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### Psychology's Struggle to Locate a Moral Vision in a Value-Neutral Framework: A Hermeneutic Perspective on Standard 3.05 of the APA Ethics Code

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PSYCHOLOGY'S STRUGGLE TO LOCATE A MORAL VISION IN A VALUE-NEUTRAL  
FRAMEWORK: A HERMENEUTIC PERSPECTIVE ON STANDARD 3.05 OF THE APA  
ETHICS CODE

A Dissertation

Presented to the Faculty of  
Antioch University Seattle  
Seattle, WA

In Partial Fulfillment  
of the Requirements of the Degree  
Doctor of Psychology

By  
Tammera M. Cooke  
November 2017

PSYCHOLOGY'S STRUGGLE TO LOCATE A MORAL VISION IN A VALUE-NEUTRAL  
FRAMEWORK: A HERMENEUTIC PERSPECTIVE ON STANDARD 3.05 OF THE APA  
ETHICS CODE

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Seattle at Seattle, WA in partial fulfillment of requirements for the degree of

DOCTOR OF PSYCHOLOGY

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## ABSTRACT

PSYCHOLOGY'S STRUGGLE TO LOCATE A MORAL VISION IN A VALUE-NEUTRAL  
FRAMEWORK: A HERMENEUTIC PERSPECTIVE ON STANDARD 3.05 OF THE APA  
ETHICS CODE

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This research followed hermeneutic tradition by examining what is often unquestioned in clinical practice as it pertains to the moral, political, and philosophical foundations that underlie the American Psychological Association's (APA) *Ethical Principles of Psychologists and Code of Conduct* (2002, 2010) and Standard 3.05, Multiple Relationships—it's meanings and controversies. It did so in order to better understand the cultural influences reflected in and the political consequences that emanate from the Ethics Code. Data for this study were collected via semi-structured qualitative interviews with two American psychologists who lived in Washington State, experienced living and working in rural communities, and had practiced with patients from cultures other than their own. This process generated ideas about the larger picture of the social landscape in which the participants and psychotherapy in general are embedded. The interpretive method of analysis proposed by hermeneutic researchers Leonard (1993), Plager (1994), and Stigliano (1989), was used to identify key themes that arose from the data. Three over-arching themes were derived: Participants' confused, anxious, and fearful reactions to Standard 3.05; Problems with the Ethics Code; and Defenses the Participants' enacted to protect against their conflicts and fears. By abstracting from the themes and case-studies, two broad conclusions emerged. First, the authors and interpreters of the APA Ethics Code seem to have

understated the influences of other cultures, traditions, and various ethnic understandings that run counter to Western ideas about individualism and communalism and small town/rural life.

Second, the interviews contained material that indicated the proceduralism present in mainstream psychology is an impediment to a better understanding of moral issues, relational processes, and thus ethical outcomes in the work of psychologists. Reflections about possible areas for further research and unanswered questions about ethics education and training are also included. This dissertation is available in open access at AURA, <http://aura.antioch.edu/and> Ohio Link ETD Center, <https://etd.ohiolink.edu/etd>.

*Keywords:* APA Ethics Code, Standard 3.05, Multiple Relationships, Hermeneutic Study, Western Individualism.

## Dedication

This dissertation is dedicated to my parents: the ones who brought me into this world with the hope that I could have a good life, follow my dreams and pursue higher education; and the ones who raised me with love, beauty and helped to make the realization of those hopes and dreams possible. To my committee whose noble friendship and unfailing dedication taught me profound lessons about patience, the value of attending to the process and the importance of keeping it real; and to T. and Abbie who walked beside me during times of darkness and lightness.

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I'd like to acknowledge with gratitude every single person who edited this project. My extra-long sentences and tendency toward wordy elaborations were at full bore throughout this process. Editing was not an easy task. The good that lies at the heart of this dissertation, has been made visible, brighter, and smoother because of your wisdom, humor, and gentleness. I would not have been able to complete this without your generosity and kindness. Thank you.

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## Introduction

Where do our rules and policies come from? They have been developed by our profession. If they don't fit the circumstances then it is our responsibility to challenge them, to undo them. Taking a questioning or skeptical stance will help us avoid being oppressed by our own body of knowledge. (Anderson, 2007, as cited in Everett, MacFarlane, Reynolds, & Anderson, 2013, p. 19)

This hermeneutic research followed the tradition of examining what is often unquestioned in clinical practice as it pertains to the moral, political, and philosophical foundations that underlie the American Psychological Association's (APA) *Ethical Principles of Psychologists and Code of Conduct* (2002, 2010) (hereinafter referred to as the Ethics Code) and especially Standard 3.05, (hereinafter referred to as Standard 3.05) which specifically addresses multiple relationships.

The Ethics Code was developed to guide U.S. psychologists in ethical practice. Psychologists such as Anderson (1997), Everett, MacFarlane, Reynolds and Anderson (2013), Lazarus and Zur (2002) and Sue and Zane (1987, 2009) have suggested that regardless of whether psychologists' work in small communities, funded research programs, academia, or private practice, multiple relationships will inevitably be part of the work. Accordingly, they have argued that it is not a question of whether there are multiple relationships, or whether we should engage in them, but rather how we, as a community of psychologists, conduct ourselves in them.

The profession of American psychology appears to be struggling with how to address, discuss, and better understand problems related to moral understandings about ethics and clinical practice. For instance, in 2015 the highly publicized independent review commissioned by the APA and conducted by former Assistant U.S. Attorney David Hoffman, (Hoffman Report, July 2015), began circulating in mainstream media outlets. In *Impunity and the American*

*Psychological Association* (2015), journalists Amy Goodman and Dennis Moynihan stated that the Hoffman Report revealed what “whistle blowers and dissident psychologists have long maintained for decades, the APA’s repeated denials that some of its 130,000 members were complicit in torture” (para 2 and 3). The Report (2015) found that:

The APA made these ethics policy decisions as a substantial result of influence from and close relationships with the U.S. Department of Defense (DoD), the Central Intelligence Agency (CIA), and other government entities, which purportedly wanted permissive ethical guidelines so that their psychologists could continue to participate in harsh and abusive interrogation techniques being used by these agencies after the September 11 attacks on the United States (p. 1) (see also Report to the Special Committee of the Board of Directors of the American Psychological Association: Independent Review Relating to the APA Ethics Guidelines, National Security Interrogations, and Torture, 2015)

During the 1970s ethical questions about sexual dual relationships received a great deal of attention in both the professional literature and the popular press (e.g., Marin, 1979). Throughout the 1980s and early 1990s articles citing the devastating nature and the damage that occurred as a result of therapists engaging in sexual relationships with patients appeared in mainstream newspapers such as the *Seattle Times* and the professional literature (Bartlett, 1993; Hare-Mustin & Marecek, 1994). Those two articles noted that an estimated 10 percent of professional encounters involved sexual experiences between therapists and patients. Since the late 1980s and early 1990s, there have been efforts by the profession and legislative bodies to formally prohibit sexual relationships between therapists and patients as unethical (Herlihy & Corey, 1992). Across the country, courts and licensing boards have heard increasing numbers of sex-related allegations and malpractice lawsuits. Brown (1993) wrote that it is troubling that the

ongoing historical record of therapists who commit these types of ethics violations with patients and the abuses of vulnerable persons even though psychologists know by virtue of their training that such practices often lead to harm. Moreover, Hare-Mustin and Marecek (1994) discussed concerns about the tendency of mainstream psychology to construe differences and the domains of morality and relational processes as “the abstract qualities of individuals [rather than] the circumstances of varying groups. . . . results in treating [difference] as irrelevant and [something that] can be put aside” (p. 533). But the need for ethical standards is essential in maintaining a structure of ethical conduct designed to protect patients and clinicians from exploitation and power differentials; it needs to be managed wisely (Edelstein, 2011; Marin, 1979). At the same time, the values and ethical standards that are reflected in professional ethics codes and have not occurred in a vacuum but rather emerged from and are situated within a particular cultural paradigm (Taylor, 1994; Cushman, 2015). This is to say, the principles that underlie the Standards in the Ethics Code are also the product of assumptions and perspectives that emerge from the philosophical traditions of Western science as a value-neutral framework. It’s a framework that presupposes the separation of morality from practice. More specifically, it begs the question: how do psychologists engage in the critical processes and the challenges of having to make moment-by-moment judgments based on who and what is in front of them if they cannot draw from their embodied moral understandings?

Why do such violations continue to occur despite the Standards psychologists have a responsibility to uphold and what can be done about those violations? The answers are complex. Some (e.g., Gottlieb, 1993; Meyers, 2005) believe the solution is simply to make the prohibitions clearer and the punishments harsher. But others (e.g., Bransletter & Handelsman, 2000; Everett et al., 2013; Sonne, 1994) believe that the violations indicate a far more serious problem and

wonder whether the Ethics Code adequately addresses the type of questions that are necessary to provide psychologists with clear guidance about what multiple relationships are and when they might constitute unethical conduct.

### **The APA and Multiple Relationships**

The General Principles outlined in the APA Ethics Code frame and reflect the highest ideals psychologists are to aspire towards and use to guide their practice. Standards intended to govern psychologists conduct are also outlined. In 2002, 2010 revisions to the Ethics Code reflected changes in the both the General Principles and Standard 3.05. For example, in the 2002, 2010 version of the Code it states that psychologists are committed to:

Increasing scientific and professional knowledge of behavior and people's understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations, and society. Psychologists respect and protect civil and human rights and the central importance of freedom of inquiry and expression in research, teaching and publication. They strive to help the public in developing informed judgements and choices concerning human behavior. ... The General Principles are aspirational goals to guide psychologists toward the highest ideals of psychology.

Although the Preamble and General Principles are not themselves enforceable rules, they should be considered by psychologists arriving at an ethical course of action. The Ethical Standards set forth are enforceable rules for conduct as psychologists. ... the fact that a given conduct is not specifically addressed by an Ethical Standards does not mean that it is necessarily either ethical or unethical. (APA, 2002, 2010, p. 3)

The General Principles, the very highest ethical ideals of the profession that are to guide psychologists in their practice include: Principle A: Beneficence and Nonmaleficence, Principle:

B: Fidelity and Responsibility, Principle C: Integrity; Justice and Principle D: Respect for People's Rights and Dignity. Standard 3.05 states that:

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

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

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

b) If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen, the psychologist takes reasonable steps to resolve it with due regard for the best interests of the affected persons and the maximal compliance with the Ethics Code.

c) When psychologists are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, at the outset they clarify role expectations and the extent of confidentiality and thereafter as

changes occur. (See also Standards 3.04, Avoiding Harm and 3.07, Third-Party Requests for Services. (APA, 2002, 2010, p. 6)

There is no doubt that clinicians are grappling with challenging questions about the ethics of multiple relationships and psychological boundaries in the clinical hour. Standard 3.05 is one example of this phenomenon. Professional associations such as the APA have proposed solutions and attempted to define multiple relationships as a way to provide a structure that may help address some of the problems and issues of concern related to multiple relationships and power differentials within the therapeutic context. Despite this, it appears that ethical boundary violations continue to occur, and questions remain about how clinicians can avoid them. Other larger problems related to questions about ethics and practice, have moved psychologists such as Cushman (in press) to suggest that the approach that mainstream models and professional organizations such as the APA have adopted ethics education and training models that exclude teaching clinicians how to engage in moral discourse leaving vast inadequacies with profound consequences:

The incompatibility between mainstream psychology's modern-era scientism and learned moral discourse is manifested in how psychological ethics is usually taught in mainstream American psychology graduate programs. The lack of a solid grounding in critical historical, philosophical, and psychodynamic relational or intersubjective study results in a lessening of what Gadamer called practical wisdom. ... Many writers in the tradition of the Interpretive Turn (e.g., Goodman & Severson, 2016; Orange, 2010, 2011; Stolorow, Atwood, & Orange, 2002) suggest that type of mainstream psychotherapy tends to leave practitioners poorly prepared to treat current psychological maladies or

make the ethical decisions that inhere in their daily professional lives. (Cushman, in press, personal communication, pp. 23-24)

In response to issues and concerns brought forth by psychologists regarding multiple relationships, Standard 3.05 was revisited by the APA. Behnke (2004), then Director of the APA's Ethics Office, commented that:

Often, though, I find myself thinking that a discussion ostensibly about the ethics of multiple relationships is not really about ethics at all. What I mean is that often such discussions pose a specific question: whether a multiple relationship will lead to impairment or risks exploitation or harm. All the participants agree that if the multiple relationship were likely to lead to impairment or such risks, the relationship should be avoided. Thus, the debate is not about values--protecting from harm and promoting welfare--but is rather about what effect a particular multiple relationship will have on a particular client. While the answer to this clinical question has profound ethical implications, the disagreement remains on clinical and technical grounds. As psychologists, we can agree upon and share the underlying values. The new definition of Standard 3.05 in the Ethics Code is an excellent example of how defining multiple relationships in this particular way meets the goals of protecting and educating the welfare of the public. (p. 66)

From a hermeneutic perspective, the privileging of a value-neutral framework, compartmentalization, and the notion that one can bracket or separate moral understandings, history and philosophy from one's clinical practice is problematic. It is problematic because such a view results in a characterization of the therapeutic relationship as one in which the psychologist must be an objective and rational clinician who should be concerned with technique

over guiding philosophical (ethical) principles (Richardson, Fowers, & Guignon, 1999). However, as others such as Duran (2006) and Gergen (2010) have argued that the self is inherently multiple and therefore complex. A linear conception of the self can often lead to an understanding of the individual and the problems they experience as issues that are contained to their own personal lives and separated from the larger social, cultural environment. The efforts by the profession both within mainstream psychology (e.g., APA) and those who subscribe to traditions that counter mainstream values (e.g., Duran, 2006; Everett, MacFarlane & Anderson, 2013) have attempted to explore a more integrated perspective that includes context and other cultural variables that intersect with ethical guidelines and codes of conduct from a broader, multicultural perspective (Sue & Sue, 1999; Sue & Zane, 1987). However, a review of the professional literature on these issues suggests that the study of ethnicity, locality, and diverse cultures tend to offer conceptualizations and generate research findings that are only examined through the employment of objective methods and empirically driven practices (Chung, 2005; Hoffman, 2009; Pederson, 1999). Objective methods, that Hoffman (2009) and Stern (2013) have maintained reduce cultural and moral concerns to trivialities.

### **Ethnicity and Locality**

While every professional scenario holds the potential of a multiple relationship, not all multiple relationships are created equal. Nor are personal relationships the same as professional relationships. Indeed, Gabbard et al. (1994) argued that precisely because of the inherent difficulties that multiple roles present in psychologists work and relationships is why it is important and necessary to maintain clear ethical and psychological boundaries. In addition, because of the depth and scope of the complexities of the various ethical issues psychologists encounter, there is a special duty of the psychologist to be able to discern between the clinician's

own needs and values and the values and needs of their patients. As many psychologists have come to learn, this is an extraordinary challenge because there are many types of relationships, diverse perspectives, and approaches that influence how clinicians conduct themselves in their relationships with others.

Sampson (1988) emphasized the importance of including cultural understandings in discussions about professional ethics. The inclusion of cultural understandings is necessary because culture accounts for the individual's lived experiences and give us clues to as to how a society has come to interpret their own selves in their own culture. An example of this can be found in Littleford's (2007) study of conceptions of multiple relationships in Asian American communities. The findings suggested that multiple relationships were considered to be an integral aspect of community and cultural life. However, there seemed to be an absence of an awareness about how their findings tended to general the experience of Asian Americans a cultural and somewhat categorical group that felt this way. Yet, the use of the Asian as if it were a blanket to cover the millions of varying and diverse languages, traditions and community and tribal norms of Asian people. Another example, of how objectivist, linear models when used to examine culture, ethnicity, locality and multiplicity can lead to a particular conceptualization of a Western cultural norm about the therapeutic relationship included a personal communication in which, Tien Liang a Chinese-American psychologist lived and practiced in both the U.S. and China. She noted (Liang, personal communication, January 15, 2015) that the concept of the clinician's role and the therapeutic relationship as an autonomous relationship was a difficult concept for many in the Chinese culture to grasp and she struggled to find ways to translate this Western idea about the patient's right to confidentiality in the therapeutic relationship. From her vantage point, the Western philosophical assumptions about privacy, individualism, and

confidentiality that underlie the Ethics Code she felt she needed to follow as an American psychologist when used with practitioners in China it often created challenges and conflicted with Chinese culture. Duran (2006) also addressed the challenges and impact of using Western driven practices in general, but also with regard to multiple relationships. He argued that in American Indian and Indigenous groups, there are multiple roles and responsibilities that a psychologist or clinician will have in these communities. This way of being is considered to be quite normative and an essential part of a strong and vibrant community. For example, Duran (2006) noted that in a variety of tribal cultures “it would not be considered inappropriate or uncommon for a Shaman (the identified healer in the community) to have dinner with the family of a patient or to involve them in spiritual ritual and healing if necessary” (p. 22).

Others such as Zur (2007, 2012), Lazarus and Zur (2002), and Herlihy and Corey (1992) have also pointed out the importance of geography and locality which they believe cannot be overlooked when considering the various meanings that accompany multiple relationships in different contexts. According to Zur (2007):

A social multiple relationship is one in which a therapist and client are also friends, acquaintances or have some other type of social relationship within their community. ...

A professional multiple relationship is where a psychotherapist/counselor and client are also professional colleagues in colleges or training institutions, presenters in professional conferences, co-authors of a book, or other situations that create professional multiple relationships. ...Institutional multiple relationships take place in the military, prisons, some police departments and mental hospitals where multiple relationships are an inherent part of the institutional settings. ...Forensic multiple relationships involve clinicians who serve as treating therapists, evaluators and witnesses in trials or hearings.

...Supervisory relationships inherently involve multiple relationships and multiple loyalties. A supervisor has a professional relationship and duty to the supervisee and to the client, as well as to the profession. ...A sexual multiple relationship is where a therapist and client are also involved in a sexual relationship. (pp. 1-6)

There is no question that sexual relationships in psychotherapy need to be avoided. Edelstein (2011) discussed how when the presence of a sexual/romantic relationship occurs between a therapist and their patients, or a teacher and student role, it can be problematic in important ways because it involves or invites role confusion about the power differentials within in these relationships. Edelstein addressed this issue in the context of spiritual teachers and their students/followers. However, these same elements similarly exist within the therapeutic relationship. Zur (2007) also argued that non-sexual multiple relationships, while difficult to negotiate in a number of ways, do not always lead to exploitation, sex, or harm. There are various situations, contexts, and people are unique. Therefore, clinicians need to be able to make decisions based on what they perceive might be happening, and this is often dependent upon an element of the unknown. It is unknown because there are multiple possible ways the situation could play out and it is the role of the clinician to attend to this awareness, so that they will be able to make their best judgements about their encounters and in various contexts (Hoffman, 2009). For example, multiple relationships can be many things simultaneously. They can be: ethical or unethical, legal or illegal, avoidable or unavoidable, and even mandated. They can be planned, anticipated, or they might emerge unexpectedly. They can exist concurrently or sequential and vary in levels of involvement (e.g., from low/minimal to intense. In settings and locales such as correctional facilities, prisons and/or the military, psychologists have an ethical obligation to ensure the safety of the institution as well as the individuals who dwell there. In

some cases, this includes situations where there are prisoners of war or detainees who are considered enemy combatants). Engaging in multiple relationships is not always antithetical to setting psychological boundaries, challenging perhaps, but achievable and sometimes necessary (Edelstein, 2011; Tomm, 2010; Zur, 2007).

Everett, MacFarlane, Reynolds and Anderson (2013) and Sue and Zane (1987, 2009) have also suggested that in small communities and rural areas multiple relationships are often considered to be social relationships that are a normal and healthy aspect of life. These authors have challenged mainstream psychological interpretations of multiculturalism and multiple relationships. A viewpoint that tends to promote the notion that there needs to be a blanket avoidance of them, or in the least psychologists need to be wary of them and are discouraged from actively engaging in them. This is a conceptualization that has also contributed to the emergence of approaches that rely on ethical-decision making models to navigate morally ambiguous and often confusing relational processes that emerge in the therapeutic relationship. Zur (2007) asserted that attempts to minimize and reduce the positive aspects of multiple relationships leaves open the possibility that a patient may experience social isolation and disconnection from the therapist.

### **Statement of the Problem**

What appears to be absent from Behnke's (2004, see p. 66) explanation is an acknowledgement of the relationship between moral understandings and the profession's Ethics Code. Furthermore, the underlying assumption informing this (Behnke's) argument: There needs to be a separation from personal and professional values; and that humanity can separate their moral selves from their professional selves. What is the impact of such a stance on our patients, colleagues, communities, and society? How is it possible to offer substantive and helpful

interpretations and treatments about what our patients value if clinicians are told they must not talk about their own (professional) values in the therapeutic context? There is an opportunity for the profession to consider asking itself how its current notions about multiple relationships and ethics education and training are preparing psychologists to be able to engage in meaningful discussions about their values and the enactment of such values in the therapeutic relationship with their patients and colleagues. For instance, what happens when psychologists hold ethical positions and use therapeutic practices that differ from what mainstream psychology is doing or believes to be “best practice?” How does the profession treat those psychologists who are from cultures with backgrounds and traditions that counter Western assumptions about psychological health and well-being? Most psychologists want to be ethical. They do their best to do the right thing as they see it. However, what I have discovered from my literature review and even my own lived experience as a psychologist in training is that it is difficult to find spaces to engage in meaningful discourse about the underlying assumptions that inform the discipline’s professional ethical standards and what following those might mean. Dialogue (e.g., Gadamer, 1989) is difficult, but if psychologists cannot talk about and historically situate the ethical Standards they are supposed to follow and use to guide them in arriving at ethical outcomes in their practice, then the profession must also consider what kind of understanding its theories and ethics models are teaching and training psychologists to value. Are these current approaches to ethics education and training leading to a better understanding of how the practices generated by the profession are impacting the welfare of the therapeutic relationship with their patients, and their relationships with their colleagues and the public? So here is the conundrum: if the discipline accepts the notion that the disconnection between morality and practice is the best way to avoid enacting harm and protecting the public, does the separation of values from practice

make the awareness and discussion of values impossible and thus, leading to the unintended or unconscious recapitulation of oppressive practices and approaches?

The controversies pertaining to Standard 3.05 and the Ethics Code also reflect larger philosophical problems about the meaning and place of moral understandings in modern-era social sciences such as psychology and graduate level education and training. These controversies remain unresolved. There are larger issues about the philosophical framework of the discipline of psychology and the failure of mainstream ethics education and training in addressing these kinds of challenges. These are arenas that reach far beyond the domain of any single research project. My dissertation is no exception. In fact, given the future political (and financial) consequences of proposing such all-encompassing philosophical changes, it seems unlikely that those changes will be made any time soon. However, it is hoped that by focusing on Standard 3.05 and the controversies that adhere in it, various insights can emerge about what may be problematic about privileging a framework that seeks to separate morality (it's soul or heart) from the social sciences (the study of its behavior).

