonably could be expected to influence the client's decision making. (Also see Standard III.28.)

II.29 Not encourage or engage in sexual intimacy with students, trainees, or others with whom the psychologist has an evaluative or other relationship of direct authority. (Also see Standard III.28.)

II.30 Be careful not to engage in activities in a way that could place incidentally involved individuals or groups at risk.

II.31 Ensure that any incidental findings suggesting that intervention may be needed to avoid serious harm are communicated as soon as possible to research participants and contract examinees.

II.32 Be acutely aware of the need for discretion in the recording and communication of information, in order that the information not be misinterpreted or misused to the detriment of others. This includes, but is not limited to: not recording or communicating information that could lead to misinterpretation or misuse by those having access to or receiving the information; avoiding conjecture; clearly labelling opinion; and communicating information in language that can be understood clearly by the recipient of the information.

II.33 Give reasonable assistance to secure needed psychological services or activities, if personally unable to meet requests for needed psychological services or activities.

II.34 Provide a primary client, if appropriate and if desired by the primary client, with reasonable assistance to find a way to receive needed services in the event that third party payments are exhausted and the primary client cannot afford the fees involved.

II.35 Maintain appropriate contact, support, and responsibility for caring until a colleague or other professional begins service, if referring a primary client to a colleague or other professional.

II.36 Give reasonable notice and be reasonably assured that discontinuation will cause no foreseeable material harm to the primary client, before discontinuing services.

II.37 Establish suitable procedures for responding to emergencies, including procedures for situations in which they are unavailable due to illness, absence, death, or technology failure.

II.38 Screen research participants and select those least likely to be harmed, if more than minimal risk of harm to some research participants is possible.

II.39 Act to minimize the impact of their research activities on research participants' behavioural patterns, or on their physical or mental integrity.

Offset/correct harm

II.40 Terminate an activity when it is clear that the activity carries more than minimal risk of harm and is found to be more harmful than beneficial, or when the activity is no longer needed.

II.41 Refuse to help individuals and groups (e.g., couples, families, organizations, communities, peoples) to carry out or to submit to activities that, according to current knowledge, or legal or professional guidelines, would cause serious physical or psychological harm to themselves or others.

II.42 Do everything reasonably possible to stop or offset the consequences of actions by others when these actions are likely to cause imminent serious bodily harm to themselves or others. This may include, but is not limited to, the possibility of disclosing some confidential information to appropriate authorities (e.g., the police), an intended victim, or a family member or other support person who can intervene. (Also see Standard I.45.)

II.43 Act to stop or offset the consequences of seriously harmful activities being carried out by another psychologist or member of another discipline, when there is objective information about the activities and the harm. This may include reporting to the appropriate regulatory body, authority, or committee for action, depending on the psychologist's judgment about the person(s) or body(ies) best suited to stop or offset the harm, and would be consistent with the privacy and confidentiality rights and limitations of the individuals and groups involved. (See Standards I.45 and IV.17.)

II.44 Act also to stop or offset the consequences of harmful activities carried out by another psychologist or member of another discipline, when the harm is not serious or the activities appear to be primarily a lack of sensitivity, knowledge, or experience. This may include talking informally with the psychologist or member of the other discipline, obtaining objective information and, if possible and relevant, the assurance that the harm will discontinue and be corrected. If in a vulnerable position (e.g., employee, student, trainee) with respect to the other psychologist or member of the other discipline, it may include asking individuals or groups in less vulnerable positions to participate in the meeting(s). Any action taken would be consistent with the privacy and confidentiality rights and limitations of the individuals and groups involved. (See Standards I.45 and IV.17.)

II.45 Be open to the concerns of others about perceptions of harm that they as a psychologist might be causing, stop activities that are causing harm, and not punish or seek punishment for those who raise such concerns in good faith.

II.46 Not place individuals or groups (e.g., couples, families, organizations, communities, peoples) needing service at a serious disadvantage by offering them no service in order to fulfill the conditions of a research design, when a standard service is available.

II.47 Debrief research participants in such a way that any harm caused can be discerned, and act to correct any resultant harm. (Also see Standard III.25.)

Care of animals

II.48 Treat animals humanely and not expose them to unnecessary discomfort, pain, or disruption.

II.49 Not use animals in their research unless there is a reasonable expectation that the research will increase understanding of the structures and processes underlying behaviour, or increase understanding of the particular animal species used in the study, or result in benefits to the health and welfare of humans or other animals.

II.50 Keep themselves up to date with animal care legislation, guidelines, and best practices, if using animals in direct service, research, teaching, or supervision.

II.51 Use a procedure subjecting animals to pain, stress, or privation only if an alternative procedure is unavailable and the goal is justified by its prospective scientific, educational, or applied value.

II.52 Submit any research that includes procedures that subject animals to pain, stress, or privation to an appropriate review panel or committee for review.

II.53 Make every effort to minimize the discomfort, illness, and pain of animals. This would include using appropriate anaesthesia, analgesia, tranquilization and/or adjunctive relief measures sufficient to prevent or alleviate animal discomfort, pain, or distress, when using a procedure or condition likely to cause more than short-term, low-intensity suffering. It also would include, if killing animals at the termination of a research study, doing so as compassionately and painlessly as possible.

II.54 Use animals in classroom demonstrations only if the instructional objectives cannot be achieved through the use of electronic recordings, films, computer simulations or other methods, and if the type of demonstration is warranted by the anticipated instructional gain.

Extended responsibility

II.55 Encourage others, in a manner consistent with this *Code*, to care responsibly.

II.56 Assume overall responsibility for the scientific and professional activities of their assistants, employees, supervisees, students, and trainees with regard to the Principle of Responsible Caring, all of whom, however, incur similar obligations.

Principle III: Integrity in Relationships

VALUES STATEMENT

The relationships formed by psychologists in the course of their work, regardless of the communication modality used, and regardless of whether they are with identifiable individuals or groups or with the public at large, embody explicit and implicit mutual expectations of integrity that are vital to the advancement of scientific knowledge and to the maintenance of public confidence in the discipline of psychology. These expectations involve a commitment to truthfulness, and include: accuracy and honesty; straightforwardness and openness; maximization of objectivity and minimization of bias; and avoidance of conflicts of interest. Psychologists have a responsibility to meet these expectations and to encourage reciprocity.

In addition to accuracy and honesty, and the obvious prohibitions of fraud or misrepresentation, meeting expectations of integrity is enhanced by self-knowledge and the use of critical analysis. Although it can be argued that science is value-free and impartial, scientists are not. Personal values and self-interest can affect the questions psychologists ask, how they ask those questions, what assumptions they make, their selection of methods, what they observe and what they fail to observe, and how they interpret their data.

Psychologists are not expected to be value-free or totally without self-interest in conducting their activities. However, they are expected to understand how their own experiences, attitudes, culture, beliefs, values, individual differences, specific training, external pressures, personal needs, and historical, economic, and political context interact with their activities, to be open and honest about the influence of such factors, and to be as objective and unbiased as possible under the circumstances.

The values of openness and straightforwardness exist within the context of Respect for the Dignity of Persons and Peoples (Principle I) and Responsible Caring (Principle II). As such, there will be circumstances in which openness and straightforwardness will need to be tempered. Fully open and straightforward disclosure might not be needed or desired by others and, in some circumstances, might be a risk to their dignity, well-being or best interests, or considered culturally inappropriate. In such circumstances, however, psychologists have a responsibility to ensure that their decision not to be fully open or straightforward is justified by higher-order values and does not invalidate any informed consent procedures.

Of special concern to psychologists is the provision of incomplete disclosure when conducting research for which informed consent is required (i.e., not informing participants of something that would normally be disclosed as part of obtaining informed consent), or the use of deception (e.g., temporarily leading research participants to believe that a research project has a purpose other than its actual purpose; providing research participants with other false information). These actions sometimes occur in research where full and accurate disclosure would likely influence the responses of the research participants and thus invalidate the results. Although research that uses such techniques can lead to knowledge that is beneficial, such benefits need to be weighed against the research participant's moral right to self-determination and the importance of public and personal trust in psychology. Psychologists have a serious obligation to avoid as much as possible the use of such research procedures. They also have a serious obligation to consider the need for, the possible consequences of, and their responsibility to correct any resulting mistrust or other harmful effects, when incomplete disclosure or deception is used.