Behnke's (2004) statement that Standard 3.05 and the debate psychologists were having about it, concerned issues that involved technicalities and not values. This ethical stance raises several questions about the contextualization of the ethics of multiple relationships and the psychologist's ethical obligation to responsibility to adhere to (or at least aspire towards) the Ethics Code. In addition, the question of how psychologists are to conduct themselves in their professional relationships when they find themselves in varying roles and are from ethnic and cultural traditions that differ from the values that inform their professional Ethics Code and its Standards? Behnke's conclusion or rather his assumption, was that psychologists' questions are not related to the ethics of multiple relationships at all, but rather their questions are about

“technical grounds” (p. 66). Given ample consideration of the many harm-reduction and risk-management models that presently dominate graduate level and continuing ethics education courses why do psychologists continue to act in ways that run counter to what Standard 3.05 dictates? Or what might compel them to continue to follow it if it does not align with their own values?

From a hermeneutic point of view, the absence of something can be just as important as its presence. In light of the philosophical challenges posed by the Ethics Code and the existing controversies regarding multiple relationships that remain unsettled, there is less than optimal guidance for individual psychologists who are striving to comply with the ethical expectations of the field. However, when faced with the real- life complexities of day-to-day practice, and/or when they hold moral understandings about therapy and practice that may run counter to Western notions of individualism and communalism, ethnicity and culture the Ethics Code seems to fail them in navigating such rapids. For this reason, in order to better understand psychologists needs, concerns, and experiences there is a need to examine the experiences of psychologists who have to consider Standard 3.05 in their practice. It is my hope that in learning about the unspoken dilemmas related to the proceduralism imposed by the Ethics Code, this research will contribute to a larger discussion about ethics, morals, and relational processes in the practice of clinical psychology.

### **Description of the Study**

This hermeneutic research followed the tradition of examining what is often unquestioned in clinical practice as it pertains to the moral, political, and philosophical foundations that underlie the APA’s (APA) *Ethical Principles of Psychologists and Code of Conduct* (2002, 2010) and Standard 3.05, Multiple Relationships—it’s meanings and

controversies—in order to better understand the cultural influences reflected in and the political consequences that emanate from the Ethics Code. Data for this study were collected via semi-structured qualitative interviews with two American psychologists who lived in Washington State, experienced living and working in rural communities, and had practiced with patients from cultures other than their own. This process generated ideas about the larger picture of the social landscape in which the participants and psychotherapy in general are embedded. The interpretive method of analysis proposed by hermeneutic researchers Leonard (1993), Plager (1994), and Stigliano (1989) was used to identify key themes that arose from the data. By abstracting from the themes and case-studies, two broad conclusions emerged.

**Ethics in psychology and social contexts.** In the United States, the profession of psychology is one of the many institutions involved in framing societal issues and problems. As an embodied social institution, the profession holds a highly influential role within the cultural frame. A role that assumes the responsibility for understanding the human condition and generating explanations and treatment methods to address and/or ameliorate suffering or provide healing in some form. As a social institution, the discipline also plays a part in determining how these treatments are to be implemented (Furedi, 2004; Rose, 1989). For psychologists, one way of arriving at substantive understandings about our methods and practices is to interpret the social and political issues that society seems to be contending with. For example, what are we as culture arguing about? What are we wearing? What is important to us or what is causing suffering is also often reflected in the concerns of our patients who are seeking treatment. Critical psychologists such as Anderson (1997), Hickenbottom-Brawn (2013), Samuels (2006) and Sugarman (2015) have suggested that it is critical for clinicians to consider the struggles of their patients through the lens of these social and political problems as a means of enacting

therapeutic change. However, in mainstream psychology reflected in the subsequent research findings it generates, there seems to be an absence or minimization of the inextricable socio-historical and political issues influencing what patients and culture consider to be the problem and the solution. The objectivist methods that are often employed in mainstream research endorse a frame of referenced that contributes to the problems many patients and clinicians wrestle with because it often ignores, reduces, and externalizes the patient's struggles. As a result, a disconnection of those spheres occurs and becomes vulnerable to perpetuating the notion that the patients should be disconnected from their selves or somehow compartmentalize multiple aspects of themselves in different contexts and relationships. In other words, attending to culture is important because often the social enactments that are occurring in society will also repeat in the clinical context (Cushman, 1995; Gerber, 1990; Liang, Davis, Arnold, & Benjamin, 2012).

Tjeltvet (1989) stated that professional ethics codes exemplify an ethical ideal. These codes are one way that a society attempts to articulate or codify social standards of conduct. Within the profession of psychology, ensuring that psychologists are well prepared to understand and apply ethics in their practice, ethics training and continuing education are mandated requirements for new and seasoned psychologists alike. Psychologists are not only expected to be proficient in their knowledge and application of ethics principles and standards, they are also obliged to know how to avoid ethical pitfalls and navigate complex and often ambiguous ethical dilemmas. They must do so at the risk of incurring sanctions and other negative consequences (Liang et al., 2012). Being ethical is valuable to psychologists and there is no shortage of information about what is expected of psychologists and how they can tailor their practice to ensure that they are behaving ethically. Psychologists receive ample training on ethics, the Ethics

Code, and relevant state laws. Despite this, complaints to the regulatory boards, state ethics committees, and professional associations about misconduct continue (Meyer, 2005; Tien et al., pp. xii-xiv). According to Sonne (1994), “ethics complaints based on multiple relationships and professional role confusion continued to increase and involvement in multiple relationships was one of the most frequent causes for termination from the APA” (pp. 336-7). These issues and concerns about ethical boundary violations in counseling and psychotherapy were serious enough that the APA commissioned research and examined how they could implement changes in state law and regional legislation to address the problems. Despite these changes, psychologists continue to act in ways that seem to undermine and impact public trust in the clinician’s ability to adhere to those Standards.

Tjeltvet (1989) argued that:

Addressing the ethical character of the processes of therapy, of any therapy relationship, or of therapy in general, needs to begin by rejecting a pernicious falsehood: therapists *either* provide objective, value-free therapy *or* impose their values on clients. It is not possible, with rare exceptions, for therapists to impose their values on clients. Influence, yes; impose no. ... If therapists could impose their values they could also impose mental health, quickly eliminating the problems clients bring to therapy. Therapy would then be universally effective and there would be little need for therapists. (pp. 157-159, italics in original).

In addition, when the ethical concerns about multiple relationships are defined and reduced to an issue of technique, psychologists’ must attend to their technique and this shifts their attention away from challenging clinicians to examine and critique the values they hold and how those values might intersect with the patient’s values. Consequently, this interpretation has

lead clinicians to think about the therapeutic relationship as a cause - effect-outcome rather than being able to acknowledge and understand the inherent complexities and nuances of their clinical work.

### **Rationale for Study**

Standard 3.05, Multiple relationships is just one of many ethical debates the profession is struggling to have about the Ethics Code. The emergent challenges, controversies and unanswered questions have highlighted the complexities of practice and the absence of an adequate resolution to some of the problems. Many clinicians do turn to the Ethics Code for guidance in how to address ethical dilemmas. However, over the decades, psychologists have provided commentary and critiques pertaining to the role and function of professional ethical guidelines. Some have questioned its adequacy and helpfulness, especially for clinicians who live and work in communities, cultures and contexts where multiple relationships are a reality. Everett et al. (2013) asserted that:

Professional ethical guidelines commonly advise counsellors to avoid dual relationships wherever possible but generally have not provided guidance for situations where this is not feasible. This [has left] queer, Two Spirit, and/or trans counsellors open to negative judgments, possible accusations of unprofessionalism, and practices of self-surveillance that limit their ability to live, work, and actively participate in the communities they serve. (p. 14)

Lazarus and Zur (2002) and Sue and Zane (1987, 2009) have also written about the inevitability of multiple relationships in psychologists' work. For example, psychologists reside in small communities, work in funded research programs, academia, and/or in private practice. According to these authors, professional ethics codes convey a limited perspective and fail to

understand the myriad issues, multiculturalism, and other considerations that clinicians must contemplate when determining what might constitute an ethical course of treatment for their patients and how to collaborate with other professionals in achieving the clinical aim (Behnke, 2004; Zur, 2012). However, according to Behnke (2004) relating and the therapeutic relationship within a clinical context occurs when one independent, free-standing self-contained Western self-interacts with another independent, free-standing self-contained Western notion of the self (p. 66). If the profession wishes to examine the possibility of achieving a deeper, more inclusive comprehension of its own stance on this issue then they must consider how to engage in a more critical examination of the how the Western philosophical definition of the self permeates their assumptions about their practices.

### **Ethics Defined**

Ethics is a multi-dimensional and vast discipline. For the scope of this project, I have provided a brief list of general ethics definitions that are commonly accepted in the field of ethics, and more specifically, within the profession of psychology. There are many meanings attached to the term ethics. However, according to Walsh (2015) “ethics refers to a set of certain, aspirational moral values and principles that are intended to guide ethical conduct” (p. 69). Tjeltvet (1999) has also defined different types of ethics. These included: *General Ethics*, a person’s own standards of right and wrong; *Theoretical Ethics*, the intellectual grounding for mandating that the therapist maintains client confidentiality and the reasons for that ethical standard; *Clinical Ethics*, the practical clinical challenge of reducing patient’s depression and working in partnership with the patient so that the patient changes in the best possible direction. McIntyre (1984, 2007) also considered the influence of culture on the development of ethical

beliefs or the morality of the community. He emphasized the role of the community in shaping virtues (virtue ethics) and thus developing social responsibility (social ethics).

Teo (2015) addressed the philosophical foundations of psychology's professional ethics codes and summarized five perspectives on moral philosophy and their ethical applications featured in psychological literature. These included: *Virtue Ethics* that focus on the ideal rather than the obligatory and on the intentions of the actor rather than the consequences; *Deontology*, that emphasizes the rightness of an action depends upon whether we perform it in accordance with, and out of respect for, absolute and universal ethical principles; *Consequentialism* that emphasizes the social and analytical domain concerned with the consequences or ends of ethical actions; *Relationality* that stresses an ethic of care for the quality of the relationships in which we engage; and *Communitarianism* holds that ethical action flows from community values and traditions.

In mainstream psychology ethics textbooks, definitions and case vignettes are presented by a variety of authors. For example:

- *Ethics* as defined by Knapp and VandeCreek (2006), is a general term that refers to values, how we ought to behave, and what constitutes proper conduct (p. 1).
- *Practical or applied ethics* according to Beauchamp and Childress (1994, 2001) refers to the application of ethics or specialized areas or professions, such as psychology.
- *Remedial ethics* tends to be punitive and is designed to deter psychologists from doing harm.
- *Positive Ethics or aspirational principles* (e.g., *the spirit of the code*) is generally interpreted or viewed as a voluntary effort to do the right thing as motivated by

individual and the collectives' deeply held moral principles. This is reflected in the aspirational principles of the APA Ethics Code and in writings on positive or active ethics. (Handelsman, Knapp, & Gottlieb, 2009)

Knapp and VandeCreek (2006), Nagy (2005) and Tjeltvet (1999) have suggested that generally, psychologists in the U.S. tend to use the word ethics to refer to both the mandatory floor and minimum standards adopted by the profession. The guiding principles and any efforts psychologists make to follow those ideals extend beyond the minimum standard and are considered voluntary efforts. The remedial approach that is often taught in ethics education and training focuses almost exclusively on the laws or standards designed to protect the public from harmful actions by psychologists. This typically encompasses the need to retain knowledge about state and federal laws regulating the practice of psychology, the regulations of state licensing boards, and the enforceable Standards in APA Ethics Code. At the same time, Knapp and VandeCreek (2006) pointed out that "being technically legal is not the same as being morally sensitive" (p. 3) and teaching psychologists that meeting the minimum ethical standard does not necessarily mean that one is behaving ethically. These authors point out that psychologists are also expected to be mindful of their practice and conduct themselves in a conscientious manner (APA, 2002, 2010). Bricklen (2001) and Knapp and VandeCreek (2006) have also argued that disciplinary codes are often limited because they are inherently promoting a form of prescriptive conduct rather than applied principles. It is thought by these authors that clinicians would be better at fulfilling the minimum professional responsibilities if they understood and could apply the moral principles that underlie the disciplinary codes. It is my hope that this dissertation will provide a useful point for ongoing discussions regarding the concerns psychologists are expressing about the consequences of adopting a framework that seeks to separate what is very

particular and personal to psychologists in their work—their values from their professional lives. It seems that the complexities of human relationships and the conflicts and dilemmas that many psychologists face in their day to day lives and work are absent from the profession's notions about how well its Ethics Code is working.

### **Outline of the Dissertation**

This dissertation consists of four chapters. In Chapter One I provided an overview of the study. In Chapter Two I included a review of scholarly research and opinions relevant to the focus of this study. In Chapter Three I described the theoretical framework and methodology used for data collection and analysis. Finally, in Chapter Four I included a presentation of the data and identified themes, my reflection and interpretations about the implications found in the data. I also offered recommendations for further study and final remarks that entailed unanswered questions that remained after this study concluded. I have also included a complete list of References followed by several Appendices that included sections: Foregrounding, Researcher Process Notes, Recruitment Letter, Pre-screen Questions, Informed Consent Form, Interview Schedule, and Participant Demographics Form.

## **Background and Literature Review**

In order to attain understanding of the relationship between Standard 3.05 and the impact it had on clinician's interpretation of multiple relationships and their professional practice, I reviewed scholarly research and opinions about this topic from three perspectives: 1) The socio-historical and political function of professional codes of ethics, including the history of the APA Ethics Code, problems with the Code and Standard 3.05, ethics, education and state law; 2) I also reviewed literature germane the philosophical foundations that undergird the Western conceptualization of the self and have facilitated a cultural understanding of the self as a relational being. This necessitated a brief overview of American modern public philosophy, therapeutic culture, and the dominant ideology's assumptions about self-control and reason because these are notions of that reflect the culture's sense of self-identity as moral agents; and 3) I interviewed two American psychologists about their experiences with Standard 3.05 and multiple relationships. This included semi-structured in-depth qualitative interviews that I developed into case-studies, analyzed and abstracted prominent themes and sub-themes that emerged from the texts.

### **Codes of Ethics**

Ethics codes and the arguments they often reflect have a long history. Earliest accounts of codes of honor appeared as early as the fifth century B.C.E. in Greek literature (Winnau, 1994). One well known example might be: The Hippocratic Oath or the ideal of the physician. When physicians entered the discipline of healing, they took a Hippocratic Oath as a way of demonstrating that they understood and shared the underlying philosophical principles from which they were to draw upon when using their healing abilities. For the physician it was an ethical duty to preserve, restore health. However, above all the physician was committed to the

good and welfare of the patient and the doctor-patient relationship. It might seem strange that an Oath of honor that was enacted nearly 2500 years ago, remains one of the most prominent ethical ideals in medicine today (Winnau, 1994, p. 286). Within the arena of ethics, ethicists believe that they must consider a variety of perspectives across disciplines as a means of better understanding of morality. Due to the discipline's vastness of scope and the rigor and time it takes to engage in ethical analysis which attempts to clarify, evaluate, and justify the values tied to professional conduct. This is an immensely difficult task. Often professional ethics codes are one way of helping the profession to employ the ethical analysis through ethics codes (Tjeltvet, 1999). Moreover, Walsh (2015) argued that often professional ethics codes:

Represent the application of ethical principles and values which are prescribed in concrete, enforceable behavioral standards for ethical action. An ethics code organizes into an accessible framework a given national organization's expectations for ethical conduct in all aspects of the discipline. Ethical guidelines, however, are distinct from standards, as guidelines only represent recommended action. (p. 70)

Tjeltvet (1999) also noted that “in the context of counseling and psychology in the U. S., therapeutic practice and professional conduct (or behaviors) are typically defined and interpreted through the lens of the APA Ethics Code which sets standards that govern the interactions of its members and the profession (e.g., patients/clients and colleagues)” (p. 19). Other associations of psychotherapists such as, the American Psychological Association, American Association for Marriage and Family Therapy, American Psychiatric Association; National Association of Social Workers etc. have their own code of ethics. Haas and Malouf (1995) noted that those who enter the profession of psychology typically understand that psychologists will have to “take on special duties to persons who enter professional relationships with them” (p. 2). Therefore, it is

important that as professionals they agree to abide by the ethical Standards set forth by the profession's code of ethics (Ozar, 1995; APA, 1992, 2002, 2010).

There are important aspects of ethics and professional ethics codes. One, the code's capacity to limit the freedom of therapists to influence patient(s) values (Tjeltvet, 1999). At the same time, Caplan (1989) cautioned that knowledge of ethics consisted of knowing moral traditions and theories as well as how to apply those theories and traditions in ways that contributed to the comprehension of moral problems. Ethical expertise, Caplan suggested "involved the ability to identify and recognize moral issues and problems" (p. 85). At the same time, he also warned that because the role of a certain moral expertise within society holds the "threat of abuse or error so great" that the socially sanctioned roles that are assigned to moral experts, must be confined to the tasks of exhortation and giving advice" (p. 74). When societies create an elite of moral experts they are also in danger of handing over to the elite the authority to impose judgements on others. Tjeltvet (1999) argued that the practice of psychotherapy in American psychology tends to "involve particular answers, or sets of answers to the questions of theoretical ethics. In this way, psychotherapy is not simply value-laden; it is laden with ethical theory and values about our practices" (p. 52).

One of the central themes embedded in the professional literature concerning psychotherapy's value-ladenness is the necessity of clinicians to be aware of their own moral values and those of the profession (Aldeman, 1990; APA, 2002, 2010; Corey, Corey, & Callanan, 1990; Tjeltvet 1999). However, critical and hermeneutic thinkers such as Cushman (1995), Duran (2006), Rose (1999), and Walsh (2015) have suggested it is difficult to critique the underlying values that inform psychology's professional ethics when the essence of

psychotherapy and the goals it identifies often reflect Western cultural values and claims made by the profession about what constitutes ideal human functioning and well-being.

Strupp (1980) and Varma (1988) also argued that the influence and emphasis on values that include autonomy, individualism and scientism have been and continue to be endorsed through psychotherapy practices. Feminist thinkers such as Ballou (1990) and Butler (1990) have long criticized and challenged the dominant ideology's implicit values that exist in mainstream therapies and codes of ethics. Another example, was provided by Jensen and Bergin (1998) who conducted a comparison study with mental health professionals that examined the religious values and beliefs of the clinicians and the relationship between their values to the counseling processes. Their findings conveyed that "96% of American therapists considered autonomy as an essential value and was 'important for a positive, mentally healthy life-style'" (p. 293). The significant (unseen) influence of a shared language that these clinicians used to describe valued characteristics about what the West assumes to be the good or the ideal can also be seen in frequently used words such as "healthy, well-adjusted, appropriate, mature, and rational. These are common place terms that are not just descriptive, but are also value-laden" (Tjeltvet, 1999, p. 33).

Duran (2006) also discussed the implications of a culture that is unaware of the monism of its own paradigm. For instance, he argued that when therapists are unaware of the constraints and assumptions that are inherent in their culture's paradigm, it can blind the clinician's ability to recognize and understand the limitations of their conceptual framework. This in turn, limits their capacity to consider alternative ways of conceptualizing psychological well-being and treatment methods. Duran provided an example of how this occurrence in Western culture is enacted between therapists and their patients. He noted that when clinicians are pressured to identify and

label their patient within the categorical bounds of the prescribed paradigm even if the label may not fit with other possible variations of the patient's experience (pp. 21-22). Others such as Varma (1988), and Paris (1995) have also highlighted the domination of Western values in psychology. Varma specifically stated:

In contrast to US [American] individualism and emphasis on autonomy, mutual interdependence is important to the well-being mental health of its citizens, other peoples in their ethics, emphasize tribal community, family, belonging, and reciprocity. Such cross-cultural ethical reflection can help us to understand our own ethical positions, which is crucial when therapists work with clients. (p. 30)

Many writers believe that there are inherent problems in the structure of professional ethics. Though Ozer (1995) suggested that there are aspects of the structure that may be beneficial. For instance, there is a social dimension in professional ethics that is constituted by the discussion between professionals and members of society. In addition, the professional obligations and content when delineated in ethics codes can be worked out, affirmed, or revised. This occurs through dialogue within the discipline and includes the members of professional groups and communities they serve.

Nonetheless, the limitations in scope of professional codes remain problematic for several reasons. Critics of professional codes such as Orlowski (2009) and Veatch (1989) have pointed out that the purported partners in the psychotherapeutic endeavor (the patient) as well as other key stakeholders are often left out of the discussion about ethical standards, the development of new standards, and revisions of the code. Additionally, Tjeltvet (1999) argued that "professional codes feature several areas of discontinuity with the broader ethical issues raised in philosophical ethics, clinical ethics, virtue ethics, social ethics, and cultural ethics" (p. 20). This is unlike the

sort of multi-disciplinary effort that is common in other disciplines such as bioethics. For example, “professional ethics are typically generated from within a profession and rarely draw upon intellectuals and philosophers outside of that profession” (Tjeltvet, 1999, p. 20). They also generally only apply to the members of a discipline and often refer role-specific functions of the professional (Bassford, 1990). Typically, codes of professional ethics do not address the complex and multi-dimensional ethical analysis of actions the clinician might have to engage and refer to for guidance when it comes to better understanding the issues and value-laden dilemmas patients might present with (e.g., whether it is wrong for a patient to lie to their partner). Nor do they provide the reasons and rationale that ground the philosophical principles and inform the standards they contain (Tjeltvet, 1999). Psychologists for example, do not engage in sexual intimacies with current patients and any person(s) who may be connected to the patient (see Standards, 10.05, 10.06, 10.07 & 10.08, APA, 2002, 2010). At the same time, Standard 3.05 dictates that psychologists also:

Refrain from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist’s objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists. (APA, 2002, 2010, p. 6)

While the Standards dictate a set of behaviors psychologists are to demonstrate, the reasons (principles) for such prohibitions are not included in the code. Tjeltvet (1999) and others have maintained, because of this absence or split between the profession’s philosophical principles and the rules generated in the Standards, there is a need for the profession to value “a full-fledged analysis of the ethical dimensions of psychotherapy and professional ethics, and to

stop moving toward a full-fledged analysis many important questions would continue to be ignored” (pp. 21-22). There are other ramifications stem from adopting a professional structure of ethical analysis that is only informed by a Western paradigm. Duran (2006) contended that the kind of viewpoint that is privileged in ethics codes has been established within the context of procedure. A perspective Duran noted, “often lends to a viewpoint that relies on a prescriptive, categorical, and dichotomous interpretation of what is considered therapeutic” (p. 21). One example he offered was when a patient does not fit into the prescriptive categories identified by the dominant ideology’ prescriptive categories, the clinician’s interpretation of the patient may tend toward seeing the patient and their struggles as untreatable, resistant to therapy, non-compliant, and/or even the cause of their own problems. (p. 21)

Critical thinkers such as Furedi (2004), Rose (1999) and Tjeltvet (1999) argued that cultural concept of a person as a professional is a modern notion. A notion that is inextricably entangled with the socio-historical and political realm. Bassford (1990) also discussed the idea of professionals in modern society. He contended that professionals exist primarily for “the purpose of playing certain social roles and to further certain social purposes” (p. 130). Certain social purposes Elshtain (1995) asserted, that will create ethical dilemmas that will be “inescapably political and frame the questions that are unavoidably ethical” (p. 757). Kendall and Chambless (1998) have also provided an example of how the relationship between politics and ethics can result in social entanglements. These authors examined the implication of the involvement of third-party payers in clinician reimbursement. The findings from their study conveyed that many third-party payers would only provide financial reimbursement for empirically validated or evidence-based treatments endorsed by the APA. Furthermore, treatments that received the approval of the APA’s standards were considered by the third-party payers to be the most

beneficial to the welfare of the public and therefore eligible for reimbursement. However, the circular nature inherent in this kind of social arrangement remains concealed because it appears as functional (Cushman, 2013; Stern, 2013; Walls, 2012). If the profession of psychology were to consider adopting a multi-dimensional structure that includes philosophy, clinical, social, political, and cultural dimensions when creating and revising its ethics code, it may help the discipline to better understand how to explore and assimilate commonalities between ethical issues faced by professionals in other disciplines (e.g., physicians, scientists and lawyers). Learning or examining how others navigate similar ethical quandaries may permit a richer ethical analysis of psychotherapy, relational processes and thus ethical outcomes that can realistically address the impositions, challenges and limitations that are generally found in the profession's discourse (Tjeltvet, 1999, p. 20).

**History of the APA Code of Ethics.** The APA did not make a public statement about its organization's ethics until 1953 (Walsh, 2015). However, Walsh reminds the profession of its historical tradition and noted that at present in the profession, "it is customary for psychologists to celebrate the practice of ethics as a moral endeavor that purports to show respect for human dignity and protection of human rights" (p. 70). Still, the discipline of psychology "flourished for nearly 70 years before the first statement of ethics from any organization of psychologists was produced by APA in 1953 and many national associations of psychologists did not have an ethics code until recent decades" (p. 70). Walsh also highlighted that although "in the U.S. ethics literature concentrates almost entirely on its own national publications and APA policies and practices, psychology organizations elsewhere and outside of the U.S. (e.g., Canada) have been able to achieve developing ethics codes and complementary literatures" (p. 70). He offered the example of the development and support of a Universal Declaration of Ethical Principles for

Psychologists was promulgated in 2008. The intention of this ethics code was to “encourage nations whose associations of psychologists did not have a code of ethics to develop their own guide grounded by universal moral principles” (p. 70; see also Gauthier, Pettifor, & Ferrero, 2010)

Prior to World War Two, “the APA had declined to develop a code, even though psychologists had initiated one in 1933” (Walsh, 2015, p. 70). Scientific psychologists had been averse to addressing applied psychologists’ practice. However, after the war had ended, the APA underwent a reorganization in an attempt to address complaints to the APA ethics committee. This resulted in the development of an ethics code whose aim was “protecting the public from quackery, charlatanism, and false advertising perpetrated by some applied colleagues” (p. 70). In 1948, the committee on Ethical Standards for Psychology was initiated to develop a set of guidelines for ethical conduct (Walsh, 2015; Pope & Vetter, 1992). At the time, neobehaviorism dominated U.S. culture, the Committee and the positions of the American psychologists of which it was comprised (Walsh, 2015; Teo, 2015). It was thought by those on the Committee that, “ethical standards derived from empirical research would yield a more practicable statement and increase the probability of ethical behavior than a declaration of ethical principles and guidelines by a small group of APA members” (Walsh, 2015, p. 70).

Under the leadership of Nicholas Hobbs, an eight-member group of men, formed a Committee on Ethical Standards. The Committee’s charge was to “survey a representative sample of APA membership about their professional activities and critical incidents involving ethical issues” (Walsh, 2015, p. 70). It was thought that by adopting a procedure for critical incidents, that mirrored what psychologists used while employed in military research during the war, “lent the ethics project scientific credibility” (p. 70; Joyce & Rankin, 2010). Members of the

APA contributed more than a thousand examples of real-life ethical dilemmas psychologists had written the committee about—both positive and negative (The First Code, 2003, p. 63). Those survey findings led to the original Code (Walsh, 2015). The original code according to Walsh (2015):

... Contained brief statements about ethical standards of practice for specific issues, such as confidentiality and informed consent, mainly concerning the conduct of research. Each area of content contained specific examples from the incidents submitted. Thus, psychologists' first code of ethics was the result of a survey of APA members' behavior that represented disciplinary consensus on best ethical practices, evidencing rather pragmatic and utilitarian foundations. ... In subsequent editions the Code's specific guidelines for ethical conduct were increasingly elaborated regarding research and professional practice; balancing costs and benefits of one's conduct was the prescribed behavior. (pp. 70-71; see also Fisher & Younggren, 1997)

The 1953 Ethics Code did not escape the influence of the scientific-professional context from which it emerged. Walsh (2015) noted that “as revelations from the Nuremberg war trials concerning the crimes against humanity committed by Nazi-affiliated scientists and physicians were becoming public the APA followed codes that were created by other professional and scientific associations” (p. 71). In part, the codes were intended “to ensure public confidence in the competency, integrity, and social legitimacy of the presumably beneficial work in which biomedical scientists and medical professionals engaged” (Walsh, 2015, p. 71; see also Hobbs, 1965).

In 1992, the APA Ethics Code reflected a significant shift from the original version and its subsequent revisions. By this time, the APA had introduced six General Principles that

represented moral aspiration along with practical Standards which represented enforceable rules of conduct (Fisher & Younggren, 1997; Walsh, 2015, p. 71). At the same time, the General Principles adopted by the profession and appeared in the 1992 Ethics Code Walsh (2015) argued, reflected “the ethical values—autonomy, beneficence, nonmaleficence, and justice. Values that originated in the development of federal regulatory regimes for the ethical conduct of biomedical research” (p. 71; see also Kitchener & Kitchener, 2011).

In the 2002 revisions of the Ethics Code, the Principles were reduced to five: Beneficence and Nonmaleficence, Fidelity and Responsibility, Integrity, Justice, and Respect for People’s Rights and Dignity. In the amended 2010 APA Ethics Code, “it was stated that these Principles were organized alphabetically rather than hierarchically, because, only the Standards should be the basis for ethical decision-making” (APA, 2002, 2010; Walsh, 2015, p. 71). Therefore, though the Ethics Code of today, references its founding philosophical, the emphasis is primarily on “procedural considerations, and scope of application” (APA, 2010, Amendments, p. 2). Thus, from the Ethics Code’s vantage point, the General Principles are considered to be, “aspirational goals to guide psychologists toward the highest ethical ideals, but are not considered to be enforceable. Whereas, the Ethical Standards are enforceable rules for conduct as psychologists” (APA, 2002, 2010, p.2).

The APA has contended that the genesis of the Ethics Code is located within the profession of psychology and the basis of the codes and subsequent standards have been and continue to be founded on empirical methods in its formulation (Tjeltvet, 1999). Yet, Nagy (1994) and Walsh (2015) as well as others have pointed out that the “the basis of the original code was derived from a survey conducted with APA members about psychologists’ opinions about situations that they believed to be ethical in nature as well as behaviors in which

psychologists should and should not engage, and not about principles psychologists should uphold” (Nagy, 1994, p. 505). The APA Ethics Committee adopted the position “that ethical standards derived from empirical research would be more practical and more likely to increase the probability of ethical behavior [rather] than a declaration of ethical principles and guidelines [generated] by a small group of APA members” (Walsh, 2015, p.70). This same claim undergirded the revisions in the 1992, 2002, and 2010 amendments. The basis of revisions of the Code according to the APA were derived from “an empirical basis as the foundation for the revisions made to the 1992 Ethics Code” (Nagy, 1994, p. 505). Though Tjeltvet (1999) has argued that in the quest to unravel the genesis of the profession of psychology and the origin of its ethics code, traditional accounts have failed to explain why the opinions of the psychologists from whom the code has been derived should be given any special epistemological weight.

**Problems with Standard 3.05.** The definition of multiple relationships in Standard 3.05 seeks to address concerns of many psychologists who practice in rural and remote settings and those clinicians who serve patients from non-dominant cultures. These issues have been explored within the mainstream professional discourse by many psychologists (e.g., Campbell & Gordon, 2003; Kessler & Waehler, 2005; Lazarus & Zur, 2002; Sonne, 1994; Sue & Zane, 2009). For example, during the 1980s and 1990s, there were several authors who voiced their concerns about the limitations that might arise if the profession adopted an ethics code that promoted the perspective of avoidance of multiple relationships as an ethical obligation. In the journal *Ethics and Behavior* several leading voices within the field of psychology including Bennett, Bricklin, and VandeCreek (1994), Borys (1994), Gottlieb (1994,) Gutheil and Gabbard (1993), and Lazarus (1994) were invited to comment on the topic of multiple relationships, boundary crossings and violations within the therapeutic context. They debated the many factors

psychologists must consider when thinking about such issues (e.g., setting, culture, expectations and theoretical orientations). Hepworth and Ryder (1990), Sonne (1994), and Sue and Zane (1987) also examined the ways in which the Ethics Code addressed multiple relationships. Sonne (1994) contended that “some segments represented a step backwards” (p. 343). Rinella & Gerstein (1994) also argued that disputes about “the underlying moral[ity] and rationale for prohibiting dual relationships [was] no longer tenable” (p. 225). Others such as Ellickson and Brown (1990), Stockman (1990), Horst (1989), and Schank and Skovholt (1997) advocated for mainstream psychology to consider clinicians who were practicing and living in rural and remote settings—especially in non-traditional and lesbian communities—encountered unique challenges when addressing multiple relationships and communal understandings related to boundaries and boundary crossings (Brown, 1991). For example, feminists such as Adleman and Barrett (1990) discussed the implications of a mythical belief that Clarkson (1994) specifically referred to as a “mythical, single relationship” and cautioned practitioners about the impracticality and “unrealistic expectation that clinicians attempt to avoid all dual relationships” (p. 32). Zur (2012) also reminded the profession that in some settings multiple relationships are mandated (e.g., military and other social institutions) and it is not simply a matter of avoiding the multiple relationship, rather the clinician must also consider to whom their primary loyalty resides. For example:

In military settings where psychologists often have primary loyalty to the Department of Defense and only a secondary loyalty to the person they are treating in the consulting room. Multiple relationships are inherent in some correctional settings, such as prisons, where psychologists have a responsibility to the security of the institution, as well as to the mental health of actual patients. (para 3)

The contributions of these early pioneers to the professional discourse about multiple relationships and clinical practice led to important revisions to the Ethics Code as it pertained to Standard 3.05. However, a review of the literature conveyed that by and large the professional discourse on the topic of multiple relationships tended to advocate a message that was consistent with most updated Codes of Ethics, which cautioned psychologists to refrain from engaging in multiple relationships, and if they could be avoided (APA, 2002, 2010), the Code simply encouraged psychologists to be cautionary, thoughtful, and careful when they engaged in multiple relationships with their clients (Lazarus & Zur, 2002). Preferably, psychologists were directed to refrain from entering into multiple relationships if possible.

It was difficult to find in mainstream literature research studies that examined psychologists' experiences with the Ethics Code and more specifically Standard 3.05 from a vantage point were philosophical, thoughtful, and could offer alternative critiques in relation the Ethics Code itself and problems stemming from the Standard. Though many authors have begun the conversation about these issues such as Duran (2006), Everett et al. (2013), and Lazarus and Zur (2002, 2012), absent from literature were examinations of the Ethics Code, the philosophical ideals that informed its Standards, and the use of in depth cultural, critical analyses from non-objectivist methods such as a hermeneutic interpretative approach. There also seemed to be a gap in mainstream literature about how clinicians interpret and experience the Ethics Code and Standard 3.05. One question that emerged and guided this research: how do clinicians address the complexities of the ethical dilemmas that multiple relationships often present? What do they do when they do not agree with mainstream's approach and suggested solutions for how to deal with multiple relationships? For example, there are psychologists who cannot and equally important may not wish to avoid multiple relationships given their cultural values and the values

of the communities in which they live and practice. Studies that attempted to examine the philosophical, moral, and political foundations reflected in the Ethics Code and the profession's Western interpretation of multiple relationships as it currently stands were non-existent. There is a need for more research (e.g., hermeneutic and in-depth case studies) that can historically situate the relationship between individual and cultural social understandings of the good as they come to light in the profession's Ethics Code. It seems vital that studies that wish to better understand what might occur—both implicitly and explicitly—and the implications of privileging of taken-for-granted assumptions that inform the Western interpretation of ethics, morality, and clinical practice.

**Problems with the Ethics Code: The importance of context.** It is reasonable to assume that psychologists may be influenced by different religious or philosophical viewpoints. However, all ethical systems that undergird therapy and frame the issues with which the profession contends are value-laden and thus will inevitably shape its discourse (Tjeltvet, 1999). This can be seen for instance, when there are questions about whether it is better to be guided by general ethical principles, or by the functional impact of one's actions on the well-being of society, or by the traits (qualities of character or virtues) that the therapist and patient optimally exhibit. Diversity is inevitable and important. Therefore, according to Tjeltvet (1999), "the extent of which psychotherapy involves values or ethical dimensions, and the *different* answers various cultures give to ethical questions need to be examined" (p. 29, italics in original).

There are also cultural analyses from Cushman (1995), Hare-Mustin (1994), and Richardson, Fowers, and Guignon (1999) that have provided a framework of integration and involves active discourse and the implicit values that undergird psychotherapy. These types of analysis are important because they can help us to learn about "both prevailing ideologies and

marginalized discourses” (Hare-Mustin, p. 19). In addition, others such as Cushman (2015), Richardson, Fowers, and Guignon (1999), Sugarman (2015), and Walsh (2015) argued that we cannot identify ethical dimensions of therapy if we do not engage in a thorough examination of the taken-for-granted assumptions and values that inform the dominant discourse. Engaging in moral discourse is the only way to help make visible that would otherwise remain hidden from view. Moreover, the notion that prescriptive conduct can and will address myriad situations and (unknowable) contingencies only exacerbates the problem because it fosters increased confusion and can be misleading. Often, the ethical issues and dilemmas professionals encounter in their work are difficult to articulate precisely because they are nuanced and emerge from broader social and political influences (Anderson, 1997). This apparent contradiction has seemed to cause a serious dilemma.

Tjeltvet (1999) asserted that the ethical principles of the psychologists hinge on a shared understanding of what is distinctly unique about the therapeutic relationship. Therefore, psychotherapy as it is defined in the Ethics Code—unlike personal relationships— is characterized by the overarching virtues of beneficence and thus, the therapeutic relationship necessitates a form of distance (APA, 2002, 2010; Beauchamp, 2013). The meaning of beneficence (or a form of distance) as it is used in the Ethics Code Tjeltvet, (1989,1999) stated, “indicates how critical it is for the psychologist to differentiate between one’s personal needs and motivations when considering patients concerns and the course of treatment” (Tjeltvet, 1999, p. 40). At the same time, as Tjeltvet (1999) has suggested, this only provides one way out of the ethical dilemma. The inference is, “the therapist who acts in a professionally responsible manner will strive to grant to patients a substantial measure of freedom to choose the values they wish, rather than imposing their values on clients” (p. 40). While this is one solution to a complex

dilemma, it also assumes that therapists will understand and agree about what constitutes professionalism and responsibility. It also necessitates that the therapist has the capacity to be able to differentiate when they may be enforcing (and reinforcing) a particular set of values and the sources that inform those values with their patients.

**Ethics codes and state law.** In the United States, it is customary social practice for the state to determine whether an ethical violation has occurred only as it pertains to state law (APA Ethics Committee Rules and Procedures, 2001). When a state defines its laws, it is the responsibility of the court to regulate these laws. However, if the law is not clear about whether an ethics violation has occurred, it is not uncommon for states to defer to the profession's ethics code (Bricklin, 2001; Koocher & Keith-Spiegel, 1998). In part, professional bodies create their own codes of conduct to provide guidance to state and outside regulatory institutions in clarifying circumstances in which an ethical violation may have occurred and where state law may be silent. In the APA's Ethics Code (2002, 2010) it states that "psychologists are not necessarily legally obligated to adhere to the profession's ethical code of conduct, but must defer to the state law in which they are practicing" (p. 2). In other words, if or when the Ethics Code conflicts with state law, state law trumps the Ethics Code. However, it is not uncommon for the Ethics Code to be recognized as a source of social, prescriptive authority in other situations that might have very different experiences of circumstance, including those activities that reside outside of the practice of psychotherapy.

**Education and training.** Walsh (2015) contended there is an expectation that psychologists within the profession "practice ethical reasoning to inform and guide [their] conduct" (p. 69). For American psychologists, the Ethics Code (2002, 2010) is one text that psychologists rely upon to provide guidance and clarification about the Standards of conduct

psychologists are to follow. This is why it is thought that education and training is “the essential link that determines a psychologist’s ethical behavior” (Behnke, 2004, p. 66). Psychologists ethical behavior according to Behnke, “stands apart from ethical behavior as a member of any other profession, or as a private individual” (p. 66) which is why Behnke believed it is important that psychologists are trained in understanding the ethical decision-making process involved in professional practice.

Indeed, in the Preamble of the current Ethics Code (2002, 2010) it is stated that the fiduciary responsibility psychologists hold within the public realm involves being, “concerned with public welfare and the work that they do which is meant to be in the service and protection of the individuals and groups with whom psychologists work” (APA, 2002, 2010, p. 3).

The philosophical ideals outlined in the General Principles of the Ethics Code:

Principle A: Beneficence and Nonmaleficence ... To strive to benefit those with whom we work and take care to not do harm... ; Principle B: Fidelity and Responsibility, They establish relationships of trust with whom we work and to be aware of our professional and scientific responsibilities to society and our specific communities...; Principle C: Integrity, psychologists are to seek and promote accuracy, honesty and truthfulness, to keep our promises in research, practice and in teaching... it is the psychologist’s obligation to consider and take heed for the possible consequences of, and their responsibility to correct any resulting mistrust or harmful effect arise from our actions...; Principle D: Justice, ... Fairness and justice and equality entitle all persons access to and benefit from the contribution of psychology...; and Principle E: Respect for People’s Rights and Dignity ... Psychologists respect the dignity and worth and rights of all people... . (APA 2002, 2010, p. 3)

Drawing from these ideals, the APA is obliged to ensure the integrity of its practices in principle and application by educating psychologists, students, and the public. The goal is to ensure there is an “understanding of how ethical principles are achieved and to train clinicians in the ethical standards of the discipline” (APA, 2002, 2010, p. 3).

This has not been an easy endeavor. In part, some of the issues of concern are related to the education and training of psychologists in how to engage in moral deliberation about their practices and the values. Values that often reflect particular ethical positions and inform the decision-making processes for many for many students, clinicians, and psychological associations (e.g., the APA, WSPA etc.). It seems difficult to locate this type of ethics education and training in many graduate psychology training programs and continuing education trainings. This has been a significant issue of concern because acting ethically requires psychologists to be able to recognize nuances inherent in ethical dilemma(s) and adapt to the challenges that shifting roles present and which they will likely encounter in their practice (Gutheil & Gabbard, 1993; Knapp & VandeCreek, 2006; Nagy, 2005; Tien, Davis, Arnold, & Benjamin, 2012, pp. xiii-xiv). The current trend within mainstream psychology offers a reflection of how ethics education and training seem to emphasize an integrated model or approach that focuses on a specific set of competency skills in applied practice.

The movement by the profession toward valuing a competency-based and applied skills-based practice approach has also reinvigorated debates about what constitutes valid certification of what kind of skills are deemed to reflect competence and guided the profession’s goals in defining these aspects. Boulder Conference of 1949 serves to remind the profession that this is not a new debate. Historically, participants at the Conference struggled directly with these similar issues and had determined that a fully useful professional psychology must be a

discipline concerned with ethical education, training, and assessment as it pertains to psychological practice and services rendered to the public (Albee, 2000). Falling in line with the Boulder supposition, the APA also proclaimed that professional psychology could not deliver maximum public benefit let alone survive as a profession unless the certification of professional knowledge, privilege, and responsibility was comprehensive in scope (Peterson, 1976). More recently, Johnson and Baker (2015) have stated there is growing attention within the profession about not only the determination of competencies and associated benchmarks, but also how to deal with the task of competency assessment. This movement also seems to have been propelled by and connected to national policy changes in education legislation and the field of psychology. For example, the *Spellings Report* (US Department of Education, 2006) and the *No Child Left behind Act* (2002) significantly influenced legislation and national policies related to accountability and the assessment of learning outcomes at all levels of education. The APA responded to this national mandate and consequently began to review and revise their own directives pertaining to education and training (Rubin et al., 2007). However, some such as de las Fuentes, Willmuth, and Yarrow (2005) noticed that teaching clinicians in how to engage in ethical deliberation in a way that prepared clinicians well, when they had to apply therapeutic techniques in a contemporary integrated fashion is only one layer of sound ethics education and training. Applied skills and techniques may be helpful however, they often do not facilitate a better understanding of the complexity of the psychological issues and concerns many clinicians confront in practice.

In 2002, recognizing the need for reform in education and training, the APA Ethics Committee concentrated on competency training in ethics education and practice. The Association of Psychology Postdoctoral and Internship Centers (APPIC) in collaboration with

cosponsors from Canada, Mexico, and the United States hosted a Competencies Conference to discuss these issues. The focus of the conference was to begin to identify training and assessment benchmarks specifically related to the development of competence in ethics, law, public policy, advocacy, and professional issues (Blevins-Knabe, 1992; de las Fuentes et al., 2005) From this group's efforts, it was determined that psychologists and psychologists in training needed to possess definitive knowledge and skills about ethical decision- making and interventions. The working group identified four core components pertaining to competence in ethics training and education identified. Psychologists must be capable of:

- 1) Appraising, adopting or adapting their own ethical decision-making model and apply it with personal integrity and cultural competence in all respects of their professional activities; 2) have “the ability to recognize ethical and legal dilemmas in the course of their professional activities (including the ability through research and consultation to determine whether a dilemma exists); 3) have the ability to recognize and reconcile conflicts among relevant codes and laws and to deal with convergence, divergence, and ambiguity; and 4) to be able to raise and resolve ethical and legal issues appropriately. (de las Fuentes et al., 2005, p. 364)

Another critical aspect related to the issue of competency in ethics education and training entailed the incorporation of the APA's published guidelines on Multicultural Practice (2003) with gay, lesbian, and bisexual individuals. The new guidelines called for training programs to teach students the importance of knowledge and skills in the areas of moral reasoning, and behaviors that demonstrated psychologists possessed an awareness of the various cultural contexts that informed the clinician's values and beliefs (Arredondo & Perez, 2006). This directive was based on the premise that if clinicians were taught to foster an appreciation and

become more aware of the differences in moral and ethical values across cultures than this would facilitate a deeper and expansive perspective about ethics. It was assumed that engagement with and exploration of one's own moral and ethical values and attitudes might help students learn important interpersonal skills that included flexibility and openness to new ideas and change in a less defensive manner, thereby enhancing the student's ability to critique the ethical decisions they might make when working with patients whose cultures and traditions differed from the clinician's (see Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists, 2003; APA, 2002, 2010).

Since one of the functions of ethical codes of conduct is to protect the rights and welfare of the public, Knapp and VandeCreek (2006) and Tjeltvet (1999) have noted that ethics codes are in a constant state of evolution. Therefore, these authors believe it is necessary that professional codes and the clinicians who are directed abide by certain standards be able to respond to the broader sociological and moral issues facing the profession. Given the socially sanctioned position psychologists hold within society, psychologists are not only judged by their current ethical standards, but also by their commitment to continuously re-evaluate and re-formulate the ethical Standards and codes of conduct to which they adhere. From the APA's perspective, as a leading organization it is thought that in part it functions to ensure that psychologists are meeting their social obligation to the validity and integrity of the professional body of psychology. One way it achieves legitimacy and reliability is by producing competent and ethical psychologists. A critical aspect of this process includes establishing ethical guidelines that are representative of the values and experiences of its membership. Another critical aspect thought to be necessary to the preservation and excellence of the profession is to ensure that professional psychology

programs are designed in such a way as to implement and enforce ethical standards by training and educating clinicians in competency-based curriculums (de las Fuentes et al., 2005).