As public trust in the discipline of psychology includes trusting that psychologists will act in ways that promote the dignity, well-being and best interests of members of the public, situations that present real or potential conflicts of interest are of concern to psychologists. Conflict-of-interest situations are those that can lead to distorted judgment and can motivate psychologists to act in ways that meet their own personal, social, political, financial, or business interests at the expense of the dignity, well-being or best interests of members of the public. Although avoidance of all conflicts of interest is not possible, some are of such a high risk to protecting the dignity, well-being or best interests of members of the public and to maintaining the trust of the public, that they are considered never acceptable (see Standard III.28). The risk level and acceptability of other conflicts of interest (e.g., dual or multiple relationships) might be partially dependent on cultural or geographic factors and the specific type of professional relationship (e.g., long-term psychotherapy vs. organizational consultation vs. community-oriented activities). In some situations, for instance, a dual or multiple relationship might be inevitable or culturally expected (e.g., in rural, Indigenous, or immigrant communities), or could enhance the benefit of an activity. However, in all such situations, the psychologist is responsible for making an honest appraisal of the benefits and risks involved in the context of the specific situation, including but not limited to: determining the feasibility of alternatives in light of those risks and benefits; deciding whether to enter into or continue the relationship; establishing relationship boundaries appropriate to the work being done (e.g., availability, in-person or social-media personal disclosure, social contact); and managing the relationship (e.g., by seeking advice or establishing other safeguards) to ensure that the dignity, well-being and best interests of the member(s) of the public are protected.

Integrity in relationships implies that psychologists, as a matter of honesty, have a responsibility to maintain competence in any specialty area for which they declare competence, whether or not they are currently practising in that area. It also requires that psychologists, in as much as they present themselves as members and representatives of a specific discipline, have a responsibility to actively rely on and be guided by that discipline and its guidelines and requirements.

ETHICAL STANDARDS

In adhering to the Principle of Integrity in Relationships, psychologists would:

Accuracy/honesty

III.1 Not knowingly participate in, condone, or be associated with dishonesty, fraud, misappropriation, or misrepresentation.

III.2 Accurately represent their own and their colleagues' qualifications (e.g., credentials, education, experience, competence, affiliations) in all spoken, written, or printed communications, being careful not to use descriptions or information that could be misinterpreted (e.g., citing membership in a voluntary association of psychologists as a testament of competence).

III.3 Carefully protect their own and their colleagues' qualifications from being misrepresented by others, and act quickly to correct any such misrepresentation.

III.4 Maintain competence in their declared area(s) of psychological competence, as well as in their current area(s) of activity. (Also see Standard II.9.)

III.5 Accurately represent their own and their colleagues' activities, functions, contributions, and likely or actual outcomes of their activities (including research results) in all spoken, written, electronic, or printed communication. This includes but is not limited to: advertisements of services or products; public information and prevention materials; personal résumés or curricula vitae; course and workshop descriptions; academic grading requirements; and research reports.

III.6 Ensure that their own and their colleagues' activities, functions, contributions, and likely or actual outcomes of their activities (including research results) are not misrepresented by others, and act quickly to correct any such misrepresentation.

III.7 Take credit only for the work and ideas that they have actually done or generated, and give credit for work done or ideas contributed by others (including students and trainees), in proportion to their contribution.

III.8 Acknowledge the limitations, and not suppress disconfirming evidence, of their own and their colleagues' methods, findings, interventions, and views, and acknowledge alternative hypotheses and explanations.

Objectivity/lack of bias

III.9 Evaluate how their own experiences, attitudes, culture, beliefs, values, individual differences, specific training, external pressures, personal needs, and historical, economic, and political context might influence their activities and thinking, integrating this awareness into their attempts to be as objective and unbiased as possible in their research, service, teaching, supervision, employment, evaluation, adjudication, editorial, and peer review activities.

III.10 Take care to communicate as completely and objectively as possible, and to clearly differentiate facts, opinions, theories, hypotheses, and ideas, when communicating knowledge, findings, and views.

III.11 Present instructional information accurately, avoiding undue bias in the selection and presentation of information, and publicly acknowledge any personal values or bias that influence the selection and presentation of information.

III.12 Act quickly to clarify any distortion by a sponsor, primary client, agency (e.g., news media), or other individuals or groups, of the findings of their research.

Straightforwardness/openness

III.13 Be clear and straightforward about all information needed to establish informed consent or any other valid written or unwritten agreement (e.g., fees, including any limitations imposed by third-party payers; relevant conflicts of interest; relevant business policies and practices; contact information of accountability bodies; mutual concerns; mutual responsibilities; ethical responsibilities of psychologists; likely experiences; possible conflicts; possible outcomes; and expectations for processing, using, and sharing any information generated).

III.14 Establish procedures for reasonably ready access by a primary client or contract examinee to confidential information about themselves in their psychological record, limited only by what may be required or justified by law (e.g., statutory law; court order; previous agreement; potential serious harm to the physical, emotional, or mental health of the individual or group; protection of the privacy or confidentiality of another individual or group).

III.15 Develop easy-to-follow procedures for primary clients and contract examinees to request corrections to any confidential information about themselves in a psychological record (e.g., inaccuracies, incompleteness, outdated); be open to making such corrections where warranted; and be open to allowing them to file a note of disagreement with the confidential information in the record if the correction is not deemed warranted.

III.16 Fully explain reasons for their actions to the individuals and groups (e.g., couples, families, organizations, communities, peoples) that have been affected by their actions, if appropriate and if asked.

III.17 Honour all promises and commitments included in any written or verbal agreement, unless serious and unexpected circumstances (e.g., illness) intervene. If such circumstances occur, then the psychologist would make a full and honest explanation to other parties involved.

III.18 Make clear whether they are acting as private citizens, as members of specific organizations or groups, or as representatives of the discipline of psychology, when making statements or when involved in public activities.

III.19 Carry out, present, and discuss research in a way that is consistent with a commitment to honest, open inquiry, and to clear communication of any research aims, sponsorship, social context, personal values, or historical, economic, or political interests that might affect or appear to affect the research.

III.20 Submit their research, in some accurate form and within the limits of privacy and confidentiality, to individuals or groups with expertise in the research area or topic, for their comments and evaluations, prior to publication or the preparation of any final report.

III.21 Encourage and not interfere with the free and open exchange of psychological knowledge and theory between themselves, their students, trainees, colleagues, team members and other collaborators, and the public.

III.22 Make no attempt to conceal the status of a student or trainee and, if a student or trainee is providing direct service, ensure that the client or contract examinee is informed of that fact.

Avoidance of incomplete disclosure and deception

III.23 Not engage in incomplete disclosure or deception in research that requires informed consent (see Standard I.20), if there are alternative procedures available, the negative effects cannot be predicted or offset, or the incomplete disclosure or deception would interfere with the understanding of facts that clearly might influence a decision to give adequately informed consent (e.g., withholding information about the level of risk, discomfort, or inconvenience).

III.24 Use the minimum necessary incomplete disclosure or deception when they are used in such research.

III.25 Debrief research participants as soon as possible after the participants' involvement when incomplete disclosure or deception is used in such research, providing clarification of the nature of the study, seeking to remove any misconceptions that might have arisen, seeking to re-establish any trust that might have been lost, and assuring the participants that the research procedures were neither arbitrary nor capricious, but necessary for scientifically valid findings. (Also see Standards II.24 and II.47.)

III.26 Give a research participant the option of removing his or her data, if the data are identifiable and the research participant expresses concern during the debriefing about the incomplete disclosure or deception, and if removal of the data will not compromise the validity of the research design and hence diminish the ethical value of the participation of the other research participants.

III.27 Seek an independent and adequate ethical review of the risks to public or personal trust and of safeguards to protect such trust if planning to use incomplete disclosure or deception in any research that requires informed consent, before making a decision to proceed.

Avoidance of conflict of interest

III.28 Not exploit any relationship established as a psychologist to further personal, political, or business interests at the expense of the dignity or well-being of their primary clients, contract examinees, research participants, students, trainees, employers, or others. This includes, but is not limited to: soliciting primary clients, contract examinees, research participants, or students or trainees of one's employing agency for one's own activities (e.g., private practice, own research study); taking advantage of trust or dependency to encourage or engage in sexual intimacies (e.g., with primary clients or other individuals not included in Standard II.28, with primary clients' or contract examinees' partners or relatives, with students or trainees not included in Standard II.29, with research participants); taking advantage of trust or dependency to frighten individuals or groups into receiving services; establishing an ongoing treatment relationship with members of one's own family, close friends, or others in a significant current or previous personal relationship with the psychologist; misappropriating others' intellectual property, including students' or trainees' ideas, research, or work; using the resources of one's employing institution for purposes not agreed to; giving or receiving financial inducements for referrals; entering into fee arrangements (e.g., bartering) that are clinically or culturally contraindicated; allowing the financial advantages of method or communication-modality choices to outweigh the dignity, well-being or best interests of primary clients or contract examinees; seeking or accepting loans or investments from primary clients or contract examinees; and prejudicing others against a colleague for reasons of personal gain.