On the other hand, de las Fuentes et al., (2005) contend that it is unwise to assume that training programs can develop a specific moral character. When it came to ethics training in many cases, Branstetter and Hadelsman (2000) found that although the participants in their study knew about ethical principles, this knowledge did not necessarily render ethical behavior. More specifically, the graduate teaching assistants who participated in their study had difficulty judging what was considered to be appropriate ethical behavior in several situations and could not necessarily identify what constituted a multiple relationship. Interestingly, while the graduate students in the study believed that sexual relationships between therapists and patients was an egregious ethical violation, it was less clear for them to delineate ethical problems when it came to students engaging in sexual relationships with teachers and within the university setting (Branstetter & Hadelsman, 2000, p. 30). It is important to note here that there are numerous Standards specifically related to exploitive relationships (APA, 2002, 2010 see also Standards 3.04, Avoiding Harm, 3.05, Multiple Relationships, 3.08, Exploitive Relationships, 7.07, Sexual Relationships With Students and Supervisees, 10.05 Sexual Relationships With Current Therapy Clients/Patients, 10.06, Sexual Intimacies With Relatives or Significant Others of Current Therapy Clients/Patients, 10.07, Therapy with Former Sexual Partners; and 10.08, Sexual Intimacies With Former Therapy Clients/Patients). The authors hypothesized that one explanation for the failure of this reasoning about sexual relationships between faculty and students were twofold: 1) there was a perception that unethical behavior is acceptable; and 2) observing faculty and/or therapists who engaged in unethical behavior sent a contradictory

message to trainees, which undermined the fundamental ethical principles that were being taught in the classroom (Branstetter & Hadelman, 2000, p. 32).

Throughout the years, the APA has spent a great deal of effort (and financial resources) to craft a professional identity that is seen as capable of bridging the multifaceted roles and responsibilities of its members. It is accepted within the profession that the various roles, contexts, and settings within which psychologists' work have broadened and some duties extend well beyond the traditional clinical setting. The emerging ethical concerns coming from the wide range of diverse psychological activities have posed challenges the APA in finding substantive ways to integrate relatively abstract philosophical principles and the practical application of those standards which once entailed a fairly narrow range of scholarly and professional roles (Fisher & Younggren, 1997). For example, it is not uncommon for psychologists to be engaged in multiple activities consecutively and in some cases simultaneously. Psychologists are teachers, researcher, engage in organizational consulting about test development, psychological assessment, counseling, psychotherapy, and forensic practice. It is important that psychologists can refer to the Ethics Code for guidance when they consider decisions that will protect the rights and welfare of those with whom they work (APA, 2002, 2010). This viewpoint, has led to a heightened expectation that graduate training programs in psychology are tasked with the responsibility of defining ethics and providing education and training that will adequately equip and assess the competence of its trainees (Kaslow et al., 2004; see also Future directions in education and credentialing in professional psychology, 2002).

However, as Knapp and VandeCreek (2007) have pointed out, if the APA is legitimately concerned with protecting the public from incompetent psychologists, then this also requires a concerted effort to address what is disguised within the curriculums that the profession is

promoting. Curriculums that are nestled in the broader socio-historical and political backdrop in which ethics training in graduate programs are embedded. The pressure to meet this expectation is strong. Training programs who hire faculty to teach in psychology programs are expected not only to be accountable for their own competence and expertise in subjects assigned to them, they are also held accountable for ensuring that their students will be competent ethical professionals. This is a challenge many graduate programs struggle to achieve. de las Fuentes et al. (2005) offered examples of elements that are needed if ethics education and training programs are going to be robust and adequately prepare clinicians under who are under the institutions charge and care. Drawing from the findings from their study, these authors found that the most vigorous clinical training programs were ones that challenged and inspired students to strive toward their highest potential, were able to talk openly about their ideals and conflicts, and where students and faculty actively engaged in and contributed to the atmosphere of their training and community (de las Fuentes et. al., 2005). In line with this, Knapp and VandeCreek (2007) cautioned about the need to eliminate as much as possible any confusion or inconsistencies between what is being taught and what is being enacted. They noted that students are very good at noticing when there are discrepancies in ethical behavior from their faculty members which begs the question: Are the informal messages communicated by faculty and the administration congruent with the formal messages being taught to the students?

### **Western Conceptualization of Self**

The importance of engaging in moral discourse about the good helps us to understand the historical time, the social and political influences, and the demands they engender in society (Gadamer, 1989). But the ability of a society to engage in discourse about their traditions and social practices is also dependent on a shared language. Having a shared language provides a

society with a way to contemplate and discuss the values embodied in those traditions and the social practices that are enacted. For instance, the location of our social and political institutions, the meaning of emotions, questions, and beliefs about where we originate from, and what is meaningful to human life are just some of the ontological issues continuously working out throughout every era (Cushman, 1995, p.17). In other words, what is being noticed about what is happening in society? The cultural trends of the historical time, such as what are we doing, fighting about, find enjoyment from, and even our clothing. Observing and examining these embedded social practices will help provide clues about what a society believes to be the good life. The individualism that permeates the fabric of American social life seems to reflect a value that implies a need for the separation or privatization of the individual's values from public concerns of society. This modern-era understanding of the good has made for difficult terrain when it comes to trying to locate and engage in moral discourse about our values. Values that are important to us and inextricably linked with matters of public life. Consequently, the assumption that one's self-identity and the individual values one might hold can and should be denied or bracketed off from a public morality and the profession's practice, can simultaneously obscure fundamental questions about what is of value in society.

In Western society, it is thought that a socially just society is one in which all groups of people, regardless of background, history, and heritage are to be included in the political, economic, and social decisions of that society (Orlowski, 2009). At the same time, in the U. S., it seems that in the pursuit of justice and welfare of the people and what is described as a just society are inconsistent with what is often communicated through many of the actions exhibited by this nation. For example, Duran (2006) contended, such ideals when interpreted through a hierarchal and narrow lens may help to explain some of the contradictions between what the U.S.

describes as a just society and what it communicates through its actions. Richardson et al. (1999) also draw attention to the consequences that emerge when a culture that is unable to locate where it stands within its historical traditions will also struggle to be able to critique its own cultural values in a way that opens the door of understanding to other ways of being and learning new things about others who do not share those same values. Ethics is an arena where knowledge and learning about the moral principles that govern a person's or a group's behavior (e.g., discourse) can take place. Yet, at present in American psychology, there seems to be an absence of space for talking about the many challenging types of moral dilemmas psychologists grapple with and situating those dilemmas historically and philosophically when trying to better understand multiple relationships in psychotherapy practice.

**Relational beings.** Relational psychoanalysts Greenberg and Mitchell (1983) contended that the human creature is a social creature and relational “by design” (p. 403). The emergence of the relational psychoanalytic movement and its growing popularity within the profession of therapy reflect the centrality of an understanding about relationships and how we have come to interpret our world. At the heart of this perspective is the notion that, as relational beings, the identified self is constituted, experienced, and understood in the context of relatedness (Gergen, 2006; Sampson, 1988). The self is not thought to be an entity created by the imposition of our social and relational experiences, but rather the self is our social and relational experiences. That is, human existence cannot meaningfully be understood solely in individual terms or separated from culture, “because meaning and identity are inherently negotiated through our interactions with others. It is through our involvement with other people that we become fully human” (Greenberg & Mitchell, 1983, p. 403).

Because both identity and meaning are traversed through interaction, the self is embodied by the processes involved in the need to establish and maintain bonds we have with others, whatever the cost might be. On the one hand, we know that we need each other and want to need each other. The construction of the self, as it develops a sense of identity while living, is dependent on other people in our lives, so it is not an easy or quick process, nor is it fixed or concrete (Gergen, 1991). In other words, as Mitchell (1988) noted we are not just parts of biologically based urges, but we are “being shaped by and inevitably embedded within a matrix of relationships with other people” (p. 3). This often entails “struggling both to maintain our ties to others and to differentiate from them” (p. 3). The struggle is complex, multifaceted and in a constant state of evolution. It’s slow. In contemporary American society, this understanding of the ongoing social emergence of the self is a notion that can be hard to realize because we live in a world that has conditioned us to want more, to have more and to achieve more as quickly as possible, whatever that entails or might cost us in other arenas (Walsh, 2015). This way of being has resulted in a culture that expects instantaneous answers to complex questions about identity that is coupled with a sense of entitlement to immediate gratification regardless of context. In American society, there tends to be a pull to determine the validity of our actions or experiences based on how others respond to our expectations (Cushman, 1995; Gergen, 1991).

The social and historical context from which relational theory has emerged is a cultural response that both reflects the deep-seated desire for authentic connection and emotional depth, yet, constantly seems to escape our grasp (Cushman, 2013). It feels out of reach in part because the unbalanced equalization of power that constitutes the Western paradigm has lent to a sense of powerlessness when attempting to oppose the socially constructed hierarchies that dictate who we are in the world (Duran, 2006; Oliver, 2004). Within the profession of psychotherapy, this

sense of powerlessness presents when clinicians who question their authoritative role in ways that challenge previously held ideas about the role of the therapist. This is a qualitative shift in conceptions about the therapeutic relationship has initiated provocative discussions pertaining to the historical conditions that gave rise to the various theoretical understandings of and implications for cultural and social life in general and political change in particular (Botticelli, 2004; Cushman, 2015; Elliot & Spezzano, 1996; Gergen, 2006).

**Modern and postmodern influences on self-identity.** The move toward globalization, the expansion of capitalism and consumerism have also brought about advances in technology that have constituted the construction of a particular self with implications that have been both helpful and not so helpful (Cushman, 1995; Richardson et. al., 1999). For instance, there have been unquestionable progressive strides in the physical sciences and technology that have proven extremely powerful in improving the human condition. These advances reflect society's capacity of increased understanding in many arenas: neurobiology, genetic disease, cancers and in some instances, have led to the full eradication of existing diseases (e.g., polio). Technological advances have also increased the speed of communication domestically and internationally, shrunk geographical barriers between countries, and lent to a heightened sensibility about how national decisions and actions impact other countries, societies and individuals. The ability to experience new and different worlds in ways that were not available to us prior to the present times has made space for the potential to expand and deepen our understanding of others and difference in ways that foster and enrich our lives which were not possible before (Gergen, 1991).

At the same time, although it is easy and encouraging to focus on the positive impact of the modern and postmodern eras, it is also necessary and perhaps more important to look at the

social implications modernity and postmodernity has had on our ability to understand and articulate who we are as individuals in the collective society. For example, Cushman (1995) argued that “in the West with its scientific practices has been unable to develop room for a moral discourse that can keep pace with its wonderful scientific practices” (p. 21). Though great discoveries continue to be achieved, in American society the struggle to develop a consensus for what is the common good and how to use its achievements for the common good remains difficult.

The paradox of globalization and technology is that it both brings us together as a larger community and creates a sense of fragmentation that can heighten our sense of isolation and loneliness. This is a mind-set that compromises our ability to grasp the wider social forces that influence who we are and the many things we share (Furedi, 2004). In previous times, communities were collective and cohesive social networks were local and contained. People could and did find an enduring sense of stability, and maintained a sense of connection with each other through the collective traditions that were established. This in turn, produced a clear, common, and unified self-identity, in that people knew who they were, what they believed in and why, because there was a cohesive narrative about the self that was tied to an external tradition. Another example of the difference between previous periods of Western pre-modern and modern life was the ways in which economic and social determinism provided a social context of relationship. During those times, the reasons for living and working with others often brought people together for purely economic circumstances. These were societal relationships that were based on “crude economic or social determinism that had little room for the individual subject” (Giddens, 1991, p. 24).

It is true that the postmodern self still lives in a world where the local life is contextualized, largely contained and constrained the physics of time and space. However, unlike previous times, the transformation and the intrusion of distance into the local life when combined with the centrality of mediated experience has radically changed the world that we live in today, posing enormous challenges and distinct pressures for the self (Giddens, 1991, pp. 187-188). First, it makes it difficult to recognize a collective coherent narrative of self-identity; and second, to preserve a coherent narrative of self-identity, these tensions and difficulties need be resolved. For instance, modern life has acquired an intensely hurried and a disjointed self-identity that in a postmodern society fails to provide a collective sense of meaning and tradition about our experiences in the same way and for the same reasons that existed before (Bellah, Madsen, Sullivan, Swidler, & Tipton, 1986; Giddens, 1991).

Finding a sense of meaning and connection with others through a virtual community as opposed to physically having to live with others or work with others in real time and space cultivates a climate in which understanding about life and the outcomes of our experiences can be and often are reduced to the interior life and personal choices of the individual (Sandal, 1996). The unified sense of a collective self-identity is no longer based on crude economics or survival; but rather gathering together as a community (or choosing to leave it) is based on the personal choices of the individual. But, in the absence of a collective sense of meaning and traditions about our experiences, can led us to feel isolated and disconnected from each other at the deepest levels of society. Furedi (2004) explained how this reorientation shifts societal institutions towards a preoccupation with the self from external- social to the internal- individual and encourages the individual to identify their suffering as the problem of the individual self rather than stemming from the social and political conditions that constitute their existence (p. 24).

From this vantage point, social problems become “redefined as private problems of the individual” (p. 24).

**Modern public philosophy.** In *Democracy's Discontent: America in Search of a Public Philosophy* (1996), Michael Sandal examined U.S. political and public philosophy. He noted that there was a shift in the civic or formative aspect of U.S. politics in recent decades from a public philosophy based on Aristotelian virtues in which political life was concerned with the highest human ends. The purpose of politics was to cultivate virtue or the moral excellence of its citizens that move them towards a public philosophy based on a liberalism that:

Insists on toleration, fair procedures, and respect of individual rights--values that respect people's freedom to choose their own values and conceives persons as free and independent selves, unencumbered by moral or civic ties they may have not chosen. (pp. 6- 8).

Central to this notion of liberalism in a procedural republic is that of a government who could be neutral towards the diverse moral and religious views of its citizens and the question of what the good life meant. It was a notion of freedom that consisted of our capacity to choose our ends. However, because it failed to provide a way to define a relevant community of sharing or some way of “seeing its participants as mutually indebted and morally engaged to begin with” (p. 17), it also lacks the ability “to inspire the sense of community and civic engagement that liberty requires” (p. 6). Yet, as noted by Sandal (1996):

The quality of character required for the kind of deliberation that distinguishes and make sense of what constitutes a moral dilemma as opposed to just mere sentiment or prejudice is the quality of the disposition to see and bear one's life circumstance as a reflectively situated being--claimed by the history that implicates me in a particular life, but self-

conscious of its particularity, and so alive to other ways, wider horizons. But this is precisely the quality that is lacking in those who would think of themselves as unencumbered selves, bound only by the obligations they choose to incur. (p. 16)

Unlike the vision of a liberal freedom so common in contemporary American political life, historically, early American understandings of freedom were based on a republican theory whose central idea of liberty depended on sharing in self-government and sharing in self-rule. Sandal (1996) stated, “to share in self-rule requires that citizens possess, or come to acquire certain qualities of character, or civic virtues, as sense of belonging, a concern for the whole, a moral bond with the community whose fate is at stake” and to share in deliberation about the common good” (p. 5). This was a conception of freedom that “required a formative politics that cultivated in citizens the qualities of character self-government require and could not be neutral towards the values and ends its citizens espoused” (p. 6). Yet, people are inevitably going to disagree about the best way to live, and since liberalism privileges fair procedures over particular ends, it is thought that the role of government is to “not affirm in law any particular vision of the good but rather, government should provide a framework of rights that respects persons as free and independent selves, capable of choosing their own values and ends” (p. 4). One of the consequences of this view Sandal has argued, is that “there is no political obligation, strictly speaking, for citizens generally” (p. 15). For example, political obligations that are voluntarily acquired by those who elect to serve their countries might tie them to that obligation and what that commitment entails, but the ordinary citizen is not bound by those same commitments. Other than the “universal natural duty to not commit injustice, the average citizen has no ties or any special obligations, loyalties or responsibilities to their fellow citizens” (p. 15).

Still, duties of membership presuppose that we are capable of moral ties that precede choice; this conception of liberalism makes it difficult to recognize common obligations and political ties that social responsibility entail. Liberalism Sandal (1996) stated:

Fails to capture those loyalties and responsibilities whose moral force consists partly in the fact that living by them is inseparable from understanding ourselves as the particular persons we are—as members of this family or city or nation or people, as bearers of that history, as citizens of this republic. It is difficult to make sense of certain familiar moral and political dilemmas without acknowledging obligations of solidarity and the thickly constituted, encumbered selves that they imply. (p. 15)

**Therapeutic culture.** Contemporary Americans live in what Furedi (2004), Lears (1983), and Reiff (1966) referred to as “therapeutic ethos.” Furedi described a therapeutic ethos as a culture that cultivates a climate in which individuals find meaning and a sense of identity in categorical psychiatric diagnoses and where prescribed treatment by an expert is necessary for wellness. Central to this socio-historical phenomenon, which grew out of the medical practices of the modern- era, is that therapy has come to mean the cure of illness through the application of science (Lears, 1983). Additionally, the dynamic between social institutions and the treatment approaches that emerge forms a reciprocal social arrangement whose function is to maintain the homeostasis of the “ethos.” The inherent bureaucratic mechanisms within these arrangements serve to enact and re-enact certain practices that will promote compliance and maintain the status quo (Sass, 1994). A present- day example of this would be the administrative demand that practitioners document diagnoses and formulate treatment plans by the third session. If practitioners resist, they do so at the risk of being deemed non-compliant, which can result in

punitive measures such as denied coverage, removal from insurance panels, or reprimand from superiors.

The economic and social determinism that in previous times provided an understanding about the self and the problems of society has now become what Furedi (2004) called an “emotional determinism” (p. 24). For Furedi, emotional determinism meant that explanations about who we are now occur within the context of how we feel about ourselves. This relocation is most evident in the cultural manifestation of individualized therapy. One example of this in American society is the culture’s conception of health and illness which are perceived as psychological, emotional and dispositional reflections of the individual. This conception of health provides an explanation about the kinds of social problems that generate anxiety, fear, and guilt. These social problems are not interpreted as the result of social or political circumstances, but of personal inadequacy and psychosis (Loss, 2002).

The rise of a therapeutic culture is also addressed by Anthony Giddens (1991) in *Modernity and Self-Identity*. Giddens attributed the rise of therapy to the emergence of what he referred to as “pure relationships” (p. 186). Pure relationships are those that perceived “as voluntary commitments which present the prospective development of trust and intimacy because they are based on the choice of the individual” (p. 186). The necessity of secure relationships in which basic trust and intimacy have been achieved are vital because they create strong connections that are “psychologically stabilizing” (p.186). When stabilizing strong connections between basic trust and the reliability of caretaking figures are present, it allows the individual to embrace feelings of security in the “object- world,” and the realm of personal relationships. This is of critical importance because of its demand and allowance for organized and continuous self-understanding that makes securing a durable tie to the other possible.

However, in a post-traditional society, given that distance and time intrude into the local life through a variety of different sources, there is also an openness to a world with an indefinite range of possibilities, encounters, environments and behaviors. Relationships based on trust are not localized like they were in earlier times. This fragmentation lends to the existence of multiple selves and the demand on the individual to conjure up different presentations of the self in varying contexts. This is a shift that has changed how today's society understands, defines, and tries to achieve close relationships.

While intimate personal relationships are essential, they also encumber the integrity of the self. In a relationship that lacks an external moral reference, the mobilization of ethical principles only occurs through "authenticity" (Giddens, 1991, p. 187). Giddens defined an authentic person as someone who knows themselves and can communicate this in a way that is tangible and can be observed in their actions. Engaging in an authentic relationship with another provides an important source of moral support, largely because of its potential integration with basic trust. Conversely, the idea of intimacy with another is often elusive, confusing, and scary, because it hinges on the basic trust and a sense of feeling good in the relationship, both of which have a relative degree of uncertainty. Those involved in an authentic relationship are making the choice to be connected and committed to each other. However, if the good feelings go away, either person can end the relationship. In the therapeutic ethos, intimacy is usually obtained through "psychological work" and can only be achieved if one or both is secure in their self-identity (Furedi, 2004, pp. 24-25). In American society, evidence of this emphasis can be seen in the vastness of psychology's role in the education and facilitation (via self-help books) of how to become more intimate, and how common it has become for people who are struggling in their relationships to seek therapy. This is an understanding driven by an

assumption that therapeutic work will facilitate a better understanding of the self, and in turn will help them “relate” better and therefore “feel better” ultimately leading to the achievement of intimacy. Though, intimacy in the way that Furedi and Giddens described requires a quality of commitment to the relationship by one person or both. It takes time and being patient with the process of developing intimacy can be difficult to learn how to do in a quick paced and fragmented environment (Furedi, 2004, p. 24).

**The human sciences.** Modern psychology and psychotherapy, as some have suggested, “Came into existence in part, as a way of dealing with the problems that characterize modern cultural life” (Richardson et. al., 1999, p. 54; see also Proffoff, 1956; Sarason, 1986). Duran (2006) noted that the “roots of psychology have been concerned with matters of the human psyche or soul in ways that are deeply enmeshed with spiritual metaphors and are inextricably tied to psychology” (p. 19). Through a simple etymological regression, he pointed out that the term psychology literally translates into the “study of the soul;” and when psychologists identify as “psychotherapists,” this identity literally translates into “soul healer” (Duran, 2006, p. 20). However, in the West, the profession of psychology largely pursues the eradication of “psychopathology” which when literally translated turns into “soul suffering” (p. 19). Moreover, in Western psychological terminology today, it is uncommon to include the terms “spiritual and soul.” It is thought by Duran that the absence of this terminology in our practice reflects an important historical and cultural shift in psychology. For Duran, this shift is indicative of the discipline’s movement away from its roots (e.g., soul or heart) and a departure from the essential meaning of the identity of a psychotherapist as a “soul healer” (p. 20). He posited that from a philosophical standpoint, if the root word of psychology literally translates into “soul,” but the focus of mainstream therapies and clinical practice is on cognition, therapeutic treatment and

prescribed practices, “the meaning of the root word becomes translated into a form of control and domination, which are contradictory to the very principles that undergird the profession’s ethics code” (Duran, 2006, p. 21; Oliver, 2004). Duran (2006) also discussed how this “dislocation from spirit and suffering may have also influenced the rise in diagnoses relating to depression, anxiety and trauma related *dis-orders* in American social life” (p. 21, emphasis in original). This is a predicament that leads one to wonder about the disconnection between ethics and morality and the ways in which it has informed contemporary theories about suffering and treatments. A disconnection or separation that has functioned in advancing the tendency of the profession to “act as if we have good answers, even when they are not available” or necessarily helpful (Richardson et al., 1999, p. 39).

**Dependence on the “expert.”** In this era, the social world appears to be diverse and comprised of many (which at times seem conflicting) authoritative experts available with solutions, explanations and treatments for our problems. It seems difficult not depend on the experts to tell us what to do or how to be in our relationships and lives. Many feel powerless and helpless in trying to understand their struggles and find some semblance of relief, but it seems difficult to find ways to resist and change the social and political circumstances of the historical time. This has also shifted the cultural frame of reference to one where a sense of control and power to change our lives and circumstances is thought to reside with the experts (Giddens, 1991, p. 194). In previous eras, tradition itself acted as the principle source of authority and although this primary authority was not located within any particular institution, it still pervaded many aspects of social life. In contrast, in the absence of a single traditional authority what has occurred instead is a pluralism of expertise spanning across different fields and shifting the placement of power from the individual to external organizations. There are numerous claimants

to authority, but there is no one determinate authority, and “numerous modes of expertise as suggested by Giddens, are fueled by the very principal of doubt and uncertainty” (p. 194). To exist amongst so many conflicting authorities, the freedom of choice can become a psychological burden for individuals who need certainty. The inundation of so many opinions from the experts creates a significant amount of pressure and self-doubt about what might be best for the person and their situation. In response to this pressure, individuals will tend to seek relief in overarching systems of authority and procedures. In its most extreme it “becomes a pre-dialect for a dogmatic authoritarianism” where people seek out the best answer or an answer they want hear rather than exploring the reasons for what might be causing the suffering (p. 196; Marin, 1979).

In a therapeutic culture where emotionalism privileges the view of emotional intelligence and the expression of one’s self, it seems curious that the human capacity would feel so ambivalent about understanding how to value emotion (Furedi, 2004, p. 33). One example of this in modern Anglo-American societies can be seen in the praising of the open and public exhibition of emotion while at the same time requiring that strong emotional responses be managed and controlled. An open display of positive emotions in today’s society is applauded and even encouraged, but when the emotional display is raw and unprocessed (e.g. rage and anger) it is discouraged and in even criticized. This is another example of how a therapeutic culture conditions the public to be suspicious of emotional expression. It is thought by Furedi (2004) that this type of ambivalence toward emotion is grounded in the belief that the source of so many of society’s problems are result of the experience and expression of emotion (negative emotions). Certainly, it is the case in U. S. culture where emotions are often “represented as objects to be managed” (p. 33). Along with this, attempts to manage one’s emotional experience also negates the project of self-discovery and communicates a message: the individual is less

than capable of managing their own emotions. By and large, the public is instructed by the experts to believe that this is a job that should be left to the “experts”, and one way to get “in touch” with their emotions is by accessing therapeutic support (p. 33). This social arrangement also creates a tacit agreement between the public and the profession about what constitutes emotional well-being and maturity that are intricately tied to the willingness of the individual to seek help from a therapist (the expert). This interpretation might also help to explain why so many resources are devoted to cultivating dependence on the “professional expert” and maintaining the status quo (Furedi, 2004).

The expansion of capitalism has likewise impacted the construction of the postmodern self. For example, huge sectors of labor and industry having been placed in the hands of the free market feeds ambitions that shape consumption and monopolize conditions of production that are driven by the aim of expanding the capitalistic enterprise (Giddens, 1991; Lichtman, 1981). In a culture where commodity reigns, it cultivates a reliance on consumerism to legitimate the need for experts undermining the location of tradition. The place of shared traditions within a society is important because it grounds the project of self-discovery in those shared practices. However, in a consumeristic culture that is disconnected from a shared tradition, identity and genuine self-development are translated into commodities or artificial possessions and goods that can be bought or sold heightening the value of shallow lifestyles. It is a way of being in which the packaging of self-actualization via self-help books and step-wise guides on how to move up in life can be found and purchased at the corner book store (Giddens, 1991).

**The ‘Psy’ disciplines.** The evidence-based claim is not without consequence. For example, one of the ways the evidence-based claim function by providing information that will influence and control the policies and procedures to be implemented by insurance companies and

the profession. The purpose and task of licensing boards are also elevated to a special status, in that the function of licensing boards is not only to regulate and enforce standards of practice, but also to invoke the power to grant the professional an expert status. Within this systemic arrangement, the message communicated to society is that only the licensed professional possesses distinct expertise that will benefit the public. This claim, in turn, creates a need for and a dependence on the expert. For decades, the West, in the name of science, has disseminated modern knowledge of what constitutes mental illness across the globe with the assumption that our approaches reveal the basis for psychological suffering (Crawford, 2006; Rose, 1999; Watters, 2010).

Historian Kurt Danziger (1979) noted that the creation and dissemination of psychological ideas influenced by the existence of a professional-academic group of psychologists have become increasingly powerful. Psychological ideas have been in existence long before this century, but what is different about the social context in late 21<sup>st</sup> century society is its recognition of “a professional group called psychologists. Because psychologists are perceived as a well -organized professional group that came into existence, they have been able to claim and monopolize the production and reproduction of psychological knowledge” (Danziger, 1979, p. 27). Nikolas Rose (1999) discussed how the social origins of modern psychology became what he referred to as the 'Psy' disciplines. These disciplines were comprised of:

Heterogeneous knowledges, forms of authority and practical techniques that constitute psychological expertise and has made it possible for human beings to conceive of themselves, speak about themselves, judge themselves and conduct themselves in new ways. (Rose, 1999, pp. xv)

The significance of celebrating the values of self-realization and the right to self-govern within modern, Western life are essentially psychological in form and structure. Rose (1999) argued that, the relationship between ‘Psy’ expertise and a culture of liberal freedom has been in place since the mid-twentieth century and has only continued to develop (pp. xxi-xxv). These disciplines are not simply a matter of ideas, cultural beliefs, or even a specific kind of practice; rather, it is the expertise they exemplify that has played a key role in constructing governable subjects and contemporary forms of political power. This in turn, has made it possible to govern human beings in ways that are compatible with principles of liberalism and democracy (p. vii). That the ‘Psy’ knowledges embody practices that depend on the co-ordination of human conduct and the utilization of the reform of human capacities in relation to certain objectives according to Rose (1999) has included:

The resolution of a range of difficulties in the practical management of human beings: helping organize and administer individuals and groups within schools, reformatories, prisons, asylums, hospitals, factories, court rooms, business organizations, the military, the domesticated nuclear family. (p. viii)

Because the production of positive knowledges (c.f., Foucault’s concept of “productivity,” *Discipline and Punish*, 1991) are presented as seemingly reasonable claims of truth and apparently impartial dispassionate expertise, it becomes possible to rule subjects within these practices and apparatuses in ways that appear to be based not on arbitrary authority, but on the real nature of humans as psychological subjects (Rose, 1999, p. vii). These new forms and the role of the human sciences, have helped to construct humans who are able to possess the ability of bearing the burdens of liberty and “exercise political, moral and even personal authority in ways that are compatible with notions of freedom and autonomy” (p. ix). For

example, in the psychological sense, the status of “adult” in Western societies is a moral imperative that binds the individual to be free. Yet, the constraints, obstacles and limitations that everyone may encounter to render life meaningful remain somewhat implacable. Thus, the project of self-realization becomes about individual choices and the necessary evidence for reaching the intended outcome (pp. xxiv-xxv).

Psychological knowledge, if understood as “a thing of this world” (Rose, 1999, p. ix), also implies that its problems, concepts, explanations, and techniques are intrinsically linked to its capacity to act as a kind of “know-how” or teacher in the governing of conduct (p. ix). However, Rose (1999) argued, to contemplate what it means to be able to express doubt about the present claims to certainty (e.g., what we know, who we are, and how we should act) by confronting them with their actual histories can be disorienting provoking more angst about what might be found, than it is to expose empirical errors or the formulation of conceptual critiques (p. x). At the same time, the lessons yielded are important because they provide insight into the principles and rules regulating the discipline. And:

Help to explain how psychology managed to establish itself as a scientific discipline and a profession to gain widespread acceptability for its claims to truth. And methodologically, it charts a path beyond the rather unproductive opposition between internal and external historical approaches to scientific knowledge. (Rose, 1999, p. ix)

There has been a steadily growing criticism of individualized conceptions of the self and the implications this conceptualization has had for society (Richardson et al., 1999; Sampson, 1977, 1988; Taylor, 1989). Moreover, critics of a fundamental distinction between the self and other have suggested that when there is a dichotomous split between the individual and the social world, it produces an isolated and alienated person. When this occurs alongside the culture’s

prevailing value of autonomy and individualism— becoming “a self-made” individual (Gergen, 2006, p. 121), inter-dependence is judged as a sign of weakness and powerlessness. It is a social world in which the individual and/or institution feels estranged and fearful of dependence which then cultivates a sense of distrust and suspicion in the motives of others. This mind-set justifies an attitude that is self-aggrandizing and the need to look out for number one or the self above others.

The rejection of the assumption of private and autonomous selves in other intellectual disciplines parallel other critiques about individualism. Derrida (1978) argued that when moral theories are based on a private, autonomous, rational self the two are fundamentally incompatible with one another. These concerns were refreshingly provocative, but they too rose out of a cultural context. They emerged from the changing context in which academic inquiry in the late 20<sup>th</sup> century was conducted. Advances in technology, transit, and the ways that society socializes and communicates has also profoundly affected today’s cultural context. There are virtually no limitations of where people might travel throughout the globe and the mobility of organizations and institutions are far reaching. This expansion of mobility introduces cultural differences and value systems that have negative and positive aspects. For example, a growing consciousness of difference in beliefs, politics, and values may collide more readily, triggering antagonistic responses in general, and in therapy hour. On the other hand, an understanding of the self as culturally constructed is growing, provoking new ideas about what constitutes reality (Aho, 2009). One of the consequences of this way of being in the world, coupled with the process of globalization, has promoted a type of dependency on relationship and connection (Furedi, 2004) in that, the reality of relationships and how we relate to each other “will depend on our capacity for relational transformation” (Gergen, 2006, p. 122).

Most proponents of these social conceptualizations of self tend to invest in the moral concerns of society with little room for passivity or neutrality about the issues (Richardson & Fowers, 1998). The absence of a grounding in more collective traditions, a felt sense of disconnection, apathy towards individual and civic duty, and preoccupations with one's self, have created immense challenges for the political activist. The call for political action whether in the therapy office or on the street conflicts with disenchantment and disillusionment about politics and one's sense of moral agency. For example, despite the civil rights movements of the 1960s and 1970s, the persistence of racial and social inequalities and the failure of modern politics to provide a viable alternative to free-market capitalism has contributed to a growing skepticism toward possibilities for effecting meaningful political change (Botticelli, 2004).

**Self-control and reason: Plato and Descartes.** Though ideals about the self has shifted across the ages (e.g., the philosophical traditions of the Greeks, the Stoics, and Descartes) they continue to influence present-day Western life. Ancient Greek concepts about the self, reason, and empirical science embodied the good and the notion of self-control and mastery through reason, themes that began with Plato, have re-emerged at various eras and Western society (Fowers, 2000; Taylor, 1988). It was thought by the Greeks that reason meant the ability to see the “order of things, to grasp ideas, and their ordering” (Taylor, 1988, p. 305). Reason was believed to be “a property of human thought and desire” and something that humans inherently desired and therefore wished to enact (p. 308). The interpretation of this ideal was a person who could be “master of himself and of reason” (p. 305). The vision of the good was enacted through moral discourse about their traditions and practices which unfolded in the public realm.

During the 17<sup>th</sup> century, the utility of reason underwent a fundamental shift. The influence of Rene Descartes's (1596-1650) notions about the separation of the mind and the

body, mastery of reason, control over one's passions, and the inhibition of emotional expression were conveyed in social life (Stolorow, Atwood, & Orange, 2002). Descartes's ideals about self-control and reason, were different from Greek and the Stoic understanding of the self which was one who interpreted reason as a capacity to see the good. Reason for Descartes was "a mechanism of control by which one could achieve mastery over passions" (Taylor, 1988, p. 304). The practical importance of reason had shifted and was no longer considered to be important in the same way. Reason was instrumental and technical with the primary function being about the domination and control of one's self. Descartes believed that certainty could only be achieved through procedures that facilitated the organization of thoughts and the accuracy of ideas. "Science as a neutral domain, could then define the goal of reason as the achievement of certainty" (p. 306). To observe with certainty and accuracy, it was important that object of study not become contaminated by individual passions or preconceived ideas. Thus, the role of the scientist was to follow a procedure that would ensure objectivity and disengagement. This procedure became known as the scientific method. It is the same value-neutral framework that continues to inform the traditions and practices of society today.

When psychology shifted away from its philosophical foundations during the 19<sup>th</sup> century, it "embraced a psychology that was more technical and the manipulation of behavior" (Danziger, 1979, p. 41). The value attributed to an objective stance became a paradigm in which the individual sought to remove themselves from their experience. It was assumed and expected that it was necessary (and good) to bracket-off any preconceptions one might have about their experience. Underlying this supposition about morality was the notion that there needed to be a separation of personal values from social issues. From this vantage point, morality encompassed personal preferences which were to remain confined to the private sphere. This made it difficult

for individual members of a society to examine their moral stance and their commitments theses stances (Richardson et. al., 1999, p. 41). In Western thought, the moral values that emerged from society's overarching commitment to the ideals of individual freedom and autonomy served to constrain the individual in considering these moral commitments from a different perspective or in a different way. The culture itself existing primarily "for liberation and fulfillment of the individual," resulted in the tendency of thinking about ethical commitments as personal improvements (Bellah et. al., 1986, p. 47). For example, Taylor (1988) argued that the Western conception of an individual self was naturally inclined toward the right to self-govern and pursue wholeness, happiness and fulfillment, and that the self would also naturally include certain moral commitments (Richardson et. al., 1999, p. 41). This taken-for-granted value fostered the development of a myopic attitude where it was assumed that all people and cultures would also naturally value these qualities and strive toward realizing them because it was their inherent right. This assumption is so common to U. S. society, it is rarely recognized that "not every age [or culture] refers to the self and human agency in the same way or there could be more than one way to interpret the self and agency now or in the past" (Taylor, 1988, p. 298). This has made it hard for many to consider that that the right to self-govern and the freedom to choose what constitutes happiness is just one way of being and may not be the same as what others and other societies want or defines fulfillment.

**Notions of self and moral agency.** Theories about human being, in whatever form they take and whatever understandings they convey, shape and are shaped by the prevailing moral commitments of a given society (Cushman, 1995; Tjeltveit, 1989). When there is a privileging of any metaphysical worldview it carries with it consequences that affect social life. As Taylor (1989) and Geertz (1973) have argued that human existence cannot occur independent of culture.

Any qualitative distinctions that are made about the self will be “intrinsic to the way individuals conduct their life and those distinctions emerged from a particular orientation toward the world. In other words, as interpretive beings, humans are inherently moral beings” (Taylor, 1988, p. 299). Because the distinctions that people make are “interpretation-dependent,” particular interpretations about morality reflect cultural understandings” (p. 299). The change in modern Western understandings about the self has also resulted in qualitative distinctions between Greek translations of the term *thyself* and a conceptualization of the self. For example, the Greeks’ reference “to know thyself” in today’s society has become a concept that refers to knowing one’s self. The modern self is not conceptualized as an embodiment of a philosophical ideal (e.g., the good). The self is interpreted as distinctly separate from the philosophical ideals that guide society and inform its values. This was a qualitative distinction, Taylor (1988) believed, that this change fostered “an illusion where the self is perceived as having selves, as if they were like have eyes, hearts, and livers” (p. 298).

Marin (1995) shed light on the value of understanding the impact of our actions. He argued that it is vital to contemplate what we do and the reasons that guide our actions because they “play a significant part in not only defining the social and moral life of our own people, but the future of countless and distant others as well, whose names we will not know...” (p. 135). The liberal individualism that constitutes the American value system features the personification of individual self-fulfillment, maximum self-awareness, and an unlimited access to one’s own emotional world. While this view point is not wrong, the value of the individual is the focal point of American life, which tends to cultivate a perspective where American’s view of themselves “as the center of [the] moral universe” (Richardson et al., 1999, p. 7). From this vantage point,

engagement in moral discourse about social conceptions of the good and how the good is to be lived out in the public realm are impeded.

The rise of capitalism in modern life has also impacted how the self has come to be understood in relation to the world (Lichtman, 1981, p. 132). For instance, “the ideals of liberal individualism and manifest destiny undergird a capitalist ideology and have served to promote the values of greater individual freedom, increased equality of opportunity, efficiency, and accountability” (Richardson et al., p. 6). The promoting of these values are not necessarily negative or unhelpful, but they are entangled with other social and political arrangements influencing what these ideals mean and the way they are lived out.

“The machine of capitalism,” Lichtman (1981) referred to, has also changed the conception of time, cultivating a shift where time has become a form of capital and therefore a currency (p. 130). For the citizens who live in a world where value and worth have become intricately entangled with productivity, the focus is not just on individual achievement and the right to a personal, unique happiness, but includes the right to pursue these at whatever the cost and regardless of how they treat others in this pursuit (Bellah et al., 1986; Sandal, 1996). A cultural understanding of a self as an entity-subject, when coupled with consumerism, has shifted the interpretation of the meaning of self as a container that exists to be filled, consuming and perhaps being consumed (Cushman, 1995).

The notion of individual liberty and the pursuit of personal happiness are important values because those pursuits embody the good; however, they are also values that emphasize an inward and highly personal focus. To situate that self and one’s action as social, interrelated, political and morally meaningful requires an effort (Bellah, Madsen, Sullivan, Swidler & Tipton,

1986). It is an effort, Furedi (2004) observed, that has resulted in a heightened sense of isolation, confusion and disconnection at the deepest levels of society.

### **Multiple Relationships and the Profession of Psychology**

Reviewing the professional literature on the topic of multiple relationships and the Ethics Code suggests the classification of multiple roles are categorized as either foreseeable or unforeseeable (Doverspike, 2008; APA Ethics Code, 2002, 2010). According to Doverspike (2008), “foreseeable (or contemplated) multiple roles are defined as those roles in which the therapist has had time to consider or contemplate before engaging in them” (p. 17). Whereas “unforeseeable (unpredicted or random) multiple roles are defined as those roles that cannot be reasonable foreseen” (p. 17). An example of a foreseeable multiple relationship would be when a therapist might consider whether to provide therapy to someone with whom the therapist has had a prior social or business relationship. An unforeseeable multiple role might be if the therapist joined a community group and later discovered that one of the members of that group was a current client.

Standard 3.05 instructs the psychologist to be judicious in their contemplation of a foreseeable multiple relationships. In the Ethics Code it states that:

A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist’s objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists. (APA Ethics Code, 2002, 2010, p. 2)

The Ethics Code has defined the term reasonable to mean “the prevailing professional judgment of psychologists who engage in similar activities and in similar circumstances, given

the knowledge the psychologist had or should have had at the time" (APA, 2002, 2010, pp. 2 & 6). However, the term reasonable has not in itself been defined and the burden of proof in such cases that an ethics violation was to be reported to a licensing board is determined by the disciplinary boards interpretation of the meaning of the phrase "could reasonably be expected" (Doverspike, 2008, p. 17). Generally, in mainstream professional literature psychologists are encouraged to consult with colleagues to ascertain how the term reasonable might be operationally defined, but by and large the assumption about multiple roles seems to reflect that "the best way to stay out of deep water is to avoid the slippery slope in the first place" (Doverspike, 2008, p. 17; Gottlieb, 1993; Gutheil & Gabbard, 1993; Meyer, 2005).

There is consensus within mainstream psychology that multiple relationships with current clients, students and supervisees that are also sexual relationships are always unethical. The Ethics Code states that "psychologists do not engage in sexual relationships with students or supervisees who are in their department, agency, or training center or over whom psychologists have or are likely to have evaluative authority" (APA, 2002, 2010; see also Standard 3.05, Multiple Relationships; 3.08 Exploitative Relationships; Standard 7.07, Sexual Relationships with Students and Supervisees).

In other ethics codes sexual multiple relationships are discouraged. For example, in the Canadian Psychological Association, *Principle II: Responsible Caring* addresses this issue:

II.27 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 personal decision making. (Canadian Code of Ethics

for Psychologists, 2000; see also Principle III: Integrity in Relationships, III.31, and Avoidance of Conflict of Interest)

Professional associations in the U. S. tend to agree that non-sexual multiple (or dual) are not themselves inherently harmful, nor are they always unethical or avoided (Herlihy & Corey, 1992, [in Counseling]; Reamer (2003) [in Social Work]; Watson II, Clement, Harris, Leffingwell, & Hurst (2004) [in Education]; and Zur (2007) [in Psychology] (see also, APA, 2002, 2010). Though, business relationships between therapists and clients or where one is the employer of the other are generally ill advised. (Burke & Johnson, 1992). The current ethical standards do not specifically reference potentially difficult situations for psychologists, especially regarding multiple relationships. It is considered that psychologists will encounter moments when they might have to choose to act and decide whether to proceed in a multiple relationship. For this reason, Behnke (2004) stated that:

The definition in Standard 3.05 educates psychologists and the public about when a multiple relationship is present. The test that follows protects those with whom psychologists work, and thereby promotes their welfare, by making a safe space available for the psychologist and client to proceed. (p. 66)

In counseling psychology, Herlihy and Corey (1992) defined a multiple relationship as one that occurred:

When professionals assume two roles simultaneously or sequentially with a person seeking help. The dual relationship may exist at the beginning of the counseling relationship, it may occur during the time services are provided, or it may develop after the termination of counseling. (p. 3)

The argument Behnke (2004) makes about ethical values having little to do ethical questions about psychologists' ethical dilemmas is a common one in mainstream theory and practice (see Chapter One). Another pervasive theme in a majority of graduate psychology education and training programs is the emphasis on ethical decision-making models that are designed to help the clinician decide what action to take in different contexts. One example of this decision tree mentality is the way that it teaches clinicians how to become better at assessing: a) when an ethical conflict has arisen; b) when to think about what the next step(s) might be; and c) how one might mitigate risk to protect the clinician when situations are ethically ambiguous (Younggren & Gottlieb, 2004). This concept is believed to be helpful in facilitating sound ethical practice. Published articles and continuing education trainings about ethics, multiple relationships, and boundaries also reflect this idea and are widely available to practitioners. For example, some of these titles include:

- *Nonsexual Multiple Relationships: A Practical Decision-Making Model for Clinicians* (Sonne, 2007);
- *10 ways practitioners can avoid frequent ethical pitfalls: Boost your ethical know-how with these practical tips on avoiding common ethical quandaries* (Smith, 2003);
- *Boundary Crossing and the Ethics of Multiple Role Relationships* (An online CE Training by Koocher & Keith-Spiegel, 2013);
- *Avoiding Exploitive Dual Relationships: A Decision-Making Model* (Gottlieb, 1993);
- *Do the Right Thing* (Shallcross, 2011, American Counseling Association);
- *Crossing professional boundaries in medicine: The slippery slope to patient sexual exploitation* (Galletly, 2004).

From a legal perspective, it is thought that non-sexual multiple relationships are also less likely to produce sanctions than sexual dual relationships (Pope & Vasquez, 1991). In the early 1990s, Healy and Herlihy (1992) found that ethics complaints to state counselor licensure boards about sexual dual relationships were comprised of approximately 20% of the complaints received and about 7 % of those involved multiple relationships. However, in recent years, according to these authors, state licensing boards appear to be addressing the issue of nonsexual dual relationships more vigorously.

A multiple relationship as it is defined in Standard 305 may not prove to be harmful, according to the Behnke (2004), but “a reasonable psychologist must expect that the multiple relationship will lead somewhere problematic and therefore seek to remedy the situation as soon as possible” (p. 66). Many have argued that maintaining objectivity, assessing risk or harm, the myriad cultural considerations one must attend to are more complicated and nuanced. It would unwise to assume a single or blanket definition such as the Standard is inadequate in determining what those ideas might mean in different contexts and cultures (Barnett & Johnson, 2011; Everett, et al., 2013; Littleford, 2007; Malone & Dyck, 2011; Zur, 2007). For example, in the discipline of social work, it is not uncommon for social workers to be in situations “where they would establish more than one relationship with clients or former clients, regardless of what kind of relationship (e.g., professional, social, or business)” (Reamer, 2002, para 6 and 7). In addition, often, many social workers “will continue to have contact with their clients and see them at local supermarkets, sporting events or other community gatherings which are unanticipated and unavoidable” (para 6 and 7).