III.29 Not offer rewards sufficient to motivate individuals or groups (e.g., couples, families, organizations, communities, peoples) to participate in an activity that has possible or known risks to themselves or others. (Also see Standards I.27, I.28, II.2, and II.54.)

III.30 Avoid dual or multiple relationships (e.g., with primary clients, contract examinees, research participants, employees, supervisees, students, trainees) that are not justified by the nature of the activity, by cultural or geographic factors, or where there is a lack of reasonably accessible alternatives.

III.31 Manage dual or multiple relationships or any other conflict-of-interest situation entered into in such a way that bias, lack of objectivity, and risk of exploitation or harm are minimized. This might include involving the affected party(ies) in clarification of boundaries and expectations, limiting the duration of the relationship, obtaining ongoing supervision or consultation for the duration of the dual or multiple relationship, or involving a third party in obtaining consent (e.g., approaching a primary client or employee about becoming a research participant).

III.32 Inform all parties, if a real or potential conflict of interest arises, of the need to resolve the situation in a manner that is consistent with Respect for the Dignity of Persons and Peoples (Principle I) and Responsible Caring (Principle II), and take all reasonable steps to resolve the issue in such a manner.

Reliance on the discipline

III.33 Familiarize themselves with their discipline's rules and regulations, and abide by them, unless abiding by them would be seriously detrimental to the moral rights or welfare of others as demonstrated in the Principles of Respect for the Dignity of Persons and Peoples, or Responsible Caring. (See Standards IV.17 and IV.18 for guidelines regarding the resolution of such conflicts.)

III.34 Familiarize themselves with and take into account their discipline's guidelines and best practices for their area(s) of activity, and demonstrate a commitment to maintaining the standards of their discipline.

III.35 Seek consultation from colleagues and/or appropriate others, including advisory groups, and give due regard to their advice in arriving at a responsible decision, if faced with difficult situations.

Extended responsibility

III.36 Encourage others, in a manner consistent with this *Code*, to relate with integrity.

III.37 Assume overall responsibility for the scientific and professional activities of their assistants, employees, supervisees, students, and trainees with regard to the Principle of Integrity in Relationships, all of whom, however, incur similar obligations.

Principle IV: Responsibility to Society

VALUES STATEMENT

Psychology functions as a discipline within the context of human society. Psychologists, both in their work and as private citizens, have responsibilities to the societies in which they live or work and to the welfare of all human beings in those societies.

Two of the legitimate expectations of psychology as a science and a profession are that it will increase knowledge and that it will conduct its affairs in such ways that it will promote the welfare of all human beings.

Freedom of enquiry, innovation, and debate (including scientific and academic freedom) is a foundation of psychological education, science, and practice. In the context of society, the above expectations imply that psychologists will exercise this freedom through the use of activities and methods that are consistent with ethical requirements.

The above expectations also imply that psychologists will do whatever they can to ensure that psychological knowledge, when used in the development of social structures and policies, will be used for just and beneficial purposes, and that the discipline's own structures and policies will support those purposes. Within the context of this document, social structures and policies that have just and beneficial purposes are defined as those that more readily support and reflect respect for the dignity of persons and peoples, responsible caring, integrity in relationships, and responsibility to society. If psychological knowledge or structures are used against these purposes, psychologists have an ethical responsibility to try to draw attention to and correct the misuse. Although this is a collective responsibility, those psychologists having direct involvement in the structures of the discipline, in social development, or in the theoretical or research data base that is being used (e.g., through research, expert testimony, or policy advice) have the greatest responsibility to act. Other psychologists need to decide for themselves the most appropriate and beneficial use of their time and talents to help meet this collective responsibility.

In carrying out their work, psychologists acknowledge that many social structures have evolved slowly over time in response to human need and are valued by the societies that have developed them. In such circumstances, psychologists convey respect for such social structures and avoid unwarranted or unnecessary disruption. Suggestions for and action toward changes or enhancement of such structures are carried out through processes that seek to achieve a consensus within those societies and/or through democratic means.

On the other hand, if structures or policies seriously ignore or oppose the principles of respect for the dignity of persons and peoples, responsible caring, integrity in relationships, or responsibility to society, psychologists involved have a responsibility to speak out in a manner consistent with the principles of this *Code*, and advocate for appropriate change to occur as quickly as possible.

In order to be responsible and accountable to society, and to contribute constructively to its ongoing development, psychologists need to be willing to work in partnership and collaboration with others, be self-reflective, and be open to external suggestions and criticisms about their work and the place of the discipline of psychology in society. They need to engage in even-tempered observation and interpretation of the effects of societal structures and policies, and their process of change, developing the ability of psychologists to increase the just and beneficial use of psychological knowledge and structures, and avoid their misinterpretation or misuse. The discipline needs to be willing to set high standards for its members, to do what it can to assure that such standards are met, and to support its members in their attempts to maintain the standards (e.g., through formative and continuing education, training, supervision, and consultation). Once again, individual psychologists need to decide for themselves the most appropriate and beneficial use of their time and talents in helping to meet these collective responsibilities.

ETHICAL STANDARDS

In adhering to the Principle of Responsibility to Society, psychologists would:

Development of knowledge

IV.1 Contribute to the discipline of psychology and to society's understanding of itself and human beings generally, through free enquiry, innovation, and debate, and through the acquisition, transmission and expression of knowledge and ideas, unless such activities conflict with ethical requirements.

IV.2 Not interfere with, or condone interference with, free enquiry, innovation and debate, and the acquisition, transmission and expression of knowledge and ideas, that do not conflict with ethical requirements.

IV.3 Keep informed of progress in their area(s) of psychological activity, take this progress into account in their work, and try to make their own contributions to this progress.

Beneficial activities

IV.4 Participate in and contribute to formative and continuing education and to the professional and scientific growth of self, students, trainees, colleagues, collaborators, and the members of other disciplines as appropriate.

IV.5 Assist in the development of those who enter the discipline of psychology by helping them to acquire a full understanding of their ethical responsibilities and the needed competencies of their chosen area(s), including an understanding of critical analysis and of the variations, uses, limitations, and possible misinterpretations and misuses of the scientific paradigm.

IV.6 Participate in the discipline's process of critical self-evaluation of its place in society, and in the development and implementation of structures and procedures that help the discipline to contribute to just and beneficial societal functioning and changes.

IV.7 Provide and/or contribute to a work or team environment that supports the respectful expression of ethical concern or dissent, and the constructive resolution of such concern or dissent.

IV.8 Engage in regular monitoring, assessment, and reporting (e.g., through peer review; in program reviews, case management reviews, and reports of one's own research) of their ethical practices and safeguards.

IV.9 Help develop, promote, and participate in accountability processes and procedures related to their work, including but not limited to: continuous improvement activities; program or sector accreditation activities; and registration with appropriate licensing and credentialing bodies.

IV.10 Uphold the discipline's responsibility to society by promoting and maintaining the highest standards of the discipline.

IV.11 Protect the skills, knowledge, and interpretations of psychology from being misinterpreted, misused, used incompetently, or made useless (e.g., loss of security of assessment techniques) by others.

IV.12 Contribute to the general welfare of society (e.g., improving accessibility of services regardless of ability to pay) and/or to the general welfare of their discipline, by offering a portion of their time to work for which they receive little or no financial return.

IV.13 Uphold the discipline's responsibility to society by bringing incompetent or unethical behaviour, including misinterpretations or misuses of psychological knowledge and techniques, to the attention of appropriate authorities, committees, or regulatory bodies, in a manner consistent with the ethical principles of this *Code*, if informal resolution or correction of the situation is not appropriate or possible.

IV.14 Enter into or continue with only those agreements or contracts that allow them to act in accordance with the ethical principles and standards of this *Code*.

Respect for society

IV.15 Acquire an adequate knowledge of the culture, social structure, history, customs, and laws or policies of organizations, communities, and peoples before beginning any major work there, obtaining guidance from appropriate members of the organization, community, or people as needed.

IV.16 In their scientific and professional activities, convey respect for and abide by prevailing mores, social customs, and cultural expectations of organizations, communities, and peoples, provided that this does not contravene any of the ethical principles of this *Code*.

IV.17 Familiarize themselves with the laws and regulations of the societies in which they work, especially those that are related to their activities as psychologists (e.g., mandatory reporting, research regulations, jurisdictional licensing or certification requirements), and abide by them. If those laws or regulations seriously conflict with the ethical principles contained herein, psychologists would do whatever they could to uphold the ethical principles. If upholding the ethical principles could result in serious personal consequences (e.g., jail, physical harm), decision for final action would be considered a matter of personal conscience.

IV.18 Consult with colleagues or appropriate others, including advisory groups, if faced with an apparent conflict between abiding by a law or regulation and following an ethical principle, unless in an emergency, and seek consensus as to the most ethical course of action and the most responsible, knowledgeable, effective, and respectful way to carry it out.

Development of society

IV.19 Act to change those aspects of the discipline of psychology that detract from just and beneficial societal changes, where appropriate and possible.

IV.20 Be sensitive to the needs, current issues, and problems of society, when determining research questions to be asked, services to be developed, content to be taught, information to be collected, or appropriate interpretation of results or findings.

IV.21 If their work is related to societal issues, be especially careful to keep well informed of social, cultural, historical, economic, institutional, legal, and political context issues through relevant reading, peer consultation, and continuing education.

IV.22 Speak out, in a manner consistent with the four principles of this *Code*, if they possess expert knowledge that bears on important societal issues being studied or discussed.

IV.23 Provide thorough discussion of the limits of their data with respect to social policy, if their work touches on social policy and structure.

IV.24 Make themselves aware of the current social, economic, and political climate and of previous and possible future societal misinterpretations and misuses of psychological knowledge, and exercise due discretion in communicating psychological information (e.g., research results, theoretical knowledge), in order to discourage any further misinterpretation or misuse.

IV.25 Exercise particular care when reporting the results of any work regarding vulnerable groups, ensuring that results are not likely to be misinterpreted or misused in the development of social policy, attitudes, and practices (e.g., encouraging manipulation of vulnerable individuals, couples, families, organizations, communities, or peoples; reinforcing unjust discrimination against any specific population).

IV.26 Not promote, contribute to, nor engage in any activity that contravenes international humanitarian law (e.g., declarations, treaties, or conventions regarding: human rights; torture and other cruel, inhumane, or degrading treatment or punishment; economic, social and cultural rights; civil and political rights;

rights of indigenous peoples; children's rights; weapons of mass destruction; destruction of the environment).

IV.27 Provide appropriate individuals and groups (e.g., couples, families, organizations, communities, peoples) with any psychological knowledge relevant to their informed participation in the shaping of social policies and structures, if the psychologist possesses expert knowledge that bears on the social policies and structures.

IV.28 Speak out and/or act, in a manner consistent with the four principles of this *Code*, if the policies, practices, laws, or regulations of the social structure within which they work seriously ignore or contradict any of the principles of this *Code*.

Extended responsibility

IV.29 Encourage others, in a manner consistent with this *Code*, to exercise responsibility to society.

IV.30 Assume overall responsibility for the scientific and professional activities of their assistants, employees, supervisees, students, and trainees with regard to the Principle of Responsibility to Society, all of whom, however, incur similar obligations.

NOTES

1 The *Canadian Code of Ethics for Psychologists* is reproduced with permission of the Canadian Psychological Association. The original can be found here: https://cpa.ca/docs/File/Ethics/CPA_Code_2017_4thEd.pdf

2 Within each definition, any other terms for which there is a definition are italicized.

3 Adapted from: Canadian Psychological Association. (1985). *Guidelines for the elimination of sexual harassment.* Canadian Psychological Association.

APPENDIX B

Universal Declaration of Ethical Principles for Psychologists[1]

Adopted unanimously by the General Assembly of the International Union of Psychological Science in Berlin on July 22nd, 2008.

Adopted unanimously by the Board of Directors of the International Association of Applied Psychology in Berlin on July 26th, 2008.

Preamble

Ethics is at the core of every discipline. The *Universal Declaration of Ethical Principles for Psychologists* speaks to the common moral framework that guides and inspires psychologists worldwide toward the highest ethical ideals in their professional and scientific work. Psychologists recognize that they carry out their activities within a larger social context. They recognize that the lives and identities of human beings both individually and collectively are connected across generations, and that there is a reciprocal relationship between human beings and their natural and social environments. Psychologists are committed to placing the welfare of society and its members above the self-interest of the discipline and its members. They recognize that adherence to ethical principles in the context of their work contributes to a stable society that enhances the quality of life for all human beings.

The objectives of the *Universal Declaration* are to provide a moral framework and generic set of ethical principles for psychology organizations worldwide: (a) to evaluate the ethical and moral relevance of their codes of ethics; (b) to use as a template to guide the development or evolution of their codes of ethics; (c) to encourage global thinking about ethics, while also encouraging action that is sensitive and responsive to local needs and values; and (d) to speak with a collective voice on matters of ethical concern.

The *Universal Declaration* describes those ethical principles that are based on shared human values. It reaffirms the commitment of the psychology community to help build a better world where peace, freedom, responsibility, justice, humanity, and morality prevail. The description of each principle is followed by the presentation of a list of values that are related to the principle. These lists of values highlight ethical concepts that are valuable for promoting each ethical principle.

The *Universal Declaration* articulates principles and related values that are general and aspirational rather than specific and prescriptive. Application of the principles and values to the development of specific standards of conduct will vary across cultures and must occur locally or regionally in order to ensure their relevance to local or regional cultures, customs, beliefs, and laws.

The significance of the *Universal Declaration* depends on its recognition and promotion by psychology organizations at national, regional and international levels. Every psychology organization is encouraged to keep this *Declaration* in mind and, through teaching, education, and other measures to promote respect for, and observance of, the *Declaration*'s principles and related values in the various activities of its members.

Principle I

RESPECT FOR THE DIGNITY OF PERSONS AND PEOPLES

Respect for the dignity of persons is the most fundamental and universally found ethical principle across geographical and cultural boundaries, and across professional disciplines. It provides the philosophical foundation for many of the other ethical principles put forward by professions. Respect for dignity recognizes the inherent worth of all human beings, regardless of perceived or real differences in social status, ethnic origin, gender, capacities, or other such characteristics. This inherent worth means that all human beings are worthy of equal moral consideration.

All human beings, as well as being individuals, are interdependent social beings that are born into, live in, and are a part of the history and ongoing evolution of their peoples. The different cultures, ethnicities, religions, histories, social structures and other such characteristics of peoples are integral to the identity of their members and give meaning to their lives. The continuity of peoples and cultures over time connects the peoples of today with the peoples of past generations and the need to nurture future generations. As such, respect for the dignity of persons includes moral consideration of and respect for the dignity of peoples.

Respect for the dignity of persons and peoples is expressed in different ways in different communities and cultures. It is important to acknowledge and respect such differences. On the other hand, it also is important that all communities and cultures adhere to moral values that respect and protect their members both as individual persons and as collective peoples.

THEREFORE, psychologists accept as fundamental the Principle of Respect for the Dignity of Persons and Peoples. In so doing, they accept the following related values:

(a) respect for the unique worth and inherent dignity of all human beings;

(b) respect for the diversity among persons and peoples;

(c) respect for the customs and beliefs of cultures, to be limited only when a custom or a belief seriously contravenes the principle of respect for the dignity of persons or peoples or causes serious harm to their well-being;

(d) free and informed consent, as culturally defined and relevant for individuals, families, groups, and communities;

(e) privacy for individuals, families, groups, and communities;

(f) protection of confidentiality of personal information, as culturally defined and relevant for individuals, families, groups, and communities;

(g) fairness and justice in the treatment of persons and peoples.

Principle II

COMPETENT CARING FOR THE WELL-BEING OF PERSONS AND PEOPLES

Competent caring for the well-being of persons and peoples involves working for their benefit and, above all, doing no harm. It includes maximizing benefits, minimizing potential harm, and offsetting or correcting harm. Competent caring requires the application of knowledge and skills that are appropriate for the nature of a situation as well as the social and cultural context. It also requires the ability to establish interpersonal relationships that enhance potential benefits and reduce potential harm. Another requirement is adequate self-knowledge of how one's values, experiences, culture, and social context might influence one's actions and interpretations.