Malone and Dyck (2011) addressed the ways that the Canadian Code of Ethics for Psychologists provided guidance for psychologists about how to apply ethical decision -making

principles in rural and remote settings in northern Canada. Using case examples from their own practice in rural and remote (R&N) settings these authors concluded that “overlapping relationships, community pressure, generalist practice, interdisciplinary collaboration, and professional development concerns are aspects of R&N practice that may be more prevalent” (p. 207), and found that ethical-decision making models often did not consider R&N settings and that the Canadian Code of Ethics was limited in providing guidance.

Another question about multiple relationships in the literature addressed what clinicians should do about multiple relationships that cannot be avoided (Gottlieb, 1993; Gutheil & Gabbard, 1993; Koocher & Speigal-Keith, 2013). Although the need for guidance and professional standards regarding multiple relationships was recognized, there was disagreement about what that looked like and how to apply them. Meyers (2005) argued that multiple [dual] relationships were harmful and advised clinicians not to go down the slippery slope. Practitioners, he stated, “have an ethical obligation to avoid multiple relationships” (para 1-3). Proponents of a blanket avoidance of multiple relationships believe that avoidance is the only way to insure no harm will occur (Zuckerman, 2011). The emphasis on avoidance has significantly influenced the movement in the profession towards risk-assessment-management strategies. Education and training programs will often focus on teaching clinicians how to develop skills that help them analyze risk and determine what unethical conduct might look like. Behnke (2004) stated that:

One of functions of providing a definition in Standard 3.05 is to educate psychologists and the public about when a multiple relationship is present and the conditions of criteria to protect those with whom psychologists work, thereby promoting their welfare and making a safe space available for the psychologist and the client to proceed. (p. 66)

However, this statement raises the question about the definition of “safe space.” For instance, authors and clinicians who have advocated for an alternative, more inclusive understanding about the diverse cultural norms and communities, the definition of safe space possesses different understandings and conceptualizations in various cultures and communities (Duran, 2006; Everett et al., 2013; Sue, 2001; Sue & Zane, 1987; Zur, 2012). They noted that multiple relationships simply cannot be avoided in many settings: rural communities, the military, the deaf community, churches, and ethnic minorities who live in smaller communities. Additionally, research has indicated that multiple relationships might even increase trust and familiarity which strengthens the therapeutic alliance between therapists and clients (Everett et al., 2013; Zur, 2012). Kessler and Waehler (2005) also found that the marginalization of groups who identify with nontraditional ways of being, multiple relationships are often what qualify counselors to be effective in part, because as members of the community they possess knowledge that is culturally sensitive and relevant. For instance, Littleford (2007) suggested that Asian American communities share similar characteristics with those of rural communities and that ethical dilemmas relating to multiple relationships were present for psychotherapists in these communities. From Campbell and Gordon’s (2003) perspective, members of Asian American communities have personal knowledge about each other, tend to distrust outsiders, seek psychological help from family members or from those known by the family, and consider multiple relationships as “expected and normal” (p. 432). Sue (2001) and Sue and Zane (2009) also noted that:

Psychotherapists working in culturally diverse communities may need to self-disclose in order to increase their ascribed credibility; and that [multiple relationships] may be

essential to establishing trust and increase the likelihood of help-seeking behavior. (Sue, 2001, p. 820)

Thoughtful critiques provided by Hansen and Goldberg (1999) have drawn attention to the impact of the presentation of multiple relationships. These authors contended that:

Presentation of dual relationships as harmful and slippery on clients, clinicians, and the communities they live and work in perpetuates responses and behaviors that often collude with the implicit assumption of unethical conduct when a psychologist sees another professional whose behavior is contrary to his or her personal values. The observer may well cry unethical, when a more apt response might be I disagree. (p. 499)

In response to this dilemma, Hansen and Goldberg (1999) constructed a seven-category matrix that included the following considerations: a) moral principles and personal values, b) clinical and cultural considerations, c) ethics codes, agency or employer policies, d) statutes, e) rules and regulations, and f) case law. Rubin (2000), Schank and Skovholt (1997), Williams (1997) and Zur (2001) argued that such a narrow viewpoint about multiple relationships might cause harm to the clients and the clinicians serving in their communities. From the perspective of Queer, Two Spirit and/or Trans counsellors, Everett et al. (2013) also examined the impact of the dominant ideology on professional ethical guidelines that commonly advise counsellors to avoid dual relationships wherever possible. These authors found that the dominant viewpoint served to further the assumption that minority counsellors—in this case Queer, Two Spirit, and/or Trans counsellors needed to avoid multiple relationships—even more. For example, when Lesbian, Gay, Bisexual, Trans, Two Spirit, Queer (LGBT2SQ) counselors were hired to work within their communities, many reported that they did so at risk of being judged as less professional for belonging to these same communities and because of their involvement in multiple relationships

which were difficult if not impossible to avoid. The influence of the dominant culture's assumptions about multiple relationships and how the clinician addresses those kinds of relationships ethically appeared to impact the clinicians in this study. Many reported feeling a heightened need to self-surveillance, be hypervigilant, and constricted their social activities, participation and the kind of work they did in the communities they serve (p. 15). These authors posed important questions about the absence of a thoughtful examination of the implicit values that inform Western professional ethics codes and argued that such values may undermine the strength of these communities. Even going as far to assert that it may be "unethical for the profession to place the burden of risk and the cost involved in serving marginalized groups on the backs of individual counsellors who worked their own communities" (p. 15).

### **Summary of the Problem**

This literature review about issues of concern regarding multiple relationships in professional practice has recognized that the APA considers the importance of cultural context and has conducted research about various cultural variables (e.g., Sue & Sue, 1999; Sue & Zane, 1987). At the same time, most research on the impact of ethnicity, locality, culture, and multiplicity are often examined using objective methods and empirically driven practices. Some have argued that the methods and approaches used by the profession when examining culture is not problematized enough (Chung, 2005; Hoffman, 2009; Pederson, 1999), which has resulted in a characterization of the therapeutic relationship as one that needs to be objective, linear, and rational. The underlying philosophical assumption in the Western paradigm in which the APA's Ethics Code has emerged presupposes that morality and ethics are distinctly separate. It is thought by the APA that one way to protect the welfare of the public is for therapists to avoid the imposition of their own values onto their patients. This idea shifts the focus away from

challenging clinicians to examine their own values and how those intersect with the values their patients to an emphasis on harm reduction techniques the clinician can use to ensure they are not causing harm. In Behnke's (2004) words he asserted that "though the answer to the clinical question may have profound ethical implications, the disagreement [about Standard 3.05] remains in the clinical and technical domain" (p. 66).

Moreover, what constitutes relating and what is defined as a multiple relationship by the APA presupposes that relating only happens when one independent, free-standing Western self-interacts with another Western independent self. If the profession does not acknowledge the complex relationship between an individual's values and their professional conduct, it also makes it difficult to discuss the various ways clinical practices might contradict the underlying principles that inform its Ethics Code. The disconnection of the profession's philosophical and historical traditions from the Ethics Code is endemic in the profession, yet research conducted from non-objectivist paradigms such as hermeneutics which offers a framework from which to explore the ways Western values have influenced the profession's ethical standards is sparse indeed. Given this need, it is important to conduct research that examines psychology's moral stance and its role in American cultural life and critiques about influence of a Western philosophical definition of self.

### **Research Design**

The inquiry about the chasm between ethics and morality in American society and the profession of psychology thus far has brought to light many observations and questions that pertain to the profession's awareness about the intersection between clinical relationships and cultural values. Drawing from the literature review, the critiques and reactions from many in the field of psychology suggest that the profession's understanding of the questions that are generated from these complex issues and how to respond to concerns about multiple relationships are still quite young. One conclusion that was drawn from the literature was that the possibilities for honest dialogue (Gadamer, 1989) that invite psychologists to express their challenges, concerns, critiques, and questions are limited and in some cases disavowed (Everett et al., 2013; Sue & Zane, 1987; Tomm, 2002; Zur, 2002, 2012). What appeared to be absent from the professional discourse was an emphasis on the value of training psychologists to examine the philosophical contradictions and inconsistencies that shape the foundational values of its Ethics Code and the Standards it generates. It seems difficult to imagine how any kind of critical dispute about the Ethics Code might occur when the traditions that have informed and shaped it are denied and discounted. In addition, the difficulties of adequately comprehending and critiquing these underlying values and assumptions about ethics and multiple relationships will overwhelm creative solutions if the profession continues to ignore the awareness that some of its founding philosophical premises are located within the Modern Era Western paradigm. It is that influences frames, its methods of inquiry, traditions, interpretative understandings about its practices, and the ethical stances that inform them (Chung, 2005; Cushman & Gilford, 2000; Hoffman, 2009).

## Theoretical Framework

For this dissertation, I used a hermeneutical perspective to explore Standard 3.05 in order to better understand the cultural influences reflected in and the political consequences that emanate from the Ethics Code.

**Introduction to hermeneutics: tradition and history.** A philosophy aims most true when it first fathoms its own motives. When a philosophy fails to ask why it would want to see things in a certain way, it is subject to vast and complicated unconscious influences (Samuelson, 1979). The influence of Gadamer (1989), Heidegger (1962) and Kuhn (1970) frame this inquiry. The basic premise of hermeneutics “necessarily considers the notion that humans are self-interpreting, self-constituting beings” (Chang, 2010, p. 67). There are several assumptions about human existence that ground the theoretical framework of hermeneutics. Namely, social life and practices are embodied by basic distinctions of a community’s shared language and understandings (Plager, 1994). From this vantage point, it is assumed that all members of a society will share an intuitive way of being in the world and a way of understanding that way of being (Gadamer, 1989; Heidegger, 1962). People and things only exist within a certain cultural context and therefore cannot be understood outside of that context (Cushman, 1995). Hermeneutics assumes that humans are always and already engaged in a “hermeneutic circle” of understanding and the important thing is “not to try to get out of the circle but to come into it in the right way” (Heidegger, 1962, p. 195).

Since “it is impossible to escape from our preunderstanding, it is essential to actively engage it, incorporate it, and utilize it as the basis for new understanding” (Chang, 2010, p. 23). As such, hermeneutical study attempts to illuminate the juxtaposition of what is common in the everydayness of life in each society with what is not. Because human beings are thought to be

cultural beings, the discovery of what constitutes the good life or the what a good life means individually and as a society will inevitably embody the tension of “tacking back and forth” between the past and present, the part and the whole, the historicity that constitutes what is understood about the present, and understandings of the good (Cushman, 1995; Gadamer, 1989; Taylor, 1989). These assumptions about *being* are believed to be always and already in a hermeneutic circle of understanding about what counts as real for members of a particular society (Plager, 1994, p. 70). Therefore, because interpretation presupposes a shared understanding when researchers study a cultural phenomenon, they also inevitably study their own society. This is a departure from objective methods and systematic scientific inquiry in which the researcher and their cultural assumptions are to be bracketed and removed from the process of examination. In hermeneutics, the researcher understands and embraces the notion that they bring their own cultural frame of reference into the research endeavor and this will continually and unavoidably frame and shapes the process (Cushman, 1995).

The philosophical stance of hermeneutics also assumes that human being (Heidegger, 1962) is what Taylor (1988) referred to as an inescapably moral project situated within the “space of issues” that are created by the cultural terrain (p. 298). The plight of a society and the issues that manifest in this space is where important truths (values) about what a society believes to be meaningful and worthy of pursuit (the good) are worked out. These are brought to light through the traditions and practices that are reflected in the everydayness of social life. The meanings attributed to them are shaped by the situations and events that occur during that era. It is thought that by studying these everyday practices and artifacts the researcher can develop an understanding of the collective narrative about the people who live in that society (Cushman, 1995, p. 17). The process of examining social practices and traditions is thought to be essential to

hermeneutic inquiry because it illuminates the socio-political and historical embeddedness of understanding that constitutes the moral framework of a culture or society (p. 18). Because the everydayness of these practices is like the air that we breathe, they go unnoticed and are often taken for granted. However, becoming aware of how these practices affect ourselves and others is crucial to historical research. Therefore, hermeneutic inquiry attempts to illuminate the underlying assumptions and moral sources that inform a society's practices and traditions (Stigliano, 1989). The malleable nature of being historically situated also brings forth the realization that situations are subject to change and there are "multiple good ways to be in the moment and more generally in life" (Hoffman, 2009, p. 1043). In this way, the hermeneutic perspective gives rise to the hope that humans as moral agents can change current conditions and interpretations of the self.

There were two particular ideas that Gadamer (1989) argued against in *Truth and Method*: the notion that there is one truth out there, awaiting discovery and that certain ways of deriving knowledge (e.g., the scientific method) should be privileged over others (Chang, 2010; Hoffman, 2009; Stigliano, 1989). Hermeneutics is the practice of reflective interpretation. While it has been criticized for its potential role in generating justifiable research findings within the human sciences, it would be contrary to my understanding of hermeneutics if I were to prescribe one research method, or suggest researchers should only practice one way. At the same time, "hermeneutics as a practice for the human sciences must also be tested in the field and ably to yield concrete results as a research practice" (Stigliano, 1989, p. 47). For this to happen, "hermeneutics must be understood not as a philosophy, but as a kind of language game in which certain actions are excluded, while others are included according to criteria and strategies grounded in the use of critical reflection" (p. 47).

The basis of a shared language as constitutive of human life is central to hermeneutic theory. Therefore, it is thought that only through a shared discourse or language will the things that constitute the social world show up. In other words, things make sense to us because a society has developed agreements about what those things mean and can talk about them in meaningful ways (Plager, 1994). Hermeneutics, when understood as a research practice as opposed to one fixed methodology, is then understood as but one way to arrange the research effort. Therefore, describing what I did in this study is but one view or perspective that aims to open new ways to understand cultural notions about “research and qualitative research” (Chang, 2010, p. 24). The underlying assumptions of hermeneutic inquiry differ greatly from Cartesian assumptions about a subject-object stance in which the researcher is disengaged (Stigliano, 1989). Rather, it is assumed that human beings are social, dialogical beings whose shared understanding is always stretching before us, existing in the shared background of social practices (Plager, 1994). The researcher is focused on:

Describing and explaining how the particular social constructions of a specific society are communicated to the individuals who are born and raised within in it, how artifacts are produced by certain social constructions, and how artifacts reproduce current social constructions and reinforce current understandings of the good and concomitant arrangements of power and wealth. ... the task is to define in each culture what constitutes the broad cultural framework, the institutional structures, and the everyday artifacts that instruct, influence, and shape the individual’s moment-by-moment perspectives and experiences. (Cushman, 1995, p. 19)

Drawing from the threefold fore-structure of understanding discussed by Leonard (1993), Plager (1994) and Stigliano (1989), it is assumed that humans understand themselves, others, and

events through: *fore-having*, “we come into a situation with a practical familiarity and with background practices that shape our world and make an interpretation possible (Plager, 1994, p. 72); *fore-sight*, “because of our background we have a point of view from which we make an interpretation” (p. 72); and *fore-conception*, “because of our background we have some expectations of what we might anticipate in an interpretation” (p. 72).

The hermeneutic circle. Chang (2010), drawing from Ellis (1998), conceptualized the hermeneutic circle as a spiral with multiple loops. An initial loop may consist of multiple engagements with the same text or different data sets and represent multiple instances of engagement with many expressions of what is being studied. Subsequent loops are informed by the understandings resulting from previous loops. The passage of time will also change the conclusions that are reached at any given time within the interpretive process. Thus, these findings and interpretations will be “a unique confluence of the social, cultural, and historical moment, converging with the effective history that the researcher brings to the venture and are not considered to be a timeless truth, but a bounded interpretation” (Chang, 2010, p. 22). For example, the formation of my interpretive account began with my initial experience of thinking about multiple relationships and the Ethics Code. A second interpretive loop occurred concurrently when I reviewed and engaged the literature on ethics, multiple relationships, psychological theory and practice and led to formulation of a conceptual framework. I entered a third loop when I adapted the interview schedule based on my questions about ethics and multiple relationships and the notes and journal entries of my reflections and so on. From a hermeneutic perspective, knowledge is considered to be intersubjective and it is not possible for one to know outside of the interaction between the one who is seeking to understand that which is understood (Gadamer, 1989). It would be meaningless for the researcher to approach the data

(or phenomenon) in any other way. We “cannot escape from our preunderstanding, and therefore it is essential to actively engage it, incorporate it, and utilize it as the basis for new understanding” (Chang, 2010, p. 23).

### **Interpretive Research Processes**

Philosophical hermeneutics resists reductionism and the procedural limitations of method. Within the framework of a research methodology, the application of hermeneutic inquiry may appear philosophically incoherent, nonetheless, hermeneutic scholars follow an interpretive process that can be described. While acknowledging the limitations of procedures, scholars such as Michelle McCoy Barrett (2000), Victoria Leonard (1993), Karen Plager (1994), and Anthony Stigliano (1989) have been able to retain the philosophic assumptions of Gadamerian hermeneutics in qualitative research. These scholars have drawn from the theoretical background of philosophical hermeneutics described above and from other discipline such as nursing (e.g., Plager) that regularly utilize hermeneutic methods in research. I followed a synthesis of the processes described by these scholars discussed here:

- 1) **Topic engagement.** The interpretive process as Gadamer (1989) stated, begins with the experience of being “addressed” by the topic. Chang (2010) interpreted this experience as being “captivated by an idea or a phenomenon” (p. 24). Since meaning is “negotiated in the dialogue between the interpreting subject and another, research endeavors that are designed to understand how another interprets some phenomenon will also necessarily involve the interpreting subject’s engagement with the participants’ accounts, body of knowledge or data set” (p. 21). It is not possible for me to exclude my own culture, ideas, beliefs, values and experiences. Nor is it possible for me to discount my status and access to power as something that can be bracketed off from the interpretive process. Therefore,

I sought to bring the participants' understandings about their feelings, beliefs, and assumptions pertaining to multiple relationships and Standard 3.05 into the hermeneutic circle with my understandings, experiences, and beliefs. I also wrote about my experiences that led to my engagement with this topic and provided a summary of the interpretive assumptions I had when I approached the data.

- 2) **Identification of texts to be interpreted.** I specifically set out to generate texts and/or conduct interviews for this study because I was interested in the lived experiences of psychologists and the ways that they had negotiated multiple relationships in their practice. The development of a thematic analysis and case studies through in-depth qualitative interviews with two psychologists was an effective way to examine these issues. Selection criteria consisted of two participants who: a) had a doctorate in psychology and had been practicing psychotherapy with patients/clients who identified as being from a culture that was different from their own; and b) therapists who had been practicing psychotherapy with patients/clients who lived in rural and/or remote settings.
- 3) **Foregrounding.** According to Gadamer (1989), foregrounding entails the recognition and description of conscious assumptions. It is thought that by attending to these assumptions, the interpreter can listen to the tradition of the text in a way that allows for its meanings to be heard in distinction to the interpreter's history and traditions. I have foregrounded the assumptions of hermeneutics and my own experiences that led to the assumptions I had about multiple relationships, the Ethics Code, and mainstream theory and practice (see Appendix B). I also foregrounded the literature I reviewed, including mainstream interpretations of ethics, multiple relationships, and the philosophical and

historical influences that appeared to contribute to the Modern-Era conceptualization of a Western Self.

- 4) **Immersion in texts with research questions.** Since a hermeneutic tradition does not believe it is possible to remove biases and assumptions, during the immersion phase of data analysis I did not attempt to bracket-off my assumptions, remove or deny my biases. Although I continually used the texts to place my assumptions into question. I approached the texts and the various interpretations of them with the awareness of my foregrounded assumptions. The goal was to gain a gestalt impression of the texts. I read each text and recorded my general impressions and aspects that caught my attention. I noted or flagged statements that seemed to repeat and others that stood out as unique or evocative. I re-read the texts through the lens of the research questions I had formulated. During the analysis phase, I considered the overarching questions I had listed (see Areas of Inquiry and Research Questions sections).
- 5) **Participant Selection.** For this study, two therapists from different ethnic, racial, class and educational backgrounds, theoretical orientations, and varying years of professional experience were selected to participate. Each participant had experience working with patients/clients who were from a different culture than her own and was living and practicing in rural or remote settings. One participant self-identified as being committed to the APA and the other self-identified as being more ambivalent toward her commitment to the APA.
- 6) **Participant Criteria.** Criteria for participant selection included psychologists who: 1) identified as male or female or other and were between the ages of 20 or older; 2) were actively practicing in the field of psychology; 3) were licensed at the doctoral level; 4)

were actively practicing in a clinical setting; 5) had previous or current experience working with patients/clients who were from a culture different from their own; 6) had previously or were currently working with patients/clients who were from a rural/remote setting; and 7) were willing to describe a clinical case(s) that involved a multiple relationship. Participation was strictly voluntary and confidential.

- 7) **Recruitment of Participants.** For this study, participants were purposefully selected to ensure that they had direct experience working with patients/clients from culture other than their own and/or a rural or remote setting. For geographical convenience, I selected participants who lived in Western Washington to participate in this study. Recruitment of participants occurred through personal and professional networking and word of mouth. Potential participants were contacted by a letter (see Appendix C) that included a brief statement about the intent and significance of the study. Those who expressed interest were contacted by phone and email to schedule a time answer a few general questions to determine eligibility for this study and complete a brief Participant Demographic Form (see Appendix G). Following the initial pre-screen interview, potential participants were contacted to schedule the in-depth interview at a convenient time and location.

### **Data Collection and Analysis**

For this research study, I created verbatim transcripts of in-depth qualitative interviews and texts about Standard 3.05, Multiple Relationships in the Ethics Code in order to explore the meanings and controversies reflected in the practice of psychology and clinical relationships.

**Case studies.** Case studies are used to test, substantiate, or clarify a specific

theoretical proposition that exist in a discipline's discourse. Clinical case study material is used to illustrate particular points and are considered to be appropriate in several instances. For example, these might include:

- a) when instances of a phenomenon are rare; b) when the phenomenon is best illustrated as exemplary cases, rather than in descriptions of a population's attributes; c) when an investigation involves mobilization of resources what would prohibit more traditional analyses; d) when replications within or between a small number of cases are possible and particularly illuminating; and e) when the phenomenon is so complex as to demand extensive localized observation and description. (Antioch University Seattle, 2015, p. 3)

Scientific study and the findings that are generated within a positivist paradigm are considered relevant only if they “yield knowledge that is generalizable and theories are tested in systemic research and empirically validated” (Hoffman, 2009, p. 1046). This is contrary to research findings that emerge from non-objectivist paradigms such as case studies that tend to be placed into the “contexts of discovery” rather than “the context of justification” in scientific inquiry (p. 1046). Thomas (2011) and Simons (2009) have also noted that case studies provide an opening for the researcher to engage in the kind of in-depth exploration that considers the singular nature and even “peculiarity” of the interpretation and analysis of evidence that demonstrates significance (Thomas, 2011, pp. 65-66). The purpose of in-depth exploration from multiple perspectives, while simultaneously considering the complexity and uniqueness of the “real life” context, is research that is evidence-led and based on the inclusion of different methods (Simmons, 2009). The knowledge generated from case studies are intended to provide a deeper understanding of a topic (e.g., program, policy, institution or system) that may “inform policy development, professional practice and civil or community action” (p. 21).