THEREFORE, psychologists accept as fundamental the Principle of Competent Caring for the Well-Being of Persons and Peoples. In so doing, they accept the following related values:

(a) active concern for the well-being of individuals, families, groups, and communities;

(b) taking care to do no harm to individuals, families, groups, and communities;

(c) maximizing benefits and minimizing potential harm to individuals, families, groups, and communities;

(d) correcting or offsetting harmful effects that have occurred as a result of their activities;

(e) developing and maintaining competence;

(f) self-knowledge regarding how their own values, attitudes, experiences, and social contexts influence their actions, interpretations, choices, and recommendations;

(g) respect for the ability of individuals, families, groups, and communities to make decisions for themselves and to care for themselves and each other.

Principle III

INTEGRITY

Integrity is vital to the advancement of scientific knowledge and to the maintenance of public confidence in the discipline of psychology. Integrity is based on honesty, and on truthful, open and accurate communications. It includes recognizing, monitoring, and managing potential biases, multiple relationships, and other conflicts of interest that could result in harm and exploitation of persons or peoples.

Complete openness and disclosure of information must be balanced with other ethical considerations, including the need to protect the safety or confidentiality of persons and peoples, and the need to respect cultural expectations.

Cultural differences exist regarding appropriate professional boundaries, multiple relationships, and conflicts of interest. However, regardless of such differences, monitoring and management are needed to ensure that self-interest does not interfere with acting in the best interests of persons and peoples.

THEREFORE, psychologists accept as fundamental the Principle of Integrity. In so doing, they accept the following related values:

(a) honesty, and truthful, open and accurate communications;

(b) avoiding incomplete disclosure of information unless complete disclosure is culturally inappropriate, or violates confidentiality, or carries the potential to do serious harm to individuals, families, groups, or communities;

(c) maximizing impartiality and minimizing biases;

(d) not exploiting persons or peoples for personal, professional, or financial gain;

(e) avoiding conflicts of interest and declaring them when they cannot be avoided or are inappropriate to avoid.

Principle IV

PROFESSIONAL AND SCIENTIFIC RESPONSIBILITIES TO SOCIETY

Psychology functions as a discipline within the context of human society. As a science and a profession, it has responsibilities to society. These responsibilities include contributing to the knowledge about human behavior and to persons' understanding of themselves and others, and using such knowledge to improve the condition of individuals, families, groups, communities, and society. They also include conducting its affairs within society in accordance with the highest ethical standards, and encouraging the development of social structures and policies that benefit all persons and peoples.

Differences exist in the way these responsibilities are interpreted by psychologists in different cultures. However, they need to be considered in a way that is culturally appropriate and consistent with the ethical principles and related values of this *Declaration*.

THEREFORE, psychologists accept as fundamental the Principle of Professional and Scientific Responsibilities to Society. In so doing, they accept the following related values:

(a) the discipline's responsibility to increase scientific and professional knowledge in ways that allow the promotion of the well-being of society and all its members;

(b) the discipline's responsibility to use psychological knowledge for beneficial purposes and to protect such knowledge from being misused, used incompetently, or made useless;

(c) the discipline's responsibility to conduct its affairs in ways that are ethical and consistent with the promotion of the well-being of society and all its members;

(d) the discipline's responsibility to promote the highest ethical ideals in the scientific, professional and educational activities of its members;

(e) the discipline's responsibility to adequately train its members in their ethical responsibilities and required competencies;

(f) the discipline's responsibility to develop its ethical awareness and sensitivity, and to be as self-correcting as possible.

NOTE

1 Reproduced with permission. The original can be found at: https://iaapsy.org/site/assets/files/1057/ethical_principles_for_psychologists.pdf

APPENDIX C

Remembering Dr. Jean Linse Dixon Pettifor (1922–2015)

Dr. Jean Pettifor
in the Fall of 2015.
Photograph courtesy
of Ivana Djuraskovic.

> *"Do not go where the path may lead, go instead where there is no path and leave a trail."*
>
> Ralph Waldo Emerson

This book is dedicated, with admiration and much gratitude, to the memory of Dr. Jean Pettifor, who had an exceptional impact on psychological ethics in Canada and around the world. Jean inspired the thinking of many about ethics, psychology, and the importance of striving for a better world. Following Emerson's advice, she forged many new trails and had the graciousness and wisdom to invite many students and colleagues to join her in forging these trails. Her legacy is something for which we always will be grateful.

Jean's Story

FAMILY BEGINNINGS

Jean's life story started on 14 October 1922 in Scott, Saskatchewan, where she was born to Sophia Hansine and Charles Herbert Dixon. She was the oldest of four children. Her father was a successful farmer and her mother, who had emigrated from Denmark to Kerrobert, Saskatchewan in 1911, was a schoolteacher who became an active and strong advocate for causes impacting women and farmers. Sophia was a progressive thinker, a prolific writer, a political activist, an associate of the *Famous Five*,[1] and a friend of Agnes Macphail.[2] In 1979, Sophia's work earned her the Governor-General's Persons Award for her contributions to supporting women living in rural areas and to the farmers' cooperative movement. Biographies of Sophia have been written, and her ideas have been the source of inspiration to many people. This includes Elaine Orvedahl Hemm, who, with the direct support of Sophia, wrote her master's thesis on "The Ideas of Sophia Dixon" (1987). Growing up and seeing her mother deeply involved in social justice issues influenced Jean's way of understanding the world.

The Importance of Education

Jean during her early years as a teacher. Unknown photographer.

Not attending university was not an option for Jean or her siblings. Her mother, who worked as a domestic while learning English after immigrating to Canada and later trained as a teacher, understood the value of education. In 1946, when two of her children were finishing their bachelor's degrees while the other two were finishing their master's degrees, Sophia enrolled in university to work towards her own bachelor's degree.

An expectation of higher education was not a problem for Jean. She loved learning. She graduated with a Bachelor of Arts (with Distinction) in English and history from the University of Saskatchewan in 1944 and a Bachelor of Education from the University of Alberta in 1946. Throughout her studies, Jean also worked. Between 1942 and 1946, she taught high-school students in rural areas of Alberta (e.g., Buffalo, which is now considered a ghost town). Eventually, she added the role of assistant principal to her duties. She then attended the University of Alberta, where she graduated in 1948 with two master's degrees—one in English and another in educational psychology. That same year, she began working as a psychologist at the Alberta Guidance Clinic (in Edmonton until 1961 and then in Calgary), where she travelled from school to school conducting psychoeducational assessments of children.

Several years later, wanting to advance her studies further, Jean decided to pursue a doctoral degree. To do this, she needed to request financial support and an educational leave from the Alberta government (which ran the Child Guidance Clinics). At the time, the rules for women wishing to engage in advanced education were different than today. In Jean's own words:

> I found out later that I was given a government bursary because I was considered too old to marry and therefore could be depended on to provide return of service for the rest of my working life. Contrary to expectations, I did marry and had two children, which was considered the ultimate betrayal. I had to fight to keep my job in order to give another 28 years of service, and I struggled to get my pension reinstated because at that time married women could not pay into the pension fund unless they had a medical certificate to prove that their husbands were too disabled to support them. There were conflicting views on the nature of professional training as well as on the proper and natural role for women (Pettifor, 2004, p. 12).

In 1964, Jean graduated from Wayne State University in Detroit, where she earned her doctoral degree in psychology with a minor in education. By that time, she had married Richard Pettifor in 1961 at the age of 39, had given birth to her son Eric[3] in 1962, and was within a month or two of delivering her daughter Betty when she defended her dissertation in 1964.

Love of Teaching

Jean was a teacher at heart. She began teaching at the University of Calgary in 1967. She also taught as an adjunct professor at the Universities of Athabasca, Gonzaga, Lethbridge, and Saskatchewan. Her early courses were quite traditional—for instance, clinical psychology, personality, educational psychology, and community psychology. However, beginning in the late 1980s and early 1990s, her teaching became almost exclusively graduate-level courses in ethics and professional issues. Students were intrigued both by her personality and her approach to her courses on these topics. Jean's main message throughout her life was that ethical decisions and behaviours should be based primarily not on "rules" but on a deep respect and caring for all human beings. Rather than emphasizing the "rules" of the profession, she taught students to understand their and others' values, to respond to and think through the many stories and vignettes she used in her teaching, to explore what it means to be ethical, and to reflect on what ethics means to establishing a more just and peaceful world.