Creswell (2007) noted that in the context of case studies the idea is to “drill deep” (p. 19). This idea differs from positivist approaches that assume a distant stance toward the nature of reality, the researcher’s biases, and the language of research which tend to employ terms such as internal validity, external validity, generalizability, and objectivity. It is more common in qualitative research to use language that is more personal, literary and based on evolving definitions throughout the study rather than being defined by the researcher. Examples of some common qualitative terms the researcher might use include *credibility*, *transferability*, *dependability*, and *confirmability*,

**Texts.** I drew upon texts using the interpretive process informed by philosophical hermeneutics to highlight the areas where there are philosophical contradictions and inconsistencies in the APA’s Ethics Code that focus on its conceptualization of multiple relationships as it pertains to Standard 3.05. These include: a) the American Psychological Association’s (APA) *Ethical Principles of Psychologists and Code of Conduct*; b) Standard 3.05, Multiple Relationships in the Ethics Code; c) Literature specific to APA’s Ethics Code and multiple relationships published from 1992 to 2015 (present); and d) transcripts of the qualitative interviews with two participants.

The primary texts that I examined and interpreted in this study were selected for two reasons: they are representative of the dominant cultural discourse as it pertains to ethics and multiple relationships, and they have been widely cited within the professional literature. By analyzing these texts, my intent was to explore concerns regarding the foundational problems that undergird the Ethics Code, the notion of ethical competency, and the complexities that accompany relationships when we encounter the multiplicity of self. I explored the lack of awareness of problems that have emerged because of epistemological and ontological lines of

inquiry framed by postmodernism, social constructivism, cultural relativism, and scientific methodologies. A thorough evaluation of the problems and contradictions inherent in these philosophical positions affords the possibility of better articulating the current understanding of the connection (or lack thereof) between ethics and morality. Discussions of the ethics of relationships tend to be polarized, confusing at times, and philosophically contradictory.

**Interviews.** I developed and used a semi-structured schedule (see Appendix F). The interviews were conducted in an agreed upon location by the interviewee and interviewer that ensured privacy and was convenient for the participants. The purpose of the interview was to facilitate an open dialogue about the therapist's attitudes, feelings, expectation, reactions, assumptions, and associations toward Standard 3.05, and what had influenced and informed how they practiced. Each interview was approximately two hours in length and began with a general explanation of the study. Prior to the beginning of the interview, participants were asked to read and sign the Informed Consent (see Appendix E) and review the preliminary interview format. Before proceeding with the interview, each participant was given the opportunity to ask questions about the study and the researcher. The data from the interviews were interpreted and analyzed as described below.

**Thematic analysis.** After multiple readings of each document, I generated lines of inquiry that emerged from the commonalities in the texts. This included themes that repeated across the interviews and within each interview. These themes were informed by the theoretical background of this study, the assumptions of hermeneutics, cultural themes from the literature review, and the assumptions inherent in my research questions. Although I identified similarities when themes emerged, I also attempted to identify themes about the world that gave rise to the experiences of the participants (e.g., their clinical experiences with multiple relationships and

psychotherapy). An interpretative map emerged, and each text was re-read from the perspective of this process. General categories were identified, and those categories or themes formed the basis of my research findings.

***Identification of exemplars.*** The data generated from interviews, practices, and actions of the participants were analyzed together. From this analysis, I identified exemplars or narratives that captured the experience of being in the culture in such a way that it could be recognized in other situations that might have led to different experiences of a circumstance, including those outside the practice of psychotherapy.

***Identification of paradigmatic objects.*** The paradigmatic object is a notion Heidegger (1962) referred to as an object in the clearing that focuses and gives constancy to the clearing. It re-organizes the background against which the world shows-up. In the case of multiple relationships, Standard 3.05 allowed for the translation of the different understandings of how people relate to each other and live in the U.S. Throughout my analysis, I looked for a paradigmatic object and attended to messages about potential objects in the text.

***Question generation.*** In addition to the categories outlined by Plager (1994), Leonard (1993), and Stigliano (1989), I have added the category of question generation. Undoubtedly, my interpretation of the data will raise questions, some of which may be unanswered by the text, and the interpreter's immediate context (e.g., foregrounded assumptions). The unanswered questions may be indicative of what Donnel Stern (2013) described as an unformulated experience, where the answer is abstract (and thus seemingly unanswerable). The unformulated answer to the question becomes meaningful and articulated only in the reconstructive phase of the hermeneutic process described below.

**Reconstruction.** The final cycle of hermeneutic inquiry involved considering the results of the analysis in the context of the literature review, the history of the professional ethics codes, the foregrounding of hermeneutic philosophy and personal experiences, and the horizon of present-day socio-political culture. This phase was about reconstructing interpretations of ethics and Standard 3.05 in the Ethics Code as a system of historically grounded distinctions. Chapter 4 was primarily devoted to the discussion of the analyses within a hermeneutic and historical frame and explored the moral, cultural and political implications of the results within the framework of the overarching research question: How does being human come to light in the profession's struggle with moral dilemmas in the context of a value-neutral framework? It is assumed that in light of my experiences and cultural identity my relationship to the texts would unavoidably influence my interpretations of the results.

### **Areas of Inquiry and Guiding Research Questions**

The following questions guided this research study.

- a. What is the philosophical foundation of the Ethics Code and Standard 3.05, as it currently stands? Specifically, what are the problems that clinicians face when they work with patients from cultures, ethnicities and whose traditions are different from their own?
- b. How do Modern Era Western cultural values inform the professions' interpretation of multiple relationships? How are these values enacted in psychologists' clinical work?
- c. What are the issues and concerns that clinicians have when they work with patients/clients whose cultural traditions run counter to Western assumptions about multiple relationships? What are the experiences that clinicians who live and work in

rural and remote settings have when trying to adhere to Standard 3.05 in the Ethics Code?

- d. Do psychologists find Standard 3.05 in the Code to be a helpful guide in working with patients/clients in a rural context? Does the Standard help them address the issues and concerns they might have about multiple relationships? Why or why not? If not, then how do they modify the Standard to practice in a way that is meaningful and effective?
- e. Do psychologists agree with and share the values that inform the APA Ethics Code? If not, what values do they rely upon to understand the choices that they make?

This research followed the hermeneutic tradition of examining what was unquestioned in local practice pertaining to ethics in contemporary American psychology, what was enacted in the profession and society but was not articulated, and what has been taken for granted. I have examined the moral, political, and philosophical foundations that underlie Standard 3.05 in the APA Ethics Code (2002, 2010). I provided an overview of the perspectives from mainstream psychology and nonmainstream authors who have written about the ethics of multiple relationships, its meanings and controversies, and issues of concern pertaining to the function of Standard 3.05 in clinical practice. I provided an interpretation of the Modern Era Western self, as well as an interpretation of the value neutral framework in which scientific inquiry and research findings are interpreted. I provided an overview of the constraints that emerge when attempts to interpret multiple relationships and ethics occur within the Western scientific paradigm that privileges individualism, objectivity, and empirically validated methods of inquiry. I also provided an overview of the historical and philosophical influences of the Modern Era Western self that have led to a conceptualization of a morality as distinctly separate from public life.

## **Results, Discussion, and Recommendations**

This hermeneutic study explored Standard 3.05 of the APA Ethics Code (2002, 2010) in order to better understand the cultural influences reflected in and the political consequences that emanate from the Code. I conducted two semi-structured interviews and from them drew out common themes and developed two case studies. The in-depth qualitative interviews engaged two American psychologists practicing in rural settings, who talked about their experiences with multiple relationships in their clinical practices. I brought to this process my own attitudes and assumptions about Standard 3.05 and the Ethics Code that have been informed by personal history and experiences. A descriptive summary of my encounters, reactions and observations with both participants was also included and analyzed (see APPENDIX B). Verbatim transcripts formed the text for analysis from which three over-arching themes were derived: Participants' reactions to Standard 3.05; Problems with the Ethics Code; and Defenses the Participants' enacted to protect against their conflicts and fears.

### **Orientation to the Participants**

The participants in this study, Marlene and Stevie (pseudonyms), each presented as unique from the other. Both had experienced living and working in rural communities and had practiced with patients who they had identified as being from cultures other than their own, but beyond these characteristics, they were quite different from each other. Each shared her personal and professional struggles with the ethical dilemmas associated with multiple relationships, but their concerns and fears were based on very different life experiences. One's concerns about the Ethics Code were primarily related to professional liability. The other worried more about the potential harm to clients when she acted in ways contrary to the Code. Both had valid and reasonable motivations to consider Standard 3.05.

**Participants' Reactions to Standard 3.05.** This category was defined as the emotional reactions and responses of the participants to the challenges posed by Standard 3.05. There were three prominent themes identified here: Fear of negative consequences, Anxiousness, and Self-Doubt.

***Fear of negative consequences.*** The participants described feeling fearful of incurring negative consequences from professional associations and state regulating bodies. For example, they described that they were worried and concerned about,

***Marlene:*** Will I lose my license? Will I get sued? That was number one. ... [Because] I was engaging in a multiple relationship. I was stepping outside the typical boundaries of the clinical hour.

***Stevie:*** One of my fears is to do harm and there is this authoritarian fear that's been embedded in there [the Ethics Code] like I could get into trouble [for not following to the Standard].

The participants described experiencing fear related to the perceptions of others (e.g., colleagues, professional associations, and patients/clients). This included feeling fearful that their clinical decisions would be misperceived, judged negatively, and criticized when they attempted to consult and/or discuss their struggles and ethical dilemmas with others.

***Marlene:*** I left my [clinical psychology] program with a sense that they [professors and supervisors] wanted me to be rigid. They wanted me to have rigid boundaries. I was being far too human with the client. When I had talked about my struggles with my supervisor I felt that what I was doing was wrong and bad. ... And even at the WSPA [the Washington State Psychological Association] we would have these ethics trainings and they would say: Oh no, you [clinicians] could never do that [engage in a multiple

relationship]. And I would say, Hold it. Hold it! You don't live in a town with 12,000 people. You can't not [engage in multiple relationships]. And they [colleagues at the WSPA] were like (the participant makes a shocking facial expression to express the response received from others) ... The voice of rural psychologists was so small and unattended to that I felt like I was practicing in a little bit of a different world and I would be judged negatively. ... I think because at conventions when multiple relationships would come up they were so clearly black and white- don't. It felt weird.

**Stevie:** I fear being misperceived and judged and seen as acting unethically, and that people might perceive me as having done something unethical because people aren't always aware of what position I hold with whom and why I said what to whom... because it's being ethical one of my values I don't want to be seen as unethical.

**Anxiousness.** The participants described experiencing anxiety when they thought about Standard 3.05 and when they discussed their clinical cases that involved multiple relationships.

**Stevie:** It's anxiety provoking because we are professionals. We do know there are these ethics codes that we're all trying to abide by, but there's also some threat behind that. So, there's many prongs to this: there's the professional, there's the personal, then there's [my] own values. And so, for me, there's some anxiety.

**Marlene:** See I told you I've never had to talk about these things [questions about how to define multiple relationships] (the participant gestures anxiously with her hands in the air) I've never had to define it [multiple relationships].

**Stevie:** Interestingly, talking about the Ethics Code, the Code and the authoritarian way that it could be implemented I feel, that sometimes that can interfere with [my ability to engage with] some of this process because its fear based....It's anxiety provoking, the

Code itself can create anxiety. ... But it's interesting because that anxiety around the Code itself can then, if you just get pulled into pure self-preservation, it actually then pulls away from client self-determination- doing good-beneficence. The fear of doing harm can cripple the ability to provide something good or positive if that makes sense. So being aware of that too, that the very anxiety around our professional codes of conduct can actually then cripple some of our ability to do some really great things and allow client self-determination. ... So that niggling [that fear] can niggle at the back of my mind and create anxiety and make it more difficult to make the best decisions sometimes.

**Marlene:** What's so interesting and what I was thinking about [risk of multiple relationships and boundaries] is that I've gone to the APA risk management workshops every time they come about and I always leave there thinking, I should just... I don't want to even think about it. Maybe I should retire now, you know because it feels like they're [the APA] saying there's this and then this and about revisions in the Code, well the whole field of psychology is... I think nothing that I'm doing as a psychologist today feels like it is something that was in existence when I went to graduate school as far as treatment protocols or therapeutic orientations. Everything is so different and then you throw in the technology and you're supposed to do this or what you're not supposed to do with that. So, I go and I try to figure that out and then I come home and I think, breathe. You're really only going to work a few more years and you've never been sued yet, you're gonna make it. You know. I don't know if that really responds to your question or not.

**Self-doubt.** The participants also described experiences where they had engaged with other professionals and colleagues that caused them to feel doubt about their practice and their level of professionalism.

**Stevie:** Because we are professionals we do know there are these ethics codes that we're all trying to abide by and there's also some threat behind that. ... But it [the Code] produces anxiety, fear and anxiety. Like am I doing it just that way? Am I supposed to be doing it that way? And anxiety makes us less effective, less transparent and less accessible. But how accessible should you be?

**Marlene:** Well, if there were a client in another setting [outside of the clinical room] then I thought I was supposed to look a little more together as a person, a professional I mean. Whereas, I might act goofy or silly or you know, stuff like that with friends in that setting otherwise. There's always that question of should I, or shouldn't I? ... At some point along there, she [my client] joined the community chorus I was singing in. And I remember when she did that thinking, Oh crap. You know, I always felt like I had to behave somewhat differently if there were clients in the room.

**Stevie:** You know even as we're sitting here and talking about this, it's like I can feel my own self watching/observing myself and it's like ugh. ... You know what is it really? And even in talking about it [the Code] I feel myself wanting to... rationalize some of the things that I do or say. Questioning, rationalizing [and wondering] is this being ethical? Am I ethical? Like I'm questioning myself. And how sad is that because it can really stultify people. It can really constrain them and then ironically, close in because you go intellectual. Even my own self can feel myself closing in and what is this about? And so then, I am watching that happen.

**Problems with the Ethics Code.** This was defined as conceivable reasons for the participants' discomfort with and reaction to questions about multiple relationships. There were two prominent themes within this category: Contradictions in mainstream theory and practices and Cultural identity unique to small communities and rural living.

***Cultural identity unique to small communities and rural living.*** There were obvious implications of how the tight knit nature of small communities and cultural understandings about relationships within the participants' communities impacted how they experienced multiple relationships and clinical practice. For example, it was inevitable that they would encounter their client in other situations that were outside of the therapy hour. Both participants talked about the inevitability of these encounters and they described feeling a sense of vulnerability of being in the position of their clients knowing something about their personal lives.

***Marlene:*** I mean you can't in small communities prevent people from knowing who you are or what's going on with you and your life most of the time. I belong to a church and one time they had an open time for people to ask for prayers for different kinds of things and there were times when I would stand and share something that was going on, I mean asking for prayers, and a couple of times I had a client there who didn't belong [to the church] but she came and I didn't do that then. I didn't want to put my weaknesses and vulnerabilities and fears out there for her to examine. It didn't feel comfortable.

***Stevie:*** The multiple relationships that are the hardest for me to manage are the ones that end up impacting my personal life. So, for example, especially in smaller communities and within smaller communities, there are smaller cultural communities and being part of this smaller community and really having a lot of connections within my community, seeing clients in my personal spaces can happen and it can be very difficult to

communicate about it. So, maybe I'll see a client that I'm working with and they may be queer and as they're talking I can recognize that they are revealing a relationship with someone maybe peripherally that is within my own circle and I had no idea of that [connection] before. And then I maybe with my partner, and my partner is talking about that common person who they may also actually be talking about who is also my client and suddenly I'm in the middle of lots of multiple relationships. Some of which I cannot reveal. ...So, you're holding a lot of information and even receiving back information about you that maybe even people don't realize, and you can't say anything. Like so-and-so's therapist said this about this person and then this person did this and can you believe that? And it's your partner just talking to you about someone who may be one of your clients. This just happens, right? And especially in small, rural communities.

In another situation, Marlene described an experience when a medical problem of hers was revealed to somebody who had turned out to be a patient. They never resumed their therapeutic relationship after that encounter and she expressed lingering remorse about this occurrence.

**Marlene:** Yeah. It felt really, really awkward. You know, I think I felt too vulnerable probably. And so, I had a hard time pulling myself back into the professional role. As a professional I should have contacted [my client] and asked... you know I'd noticed [my client] hadn't made any following appointments, and asked if [they] would like to [come in for a session] or if [they had] decided to not continue treatment. Something along that line and then, but I didn't [pause].

The participants also described how, when living in small communities and being part of unique cultures within those communities, it was not unusual for therapists to see patients who

had been referred by other practitioners who lived in the same community and were friends with the referring therapist.

**Marlene:** I'll mention two different situations. One where the person was really a good friend of mine [who was a medical doctor] referred her patient to me for therapy. Her was that if she couldn't address the problem by removing it surgically, then she refers them to someone who can help them. Another one of my clients was referred by another doctor who was a very good friend of mine and was also a friend of hers [the client]. I wanted to go over to my friend's house and there was [my] client. And she [my friend] knew [that I was seeing this client] so I'm not sure how that happened. I think that the doctor who referred the client to me became part of my client's support system, and that was the client I became most intertwined with.

**Stevie:** I think in small cultural communities and queer communities it is difficult to manage privacy in one's personal life. ... Like, if I'd like to go to an event at this person's house and it happens to be a client's house or your client's partner, or maybe one step further and is a good friend that your client has spoken of and now what do you do? And how do you [deal with] that? So, being part of a small community really having a lot of connections in the queer community and also then having queer clients coming into the center, or even my own clients it's more of the discovery of multiple relationships that come up.

The participants described how the unavoidable every day encounters that characterize small town culture often positioned them in unique ways that made it difficult for them to follow Standard 3.05.

**Marlene:** It sounds terrible, but I don't want to have to have to lose something I have.

Like one time there was a woman who I worked with [at the university clinic] who asked if she could see me [as her therapist]. I knew she needed to see somebody because she was having difficulties in her marriage and her job. And I was hesitant about that because I enjoyed my personal interactions with her. And we met for lunch or coffee or something so I [could] kind of explain to her that I could see [her] but that would curtail our ability to be together in any kind of social setting. And so, she chose not to start seeing me [as her therapist].

**Stevie:** There have been situations that can be very difficult to communicate about a multiple relationship. So, for instance, maybe there's a client that I'm working with and they may be queer and as they're talking I can recognize that they are revealing a relationship with someone who maybe peripherally is within my own circle and had no idea of that connection before. How do you deal with that? Because it's not in the ethics code. ... Emerging one's [multiple relationships] are also difficult because then, there's issues of confidentiality, client self-determination and my own personal life, and it can cause difficulties on all of those domains.

***Contradictions in mainstream theory and practices.*** The participants described instances where they had encountered contradictions in prescriptive approaches that were designed to ensure that practitioners did not violate boundaries or risk harming a client. These prescriptive approaches appeared to come into conflict with the participants' own interpretations and understandings about multiple relationships.

**Marlene:** What I think, I left my graduate training there was a sense from my clinical training that they wanted me to be rigid. They wanted me to have boundaries. Which

maybe came out of that interaction with the professor I was telling you about. ... I don't think I've ever had that combination of feeling safe and respected and I don't know why. I think their orientations were all quite different and, so I just anticipated that they would want me to do a different form of therapy than what I was doing.

**Stevie:** So, a dilemma would be doing an intake and/or maybe in the first few sessions I might find out that we're in a dual relationship and then what? We've got people who have been on the [clinic] waiting list for a long time and they've made a good connection and I recognize that it's really hard to get through these doors because we work with trauma and PTSD, and sometimes by the time you've done the intake, which is an enormous step for people to take, and they've invested a lot in that step and you discuss that with them. And maybe I'm not really sure how to navigate this multiple relationship. That's really hard. So, what I'll do with clients, is I'll try to be as transparent as I can about that. Like, I will talk with them about how this is a hard thing to decide on because on one hand I really see what it took for you [the client] to come in here and I really support you [the client] in that process of facing your trauma. On the other hand, we can see that there's this is a dual relationship and I want to be sure that that doesn't cause you [the client] harm in the long run and that I want them to know that we can navigate that; that we've really looked at that and right now I may be unsure I've done that.

The participants described instances when they looked to the Code and Standard 3.05 for guidance about multiple relationships, but did not find it to be helpful. They had described situations when they had modified Standard 3.05 so that they could practice in ways that were meaningful and effective for themselves and their patients.

**Marlene:** Not necessarily. It's [the definition in Standard 3.05] more you know, try not to. And then I think the guidance about it comes through discussion with other therapists. Like I told you on the phone, I really believe in and trust the Principles of the APA Ethics. And so, those were what I was always trying to work off of - do no harm - do good. [long pause] So that, if I felt like working with a certain person and I couldn't be as effective as I ought to be, I would have said, like I have said, no this [therapeutic relationship] isn't going to work very well.

**Stevie:** I define multiple relationships as: whenever you have your role as a clinician and your role as a therapist with that person. The Standard is not helpful, not at all. When I read the Code and I read it mostly before I took my licensing exam, I learned how to answer the questions around the code according to how we would be expected to answer them, but to me that just means its...gosh, I just keep coming back to fear -based. It's like as a profession we're covering our asses. We're saying we have this Code that all psychologists must abide by so as a profession we're ethical and when we're not, we're going to censor and punish and/or maybe remediate our colleagues. So, we get to say that [we are being ethical] but for me the code is a way that we get to say that we are monitoring our profession and the conduct of professionals and therefore, we're legitimate, mainstream, [and] safe maybe? But it's not real. It's not even a tool that we can actually use as clinicians. It's more like something that we know that we have to at least present [as following] so that we're not going to be seen as someone who is conducting themselves in a harmful way. But that doesn't really mean that. It's just a perception of... because the harm I see in actual multiple relationships doesn't really fall very well under that. So, I don't feel personally, I don't feel like it's something that is a

helpful tool at all [except] that I can regurgitate it when I need to. I guess the only time I've actually seen it as positive is if we've actually had misconduct or people doing harm and [it's] used as a tool [to stop that] but, it doesn't really seem like it follows the aspirations as to why it's supposed to be there in the first place. And that's more the wild exception - the wild exception than the daily helpful practice.

The participants described inconsistencies between what Standard 3.05 told them to do about multiple relationships and their own ethical standards about how to treat their patients.

*Stevie:* I notice I'm much more anxious about it [multiple relationships] than they [clients] are. I worry about it much more than they do. They're [clients] kind of like, well, yes, we're people living in this world [laughter]. And often there's this thing that happens... it's like this... it can create this medical model response of there's something wrong with the client if they would like to see you in another situation or would like to interact with you in other situations. It's as if there's something wrong with them. So, I'm really conscious of not imposing on them as well [the notion that] there's something wrong with you if you want a relationship other than this therapeutic relationship. Because [therapy] this is interpersonal work and sometimes in our discomfort we can easily impose it on a client as if their desire for knowing about you or being involved in any other way in your life other than within the four walls of the therapeutic room, then there's something wrong with them. When [to want to know about the therapist] is a very natural human response. So, I try to make sure I'm not imposing it on them [clients] as if there's something wrong with it or with them for not seeing it the same way as maybe our profession does.