Reluctantly, Jean stopped being an adjunct professor at the University of Calgary in 2012, at the age of 90. This did not stop her, as she had found many other opportunities to share her knowledge and wisdom, and this continued after 2012 and into her 90s. Over her lifetime, Jean provided supervision to 37 graduate students (e.g., independent studies, theses, dissertations, and comprehensive examinations), authored over 249 peer-reviewed articles, many in collaboration with colleagues, was an investigator in 19 research projects, delivered over 500 presentations at national and international conferences, and provided consultation to anyone who asked.

Dedication to the Discipline and Profession of Psychology

In addition to her teaching and writing, and many local, national, and international presentations, Jean was highly active as a psychologist, both through her employment and her involvement with organized psychology. Further to her work at the Child Guidance clinics in Edmonton and Calgary, she was employed by the Alberta Mental Health Services as a director/consultant of Children's Services and later as a regional director. Between 1982 and 1989, Jean worked with the Alberta Social Services and Community Health in Calgary in a supervisory role. Throughout these years, Jean influenced countless lives. She had so much to offer, and she did.

In 1958, Jean became a member of the Psychologists Association of Alberta where she held various roles, including secretary treasurer, editor and president. A member of the Canadian Psychological Association (CPA) since 1952, she was active in the CPA's Applied Division in the 1970s. Over the years, she also held roles on the executive of several CPA sections and chaired or co-chaired several

CPA standing committees. With her special overriding interest in ethics, she was a key member of the CPA Committee on Ethics from 1980 until the time of her passing in 2015, serving as its co-chair from 1989 to 1993. In the early 1980s, Jean played an integral mentorship role with the Committee, led by Dr. Carole Sinclair (Chapter 16), and participated in the development of the *Canadian Code of Ethics for Psychologists*.[4] Once the *Canadian Code* was approved, she co-authored the *Companion Manual* to the *Code* with Carole, beginning with the second edition (1992). She joined the CPA Board of Directors and became its president in 1994. In addition, she spearheaded several sets of ethical guidelines for psychologists, including guidelines for counselling and therapy with women, non-discriminatory practice, and supervision. She presented at the CPA Convention between 1972 and 2015—never missed a year. In 2003, in recognition of her many contributions to CPA and to the field of psychology, Jean was awarded the CPA Gold Medal for Distinguished Lifetime Contributions to Canadian Psychology.

Further to her involvement at the local and national levels, Jean also forged new trails at the international level. The *Canadian Code of Ethics for Psychologists*, from its first edition in 1986, captured the imagination of several countries and there was interest in hearing more about it. Invitations began to appear to present information about the *Canadian Code* at international congresses. Jean jumped at the opportunity. She strongly believed in the importance and power of ethical dialogue in meeting the global psychology community's responsibility to do everything it can to ensure ethical behaviour by its members and to play its part in helping the world become a better and more peaceful place. So, beginning in 1995, Jean and Carole began attending at least one international congress every year, meeting and forging relationships with psychologists from around the world who had an interest in ethics. They worked hard over the following two decades, along with other international leaders in psychological ethics, to ensure that each international congress included multiple symposia and/or workshops on ethics, with presenters from different countries and cultures. Jean's inveterate organizing ability was a key component in the success of these efforts.

One important and major international event in which Jean was involved was the development of the *Universal Declaration of Ethical Principles for Psychologists*. She provided ongoing support and advice to Dr. Janel Gauthier (Chapter 21), who chaired the working group responsible for the development of the *Declaration*. In 2013, in recognition of her two decades of international contributions, Jean received the Wilhelm Wundt-William James Award for her exceptional contributions to transatlantic psychology. Although Jean was very appreciative of all the awards she received in her lifetime, including the Queen's Golden Jubilee Medal in October 2002, she was particularly proud of this one. Her Wilhelm Wundt-William James Award was the only one she hung on her living room wall, rather than in her office.

Important to note is the fact that being involved internationally did not interfere with Jean's local contributions. Between 1997 and 2010, she held several roles in the College of Alberta Psychologists, including president, member-at-large, and chair of various committees. Her energy level defied all expectations.

Jean's Legacy

Jean died peacefully in Calgary on Sunday, 8 November 2015. She often had said she wanted to live forever as there was still so much work to do. In many ways, she met this goal, in so far as she left a wonderful legacy that will continue to inspire and influence our thinking about ethics and psychology for a long time to come.

Jean taught that, with passion, hard work, persistence, kindness, humility, grace, and wisdom, there is nothing worth doing that cannot be accomplished. She also taught that when people come together to work on a shared goal, peace, justice, freedom, and humanity can prevail. Jean is as much an integral part of this book as the authors who contributed to it. In her honour, all proceeds from the sale of this book will be donated to the scholarship she created, the Dr. Jean and Dick Pettifor Scholarship Fund. It was her wish that this fund be established to support graduate students conducting research in the area of ethics, especially research with a focus on diversity. More importantly, Jean wished for every psychologist to continue to engage actively in ethical thinking and dialogue. Through her work, her teaching, her support of so many during her lifetime, and the Dr. Jean and Dick Pettifor Scholarship Fund, Jean continues to live on.

Jean in 2014 at the Rodin Museum in Paris, France.
Photograph courtesy of Carole Sinclair.

NOTES

1 The *Famous Five* included Judge Emily Murphy, Henrietta Edwards, Nellie McClung, Louise McKinney, and Irene Parlby. All from Alberta, they were highly active in promoting women's rights. In 1928, the Supreme Court of Canada ruled that women were not "persons"; therefore, they were not eligible for appointment to the Senate. The *Famous Five* challenged this ruling and, in 1929, the Judicial Committee of the Privy Council reversed the Court's decision, The *Persons Case*, as it was called, enabled women to be members of the Senate.

2 Agnes Macphail was the first female member of parliament in Canada.

3 Eric's legal name is now Deimon Slagg.

4 Information about the development process of the *Canadian Code of Ethics for Psychologists* is provided in chapter 16 of this volume.

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Contributor Biographies

JAQI ALLAN, MSW, has lived and worked on both the west and east coasts but put down roots in southwestern Nova Scotia. Serving her clients in both public and private mental health practices is a passion that allows her to advocate for equality, diversity, and inclusive services. She is a registered clinical social worker and contributes to her profession by sitting on several governance boards and committees at the provincial level, offering supervision and mentorship to new clinicians, and supporting colleagues. When not working, Ms. Allan enjoys walking the beaches at low tide, viewing the ever-changing sunsets, and discovering the wonders of rural Nova Scotia.

JON K. AMUNDSON, PhD, has been a psychologist in independent practice in Calgary since 1980, and also has a master's degree in public policy. Aside from direct service to patients, he has been an expert witness in criminal and civil matters, as well as for professional tribunals. He has taught, supervised, written, and published professionally. As well, he has been a senior/master's member of several world championship Polynesian canoe teams and has paddled these canoes across most of the Hawaiian Island channels. Dr. Amundson is grateful for the opportunity at his advancing age to still have the opportunity to speak, write, and act on behalf of professional psychology.

CAROL ARTHURS, MA, is a school psychologist in rural Nova Scotia. She works in the education system and owns a small private practice. A commitment to professional learning led her to also earn an MEd in Curriculum Studies and a certificate in applied behaviour analysis. Ms. Arthurs is passionate about supporting the diverse needs of students, families, and educators, and is an advocate for inclusive practices and equity.

NICOLE AUBÉ, PhD, has over 40 years' experience in forensic and clinical psychology. Over the last 15 years, she completed eight missions with Médecins Sans Frontières (Doctors without Borders) in Russia, Congo, South Africa, Haiti, the Central Republic of Africa, and Papua New Guinea. She has served as a board member with Doctors without Borders Canada, the Canadian Psychological Association, the College of Psychologists of British Columbia, the British Columbia Psychological Association, and le Centre Culturel de Vancouver. Dr. Aubé has received awards for her humanitarian work from both the British Columbia Psychological Association and the Canadian Psychological Association.

NORA BABIN, BA, lives in rural Nova Scotia with her husband and their fur babies. She enjoys spending time in nature, gardening, and growing her own vegetables. As a graduate in community studies, she has worked with individuals diagnosed with developmental disabilities for over 15 years in a health care setting. She plans to further her education by pursuing a variety of specialized interests. Ms. Babin passionately believes that everyone has the right to be treated equally, fairly, and with respect and dignity.

ANNE BARNFIELD, PhD, is an associate professor of psychology at Brescia University College at Western University in London, Ontario. She is a member of several organizations, including the Canadian Therapeutic Riding Association's Equine-Facilitated Wellness committee, the International Association of Human Animal Interaction Organizations Research Group, and the Horses in Education and Therapy International Ethics Task Force and their Research and Education committee. Her current research focus is on psychological aspects of equine-assisted/facilitated activities, including therapeutic riding and psychotherapy for treatment of anxiety and post-traumatic stress disorder. Dr. Barnfield volunteers at the local therapeutic riding centre, practices karate, and rides her horse, Lilliput. She lives with her husband, Richard, and their cat Chinthe.

STAN BIRD, PhD, is an Anishinaabe from Peguis First Nation. His father is Anishinaabe and his mother is nêhiyaw from the community of Ochekwi-Sipi. He graduated from high school in Peguis First Nation and received an undergraduate degree from the University of Manitoba. Since the completion of an MSc in school and community psychology in 1997, Dr. Bird has spent his entire career in Manitoba First Nations schools and communities. He obtained a PhD in applied psychology from the University of Calgary in 2009, and views culture as foundational to his work and the primary lens in the assessment of learning.

M. A. SUZIE BISSON, PhD, is a registered counselling psychologist who owns a small solo private practice in Alberta. Dr. Bisson has over 20 years of experience working with children and adults impacted by trauma. She is also a veteran of the Canadian military, which she joined at the age of 17 and retired from at the age of 26. Like many, Dr. Bisson greatly values the time she spent with Dr. Jean Pettifor, including the honour of having learned from her wisdom, being involved in every aspect of the realization of this book, and of being by Jean's side at the moment of her passing.

SHANNON D. BOYCE, DVM, is a small animal and former equine veterinarian who, along with her business partner, opened her own veterinary clinic in the spring of 2015. She is a member of several organizations, including the

Nova Scotia Veterinary Medical Association, the Canadian Veterinary Medical Association, and the American Association of Equine Practitioners. Dr. Boyce enjoys volunteering with the local therapeutic riding program when they host fun shows, helping animals in need, and riding and competing with her Quarter Horses, Luke, Abby, and Marti. She lives with her husband, Steven, on a hobby farm with their dogs, cats, horses, and goats.

JEFF CHANG, PhD, is a registered psychologist with additional certifications in couple and family therapy (CFT). He is a professor of counselling at Athabasca University. Dr. Chang also teaches in the University of Calgary's CFT certificate (Faculty of Social Work) and in the Werklund School of Education. He provides psychological services in family law matters, supervises provisional psychologists, consults on supervision and ethical issues, and directs psychological services at a special education school. Dr. Chang writes and presents internationally on high-conflict divorce, child and family intervention, and clinical supervision and wrote and curates the Psychologists' Association of Alberta's online supervision course.

BRIAN CHARTIER, PhD, is a professor emeritus of psychology at St. Thomas More College, University of Saskatchewan. He has published articles in *International Journal of Indigenous Health; Omega: Journal of Death and Dying, Illness, Crisis and Loss; Canada's Mental Health;* and the *Saskatchewan Medical Journal.* He is a registered doctoral psychologist who is currently in private practice in Saskatoon. Dr. Chartier has taught a variety of undergraduate courses, including the psychology of dying and death. He also taught graduate courses in psychological assessment and professional ethics.

IVANA DJURASKOVIC, PhD, is a registered psychologist in Calgary, Alberta. She works in a mental health clinic and a private practice, and teaches at a graduate level. Dr. Djuraskovic's area of expertise is multicultural counselling, namely counselling refugees and immigrants. Her graduate research focused on acculturation and ethnic identity reconstruction in refugees and the experiences of refugee women in counselling. Her additional interests include acceptance-commitment therapy, trauma, grief and loss, Indigenous-focused counselling, social justice, and ethics. In her free time, Dr. Djuraskovic enjoys spending time with her family, riding motorcycles, painting, and compulsively reading.

MICHELLE ARLENE DREFS, PhD, is a school psychologist and associate professor with the University of Calgary's School and Applied Child Psychology program. Her background includes previous experience as an early elementary educator, where she spent the majority of her career as a grade K4 instructor with the

Dene Tha' First Nation in Chateh, Alberta. Her research focuses on investigating the impact of intergenerational (IG) programming on students' social-emotional well-being, exploring childhood bereavement and grief, and studying clinical decision-making.

E. AIOFE FREEMAN-CRUZ, PhD, acquired supervised training in family therapy at Calgary Family Therapy Centre and completed a CPA-accredited pre-doctoral internship at the University of Manitoba Student Counselling Centre, gaining further supervised training in individual and couple therapy. Since completing her doctorate in counselling psychology, she has deepened her interest in individual, couple, and family therapy, with a special interest in the experiences and challenges of clients with diverse and intersecting identities. Presently, Dr. Freeman-Cruz works as a psychologist in Calgary, Alberta, in a community agency and private practice where she applies her systemic lens in therapy and clinical supervision.

JOAQUÍN GAETE-SILVA, PhD, is a registered psychologist in Alberta, and an adjunct assistant professor at the University of Calgary (Cumming School of Medicine and Werklund School of Education). He is the director of the Calgary Family Therapy Centre, where he also practices family therapy and clinical supervision. He is interested in therapy as a vehicle to promote social justice through relational well-being. He is the former director of Centro de Estudios y Atención a las personas (CEAP, Universidad Adolfo Ibáñez, Chile). His practice and research are informed by cultural psychology, with a focus on interpersonal conflict, problematic disruptive behaviour, change process, and clinical supervision.

JANEL GAUTHIER, PhD, is professor emeritus of psychology at Laval University in Québec, chair of the Committee on Ethics of the Canadian Psychological Association (CPA), and a former president of the CPA and the International Association of Applied Psychology (IAAP). He was a close colleague of Dr. Jean Pettifor for over 25 years. He has over 200 scientific and professional publications. Dr. Gauthier was the instigator and leader of the development of the *Universal Declaration of Ethical Principles for Psychologists*. He has received numerous awards for his distinguished contributions to the international advancement of psychology and ethics, and to education and training in psychology.

SYBIL GELDART, PhD, holds a bachelor of arts degree from the University of Waterloo, a master of arts from Western University, and a PhD from McMaster University. She is an associate professor of psychology at Wilfrid Laurier University in Ontario and serves as vice-chair of the university's Research Ethics Board. She is also a registered psychologist with the College of Psychologists of

Ontario. Both in her teaching and clinical practice, Dr. Geldart equips adults and young people with a toolbox of coping and life skills to help deal with the stressors we all face at work and school.

SHELLEY L. GOODWIN, PhD, is a registered psychologist and has a rural solo practice in Nova Scotia. She is a practitioner-scholar who enjoys the opportunity to serve the profession, and has held governance positions in provincial, national, and international psychology organizations. Her varied interests are reflected in the chapters she has co-authored in this book. She is a retired police officer and aspiring equestrian. Writing is a passion and has included journalling peer-reviewed articles in journals, and freelance articles in national magazines. She enjoyed sharing her writing experience for this book with so many intellectually stimulating and thoughtful colleagues.

PAULETTE HUNTER, PhD, works and lives on Treaty 6 Territory and the homeland of the Métis. She is an associate professor in the Department of Psychology at St. Thomas More College, University of Saskatchewan, where her research considers topics such as disability, personhood, and social inclusion; the nature of relationships among people who give and receive care; how organizations and families negotiate their caring roles; and what contributes to optimal quality in health care. She has worked as a clinical psychologist in long-term care and rehabilitation contexts. She teaches about psychology, aging, and applied ethics. Dr. Hunter enjoys reflecting on opportunities to be more ethically responsive across settings and career stages.

REBECCA LALONDE, MEd, is a registered psychologist from Saskatoon, Saskatchewan currently living on the traditional, ancestral, and unceded lands of the xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish), and səlilwətaɬ (Tsleil-Waututh) Nations. In the time since this chapter was written, Ms. Lalonde has moved into fully licensed practice and has worked alongside people living in long-term care homes, children, and students. Having served as a psychologist in Saskatchewan, Québec, and British Columbia, Ms. Lalonde is grateful for the gifts of wisdom shared by clients and colleagues whose lived experience brings a deeper appreciation for ethics in practice across Canada.

JESSICA LAMBERT, BN, is a registered nurse working in a rural-based intensive-care unit in Yarmouth, Nova Scotia. She completed her bachelor of nursing degree at Memorial University in Newfoundland. Always interested in adult education, Ms. Lambert has been a teacher's assistant at Dalhousie University School of Nursing (Yarmouth Site) and is pursuing her master of nursing degree.

TOUPEY LUFT, PhD., is a registered psychologist and a counsellor educator at the University of Lethbridge. Her lived experience as a teenager attending family therapy led her on the path to becoming a psychologist. Dr. Luft was a student of Dr. Jean Pettifor during her graduate training. She also had the opportunity to travel to South Africa with Jean as part of a Canadian psychologists' delegation. She is passionate about teaching others to become ethical practitioners and has been nominated for the Psychologists' Association of Alberta (PAA) Teaching Award (2017 and 2018) and the PAA Clinical Supervision Award (2019 and 2021).

LISA MACNAUGHTON-DOUCET, MN, is a registered nurse and an adjunct assistant professor at Dalhousie University School of Nursing in Nova Scotia. She teaches primarily population and community health in undergraduate nursing education. Interprofessional collaboration has been a foundation in her professional role as a nurse educator. Ms. MacNaughton-Doucet's scholarly interests include community health nursing and publications related to persons diagnosed with dementia and those with developmental disabilities.

JUDI L. MALONE, PhD, is a registered psychologist in Alberta, Australia, and Ireland. She is the CEO of the Psychologists' Association of Alberta, where she has gained extensive experience collaborating to strengthen the role and profile of psychology and access to psychological services for Albertans. Dr. Malone also has a wealth of scientist-practitioner experience from clinical practice, academic roles, and research. She has expertise in working with disadvantaged populations, and her clinical interests are trauma, the neurobiology of addictions, and professional ethics in rural and small communities. Dr. Malone is an adjunct professor at the University of Alberta and at Charles Sturt University.

LINDA M. MCMULLEN, PhD, is professor emerita of psychology at the University of Saskatchewan. She is the author of *Essentials of discursive psychology*; co-author (with Frederick Wertz, Kathy Charmaz, Ruthellen Josselson, Rosemarie Anderson, and Emalinda McSpadden) of *Five ways of doing qualitative analysis: Phenomenological psychology, grounded theory, discourse analysis, narrative research, and intuitive inquiry*; and co-editor (with Janet Stoppard) of *Situating sadness: Women and depression in social context*. Dr. McMullen's recent journal publications include discursive analyses of service providers' and service users' accounts of depression and the use of antidepressants.

ANNIK MOSSIÈRE, PhD, is an adjunct assistant professor at the Werklund School of Education, University of Calgary. She is also a registered psychologist in Calgary, specializing in clinical and forensic psychology, with specific research and clinical interests in the areas of trauma, justice-involved persons, first responders, and ethical decision making. Dr. Mossière has worked clinically in various third-party contexts over the years, including the Alberta Workers' Compensation Board, Saskatchewan Government Insurance, provincial and federal courts, and Veterans Affairs Canada.

HEATHER C. POWER, MSc, was born and raised in Nova Scotia where she has practiced as a clinical and forensic psychologist in both private and public healthcare settings. Her passion for the field of psychology has led her to sit on numerous boards and committees related to mental health advocacy and governance of the profession. She particularly enjoys consulting with colleagues on ethical matters and takes every opportunity available to expand her knowledge and skills in mental health service provision. She can often be found reading a book, with a dog in her lap and a cup of coffee in hand.

MAHDI QASQAS, PhD, is a father of four and a psychologist with a PhD in social work. He embarked on his "helper" trajectory over 20 years ago, an experience that has shaped the architecture and design of Psycho-Spiritual First Aid®—a mental health consultation framework to guide the development of culturally adapted and localized evidence-based practices. His current research, training, and passion revolve around "helping the helpers," particularly in supervising future mental health professionals and developing Islamic Counselling Psychology.

MARC ROSS, PhD, is a registered psychologist in Alberta who specializes in the areas of evolutionary psychology and integral studies. He has worked extensively with biofeedback and hypnosis in his practice, and also has had invaluable experience in research, teaching, and writing. Having worked with many adolescents, couples, and families over the years, he is affectionately referred to as "Dr. Wheelz" by some teens. Given his personal experience with quadriplegia, he also helps people adapt to chronic pain, disability, and physical injury.

RANDI L. SAGER, MA, is First Nations (Dakota/Saulteaux/Nêhiyaw/Métis) and German and Scottish from Okotoks, Alberta. She belongs to the Muscowpetung Saulteaux Nation Reserve in Fort Qu'Appelle, Saskatchewan. She is an Indigenous registered psychologist who works from an Indigenous perspective. She provides Indigenous counselling and creates a safe place for clients to heal in a way that they want to heal. She works from a holistic approach that integrates Indigenous ways of being and knowing and psychology. She received her master's in counselling psychology from City University of Seattle and her traditional education from Elders, Knowledge Holders, and Community Members.

INÉS SAMETBAND, PhD, is an assistant professor in the Department of Psychology at Mount Royal University in Alberta. She is a registered marriage and family therapist (AAMFT) and former clinical supervisor at the Centro de Educación y Atención a las Personas (CEAP, Chile). Dr. Sametband's scholarly and professional work is informed by discursive and collaborative approaches, and she is interested in how people make relevant preferred cultural discourses in their therapy conversations, and how therapists manage these conversations in ways that recognize and include all cultural background(s).

MEADOW SCHROEDER, PhD, received her doctorate in school psychology from the University of Calgary. She is a registered school psychologist and associate professor with the University of Calgary's School and Applied Child Psychology program. She is the former academic coordinator for a First Nations-only cohort of a masters of education in School and Applied Child Psychology program. Her research interests include the well-being of students with disabilities transitioning to post-secondary school.

DALAL SHAHEEN, MSc, is a registered psychologist in Alberta whose work over the years extends to multidisciplinary settings in different regions of the world, including Canada, USA, Egypt, and UK. She has worked with various client groups presenting with a wide variety and severity of mental health concerns and diagnoses. She has extensive experience in refugee mental health and in training provision. She also specializes in dialectical behaviour therapy, and in group development and implementation. Ms. Shaheen's experiences have given her an international and a multicultural perspective, which she uses in her clinical and professional work.

CAROLE SINCLAIR, PhD, is a retired clinical child psychologist and works as an independent scholar in the Toronto, Ontario, area. She is a member and past chair of the Committee on Ethics of the Canadian Psychological Association and led the development of the original *Canadian Code of Ethics for Psychologists* and its three subsequent revisions. She was an associate of Dr. Jean Pettifor for over 40 years and has presented and published extensively on ethics (often with Dr. Pettifor). Dr. Sinclair's particular focus is on ethical reasoning and decision making, the history of ethical principles across cultures and time, and supervision ethics.

NAN STEVENS, EdD, experienced the loss of three family members to cancer over a period of five years. This brought her to art therapy to help resolve her grief. The art therapy experience was so profound that she completed a graduate diploma in art therapy and opened her own practice. In addition, Dr. Stevens' life work focuses on advancing innovative practices for preparing teachers to be effective inclusive educators. She is the mother of a child with high needs, a teacher, a post-secondary educator, a scholar, a community advocate, and a writer. This unique combination has established Dr. Stevens as a social change agent on local, provincial, national, and international stages.

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Psychologists face ethical and cultural intricacies in their work on a daily basis. Psychology graduate training and continuing education programs often focus mainly on common ethical issues and mainstream psychological services and settings. Although this provides a wealth of valuable information, it is also necessary to look beyond the usual and mainstream.

Ethics in Action brings together thirty-four psychologists and eight collaborating professionals from allied disciplines, including nursing, social work, emergency services, and veterinary medicine, to share wisdom gained from facing ethical questions in real-world practice. These knowledgeable contributors share their experiences working with new Canadians, religious minorities, Indigenous communities, and more. They address issues of self-care, teamwork, collaboration, and interprofessional practice. They share the challenges that can arise when working within long-term care facilities, rural settings, equine-therapy settings, academia, and with people in unique circumstances.

Structured around the four ethical principles that form the *Canadian Code of Ethics for Psychologists*, this book goes far beyond the basics, building awareness of the many complex and varied ethical issues practitioners may face. Each chapter includes reflection questions, challenging readers to better understand themselves and to prepare them to respond to complicated situations from an ethical perspective.

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