**Stevie:** When my values... and maybe I have convinced myself of this but, I go back to the aspirations and that a lot of my values are in line with the aspirations. So, if I perceive and I can evaluate the code as not really being in line with the actual values that it is supposed to represent, and it doesn't, I know that it can't capture all of the situations and relationships and the [different] ways we need to operate.

The participants' described how choosing to engage in a multiple relationship turned out to be beneficial to treatment.

**Stevie:** Yes. I actually do think a multiple relationship can be beneficial to treatment because it opens up conversations about the very complexities in relationships. Being able to navigate that and talk about that with clients especially when working with trauma and doing interpersonal work. I think clients want to know who you are a person too and so there's ways to do that that are therapeutically beneficial and always... it's so complicated right... I'm not wanting to impose this on the client, but also, I want to keep opening those doors and conversations about complex relationships because often they're in some of those complex relationships themselves. And so, you can kind of model how to navigate some of that and how to be transparent and how to deal with some of the worries or anxieties that might come up around it. How to be ok about ending relationships if that's the important thing to do and giving that openness about the complexities because I think, when you acknowledge that clients might be having a hard time ending the [therapy] relationship even if they feel like it might be a good idea. So, the more there's and ability to talk about the complexities and acknowledge the difficulties [that come with] ending relationships, I think it can help the client [and] give them permission to talk about the risks and benefits without thinking that you're going to

automatically terminate because they might have some worries. So, really trying to make it as safe as possible to talk about all of those things so that the client can really make the best decision and not feel like you are going to reject them because they might have concerns about dual relationship.

**Marlene:** When the code did not align with what I chose to do [in my practice] I followed my own code. I think that came out of my own morality. My own code of ethics that said, this is a person that needs me to listen to her in the therapy hour. And honestly, I'm trying to think of all else what I did do. I remember one time I went to church with a client. She was really struggling. Her faith was like her only hope and that was her salvation. And she didn't start having any memories of all the abuse until much later in the course of treatment. She told me that she used to drag herself to therapy kicking and screaming because it was so painful for her. But she knew she had to do something and I've remembered that ever since. You know when you've got somebody putting that kind of effort and energy into it and not a lot of other help or understanding was coming from other directions... I'm not sure how long I thought about it, I just felt like this is the thing to do [to support her in these ways]. It was the right thing to do. ..., I still have contact with her sometimes. I was in her area two years ago and I met her for lunch. So, at the point when she was my client she was doing all sorts of self- destructive things and in session she was just... she was vulnerable, she was open, and she was struggling. And it was kind of like I saw this glow inside of her that and I could see who she really was. I think I struggled to convince these other people who were going to abandon her to give her a chance. I wanted to tell them that I know it's taking time. I know this and that. So, in a sense I wasn't advocating to get her food or housing, I was advocating for patience

from the people in her life who were being impatient with her. ... I think it increased her trust in me and her sense of being safe with me and so my guess is that she was able to be more open and work through more things in session. But maybe it was just because she felt there was somebody there who was listening and caring and involved with it. It was just wonderful to see how she was doing and what was going on.

The participants also described situations when they could not anticipate in advance foreseeable risks because they did not know what was going to happen in the therapeutic relationship. They described times where they felt concerned about their patients' welfare and determined it was important for them to follow-up with them even if that meant that they had to step outside of the therapy hour.

**Marlene:** Well, I didn't anticipate. I had no idea what I was getting into to, but even as I did discover that my client had severe problems and I did have experience with other clients were DID, I never had worked with the severity of chaos and fragmentation that this client exhibited. I couldn't anticipate that. And see that ties in with one of the other ethics codes and that makes it hard to feel like you're being perfectly aligned with the Code in a rural community because the Code says that you shouldn't see a client unless you have that specialized training to see a particular client. I mean we have no specialists here. ... Had I known somebody who had experience [with this particular diagnosis] right off the bat I probably would have not taken her [the client] into my private practice. I would have referred her, but I'm also not sure she would have gone by then because she was in college when I was working with her. She didn't have much money so when I saw her in my private practice I was able to see her for a smaller fee and that was important to me.

**Stevie:** Another dual relationship I ran across that's really interesting and happens in small communities and serving clientele who don't really have access to other services, is when you're working in a clinician group and one of the clinicians dies. That happened and now we're dealing with our own grief as well as the clients being transferred from that clinician to us who are also dealing with their loss of that relationship and their grief around that relationship. It's a dual relationship. It's an interesting one but it is one and feeling the ethics of continuing to provide services to clients in that environment but also, both of you are dealing with the same grief and now you are at a funeral together. And you know it's a dual relationship that's not in the books. It's really complicated and the Ethics Code I feel, doesn't really cover this especially, in small communities and collective communities and rural communities and many of the ones we intersect with. The Ethics Code doesn't always cover those or even honor those or values those.

**Marlene:** [silent pause]. I had one client who came to me as a student at the counseling center. [The client] also turned out to [have severe problems and was struggling]. And I certainly went to her apartment sometimes [silence]. In that sense, it wasn't a dual relationship but, I was just having to reach out into her private life a lot more I think.

**Marlene:** I had client who was a student and far away from home. It turned out that home was where all of the abuse occurred. There was occult abuse She also turned out to be a DID, incredibly splintered, and far beyond my ability to work [therapeutically] with her. I was not skilled enough to be working with her. But I didn't know all of that to begin with. When she started to open up with some of this stuff and that took quite a long time before she did that, I felt like I was... I was caught up in trying to keep her safe or trying to rescue her. Again, advocating... she had suffered horrific abuse at the hands of the

occult people who were also trying to get her to move back and no one believed her. The other medical doctors who were treating her were saying, oh, you know she's just crazy, she does this to herself. And I got caught up in wanting them to say [to them] no she's not just crazy. I mean she was bright, she did graduate from college, and she was all of these other kinds of positive things. So, in a sense I feel like ... I moved into wanting almost to be a guardian for her. I got caught up by her vulnerability... maybe that was it. And [long pause] all the people [who were working with her], when I was working at [the campus clinic] she was still a student, all the people in the clinic who had to work with her and staff would come and complain to me about her. And she was just accessing tons and tons of services all the time, but I just felt like she was a huge part of my life. And one time, I can only remember... well, she would call, sometimes in the middle of the night because she was frightened and terrified, and I answered her from my bed. And that's not something I had ever done with any other client. And then she started coming and pounding on my front door because she was so scared.

The participants described experiences where they found themselves in situations where they struggled to maintain objectivity when they encountered patients outside of the therapeutic hour/setting.

**Marlene:** I had a client I saw in my private practice. She was maybe [few] years younger than me She was quite charismatic and very bright. And you know she was somebody I had no other interactions with. I hadn't known her when she came to see me. She was referred by a friend, but I knew she had problems, but you know I was really drawn to her, I would have loved to have been able to be a friend to her [outside of the therapy hour].

**Stevie:** You know, when you get invited to a house and you recognize that there's a client there and your partner wants to go and wants you to go and your like, um I can't go, and I can't say why, which kind of like saying why. It gives them a clue, they know who you are, and they know who these people are and then there it is. That's a dilemma. And how do you manage that and yet abide by all of these different ethics. And these ethics can hit up against one another and it does and that's not seen in the books at all.

The participants described difficulties when they attempted to practice therapy in a way that aligned with their values but also felt constrained by the Ethics Code.

**Stevie:** The Ethics Code is fear -based and the power and control... In the work that I do and the communities that we [therapists at the center] serve, often power and control and oppression are the very roots of what causes the things that we see. And so, then the Code is also a form of that imposing upon ourselves and clients these rules that in themselves can actually then recapitulate, in my mind, some of the oppressive paradigms that create the trauma that a lot of our clients experience to begin with. It's this big systems thing that interferes with what people maybe actually do and the values that we have, the work that we do and the clients we serve. Rather than really expanding my mind into what is in the best interest of myself and my client. I mean we are in the equation, but fear-based decisions tend to be not the best decisions to make. ... because once we start making fear - based decisions rather than really value our true ethics, we make fear-based decisions that can start to interfere and create rigidity. ... And though it [the Code] has aspirations the actual implementation can be fear-based. So, I agree with aspirations and values that the aspirations reflect, but the implementation can be more fear-based and varied and not always equally applied depending on who you are and where you are.

**Stevie:** Psychologists say to our clients that you're asking for a dual relationship and that's unethical, when it's actually very natural and normal. And so then, it imposes this rule on clients that is not helpful to them, but then takes it off our [psychologists] shoulders. But then you can follow the guide [the Code] and say we're following this guide, we're following these rules and say things like well, "I'm just doing the rules and mine are the rules of ethics, and you're [the client] asking for something that's not under these rules; and that's your problem." "You're the problem, there's something wrong with you because you're wanting something that's in my profession's Ethics Code." So, acknowledging that it just doesn't make any sense from the human space you and the client come from.

The participants described experiences in their graduate psychology programs when they tried to speak out or think philosophically about ethics and then felt judged or criticized by their professors and supervisors.

**Marlene:** [long pause] At the time, there were no female professors in the department. And... [long pause] my second year [in my doctoral program] there they hired a woman and she wasn't my supervisor in practicum or anything like that, but I was in practicum with a really staunch, conservative, sexist male, with three or four other males in the thing and I was working with a client, a woman who had been battered by her husband. She had left her husband and he was stalking her. So, I was trying to help her figure out how to keep herself safe and all that kind of stuff. My supervisor said, "oh you just want her to be like you." In other words, a strong individual, independent if necessary. So, I went to the other woman [in the program], because I didn't know, you know, I was still trying to figure out how to be a therapist, and I showed her my tape and she went over it

with me and she felt like I was fine. And I just tried to maneuver the system the best I could... she quit just after a year of being there. It was that bad.

**Stevie:** My ethics class was the only class in grad school I got a B in. [laughter]. And like I said it's really ironic because I feel like ethics is one of my primary values. But, ethics is a very complicated thing and has to be responsive to a wide range of presenting issues and history and culture and it's just a really super complicated thing to navigate. And so, I tended to be a little contrary. So, when they'd say, sure we don't have sex with our clients I will agree with that, but then when they would sit down and teach ethics in a really rigid manner, then I would tend to be contrary and look for the opposing view; and at the evidence that what they were saying that you could actually make an argument that also could be unethical on the other side of things. So, in doing that, and because ethics is so important to me and such a high value, that I wouldn't just pass, and I wouldn't... my voice would keep coming forth and in my ethics class I ended up with a B. When I did talk to my professor about it, by the end of the conversation she said well, I'll give you an A in the class if you want. But I said, no that's not what I want or why I'm talking about this, don't change my grade; it's not about my grade. It's about the concepts around ethics that I am struggling with. So yes, I remember my ethics training very well. I'm proud of that B!

**Stevie:** Some of my voice was... through that process [of graduate school and clinical training], I think I lost some of my voice. I've gained other voices, but I lost some of my ability to confidently state my truth no matter where I am. Because now, this profession can be so oppressive and those who are... who use the Code in a way that can be wielded against those who speak out against it. And so, it's very comfortable to be of the people

who follow the rules and are of the majority status. That's very comfortable to be that and so, when you're a voice that speaks against it, it can be wielded very quickly against you. ...I mean it can be wielded by professionals against other professionals too. It makes it harder in a minority's mind or a minority voice speaking against this and to do that in all the places that I go. When I was more idealistic I would speak my voice and my truths wherever I went. Now, in the circles that I am in... my more professional circles, I'm quiet because I just don't want to just expose myself all the time. I'm more selective about when I speak my voice. I still have it and I still feel strong in it, I still feel like I'm doing social justice work, but it's depleted some of my confidence in doing that in certain places.

***Contradictions in mainstream theory and practices.*** This was defined as the interpretations reflected in mainstream psychology of multiple relationships, Standard 3.05, the Ethics Code, and ethical decision-making models' psychologists are encouraged to use that did not align with the participants' lived experiences, cultural traditions and communities where they lived and worked.

**Defenses the Participants' enacted to protect against their conflicts and fears.** This was defined as defensive strategies the participants enacted as a means of coping with their discomfort and feelings of vulnerability. There were four prominent themes within this category: Disguised superiority, Reliance upon proceduralism to minimize discomfort and ambiguity, Over-intellectualization, and Compartmentalization.

***Disguised superiority.*** This was defined as the use of arrogance (blind or purposeful) to disguise discomfort and defend against feelings of vulnerability when the participants did not want to discuss their views and opinions about multiple relationships, the Ethics Code, and/or

mainstream theory and practice. For example, patronizing statements directed at the interviewer, irritated and edgy responses, avoiding the interview questions, and deflection.

**Marlene:** I see we're back to boundaries here. Obviously, I have, or I wouldn't have had some of these relationships with clients that crossed some of those boundaries. It's been a long time. Anyway, do you know the Meyers –Brigg scale? I'm a J. Your questions sound very P and my answers sound very J.

**Marlene:** So, I did do things with people and my assumption was that I was bending these rules. Also through the private practice people would call me for an appointment because they had seen me interacting in the community or they knew me from some place in the community and, so I felt safe. And it's a lot messier that way. I was like, as long as nobody's looking I'm fine. You know there were a few cases where I chose not to see someone as a client because of how I knew them or because of I valued them and took something out of the relationship for myself... and that felt like it wouldn't be very easy to be objective in those circumstances. But, in most of the circumstances they were people who I knew or maybe in a group I had done social things with, but never one on one, and I never had one on one conversations beyond the normal chit chat so, I didn't feel any difficulty keeping objectivity and certainly didn't see any way it would cause them difficulties.

**Marlene:** Well for instance, I remember one woman who was in my barber shop chorus. And you know, I liked her, and we'd had done special practices together. We were front row singers and we had to learn dances to go along with the music and they'd have front row practices and that kind of thing so, I knew her a little bit more closely than I would have other people and she called and asked to see me, and I was really surprised. But you

know, my process at the time was, yes, I know her. Yes, I like her. And I don't see it causing any problem. So, I saw her. ... The way I saw it was, when we are in public I don't acknowledge them as clients and I interacted with them like anybody else in the chorus.

***Relying on proceduralism to minimize discomfort with ambiguity.*** This was defined as statements or responses made by the participants' that appeared inconsistent with and/or contradicted Standard 3.05 or their previous responses and shared opinions about the topics discussed. For example, when the participants' shifted the conversation from personal stories and experiences to written regulations.

***Marlene:*** I remember making phone calls to the APA IT for the [university clinic] about ethical questions we weren't sure how to handle in certain cases. It was more there and with the interns there... so I feel like it's always kind of been there and you know, [supposed to] work to keep [me] safe from risk...lawsuits at work. Marlene: Well, in some ways it's [the Standard] the thing that defines the risk. It says, 'do this or you'll be at risk'. Unless we want to say ethically, 'no' and then take the consequences.

***Marlene:*** But see I think that that's already here [points to the Standard in print] like it doesn't need to be modified because my values wouldn't allow me to work with a client if I thought it would [pause] put them at risk in any way. Nor would I feel like I would be an effective therapist if I weren't objective. So, I did do things with people, but my assumption was that I was bending these rules.

***Stevie:*** So, for example, because I supervise and see clients in the same clinic so that I can stay as unbiased as possible in my supervision, I try real hard not to see clients that are attached to any of the family members or relationships that other people [clinicians]

are seeing. I try. But I can't always do that. It's like I said, it emerges but, we navigate those, communicate about them and make sure that clients and other clinicians are aware of them along with all the risks and benefits and options in managing them. I have trusted people to consult with because I want to make sure I'm not missing anything. Doing that really, really good risk-benefit analysis. I think that self-awareness, that checking-in that ongoing conversation, and ongoing checking in, and then also trusted people who you know will call you out; those trusted people that you can consult with that you know are also feeling safe enough to call you out on your blind spots if it's out of your awareness.

**Marlene:** I know of situations where people have had issues like that. I can't think right off the top of my head if I ever have but, I think it's important to take the person's culture into consideration and do the things that allow them to feel safe and accepted and therefore as open as possible to what might come out of the therapy session. So, to reject things that they [the clients] were like offering or wanting to do within the session because she felt like it wasn't supposed to be there that wouldn't seem quite right. But you'd have to know in advance the culture of the people you are working with and what those gestures or experiences that their talking about mean to them.

**Over-intellectualization.** This was defined as the use of overly intellectualized explanations when the participants described the emotional impact of having to adhere to Standard 3.05 when it did not reflect the participants' values and/or cultural traditions.

**Stevie:** So, there's a lot of I don't know out there and I do... if something comes up that is clearly shared information with myself or my client and I'm in a dual relationship with then I would definitely... like I said before, I would try to use as much communication and awareness around that and empowering everybody involved to make their best

decisions for themselves and making sure that there are lots of options so that people can take care of themselves and do what they need in that. But, also recognizing too that sometimes you just... because of confidentiality, because there's so many people involved you can't always know who knows what and how. I didn't get this information in a way that I can really feel like I can accurately or convey respect to any of the partners holding confidentiality so it's...it can cause a lot of anxiety and consternation. Then I just have to back up and say, wait a minute I don't know that any of that is happening and people do have their rights to manage it in a way that they want to manage it and trusting that people will bring forth information if that is on their radar. And that we'll walk through that if it comes up and if it doesn't, I don't know.

***Compartmentalization.*** This was defined as the participants' attempts to manage the dissonance they experienced when talking about how they negotiated their personal and professional values in relation to their practices and how they situated their values in the context of the dominant Western paradigm.

***Stevie:*** So, I'll [try to] be a little more transparent about what I'm walking through and if I need to I'll just be really honest: 'this is me, not you.' I'm feeling a little uncertain about how to manage it or whether I can manage it in the best way for you and for myself. And I may need to think about that and/or consult about that.

***Stevie:*** How do I work through them [multiple relationships]? I try to start with me and be real aware of where those multiple relationships might exist and how they might be impacting the people I work with, the cases as well as myself. So, lots of awareness and communication so as I notice them, or they emerge. I will talk with all those involved as much as possible and bring in as clear of awareness as we can about them and the risks

and benefits of them, options in managing them... consultation. I do a lot of consultation with other professionals and I think that pretty much sums it up for me. Really paying attention, not denying them and not avoiding them completely because I can't, so in that acknowledgment that I can't, I'm really trying to both for myself and others where it is possible. Stevie: So, there's many prongs to this, there's the professional, there's the personal, then there's your own values. And so, for me there's some anxiety.

**Marlene:** Well, if there were another client in another setting I thought I was supposed to look a little more together as a person, professional I mean. Whereas, I might act goofy or silly or you know, stuff like that with friends in that setting otherwise there's always that question of should I, or shouldn't I?

## Case Studies

This study was guided by my desire to understand how psychologists address the ethical complexities that multiple relationships engender. I used two case studies to examine the controversies and inconsistencies the participants expressed through the lens of Standard 3.05 in the APA Ethics Code. The framework grounding these case studies followed the hermeneutic tradition of Heidegger (1962) and Gadamer (1989) which included a compilation of information that was shared in personal conversations, written email exchanges, phone conversations, and the interviews. From there, I wrote about the dynamic between myself and the participants. This included instances that reflected transference and countertransference, the contradictions and inconsistencies between the participants' narratives and the Standard, and the ways they managed their discomfort and fear. The participants in this study, Marlene and Stevie (pseudonyms), each presented as unique from the other. Each shared their personal and professional struggles with the ethical dilemmas associated with multiple relationships, but their

concerns and fears were based on very different life experiences and motivations. One's concerns about the Ethics Code were primarily related to professional liability. The other worried more about the potential harm to patients when she acted in ways contrary to the Code. Both had valid and reasonable motivations to consider Standard 3.05. I assigned a pseudonym for each participant to ensure confidentiality and protect their privacy.

### **Orientation to the Structure of the Participants Experiences**

Aspects of the participants' experiences were presented in themes. The description of their experience was carried out in an inductive and evolving fashion. The themes were used to describe the participants' experiences and reflected their behavioral reactions were presented first. Then I presented the themes that described the participants' experiences in subtler ways. Finally, I presented the themes and discussed them in a narrative form. I also included my own reactions to the participants and highlighted the interactions that occurred between us during the interviews process.

### **Marlene**

Marlene was referred to me by my dissertation Chairperson as a possible participant. They had met at a professional ethics training and had engaged in a conversation about the Ethics Code. Marlene had remarked that she practiced in a rural community and found that the Standards in the Ethics Code sometimes did not fit with her practice. When the topic of my dissertation came-up, she expressed willingness to look at the study and offered her contact information to my Chair.

**Background.** Marlene was a White woman in her late 60s or early 70s (on the demographic form she circled 60+ category). She had been practicing as a licensed psychologist for approximately 40 years. At the time of the interview had a small private practice in rural

Washington. She noted that she grew up in a small mid-western town [population approximately 10,000 people] and identified strongly with her Protestant Christian faith. She was an active member in her church and her faith seemed important to her. Marlene had decided to participate in this study because she believed it was “an obligation to support the research of psychologists in training.” However, she also stated that she was “anxious” about discussing her experiences with multiple relationships. She explained that she had been “fearful of being perceived as acting unethically because she had “engaged in multiple relationships.”

Marlene was an only child. She stated that she was raised in a family where “they didn’t talk much or go out of your way to say a whole lot.” She attributed this way of being to her German-Norwegian heritage and noted that people in her family “did not express their feelings through words.” While growing up, she described being “on her own a fair amount,” but said that being on her own helped her learn how to be more “independent.” She described herself as curious, loved learning, and had shared that one of the “good things about living in a small town was that there weren’t enough people, so you could try all sorts of things” such as, theatre, band, chorus and student government. Although she was an active participant in her community, she commented that she “didn’t really feel like she fit in at high-school and was just itching to get out of her home town.”

Marlene’s parents grew up during the Depression Era. Although her father’s parents were able to send him to college despite the economic hardship. However, higher education was not an opportunity her mother had. “Women in the 1930s weren’t going to college much and her mother’s family didn’t have any money” Marlene remarked. She recalled that her mother “struggled with a kind of bitterness and depression from time to time” and gave Marlene the only piece of advice she ever remembered, which was to “never count on a man to take care of you

and get an education.” In college, Marlene majored in German and a Fulbright scholar. She said that she enjoyed studying abroad very much. Though, when she returned to the States, despite her qualifications, “the languages were starting to go out of style” and she “couldn’t find a job just teaching German.” She said this caused her to question her career choice. One of her professors had told her about a job opportunity teaching at the college. In addition to teaching duties she was also responsible for “overseeing the students in the residence halls.” It was through this experience that Marlene had realized she “absolutely hated teaching and didn’t want to be in a position that required her to be the disciplinarian.” But, she also found that she “really enjoyed working with the students in the residence halls and had assumed the role of a kind of “dorm mother the students would come to talk to.” That’s when she decided to go back to school and earned a Ph.D. in Psychology.

Deciding where to go to graduate school was not an easy option for her. Marlene stated that she didn’t have a lot of money to pay for school so, when she was accepted to an APA accredited doctoral program that included a financial aid package she “jumped at the chance.” Yet, when she arrived at her graduate school she stated that she questioned whether she had made the right choice. She remarked that “there weren’t very many counseling psychology programs in the nation at that time,” and the emphasis of her “clinical training was on hospital administration and abnormal psychology stuff.” Marlene described her graduate program as “traditional, staunchly conservative and really pushed the students towards teaching, research and science.” There were “no female faculty members in the program.” Even though she felt like her training experience “turned out all right,” she stated that there were “real gaps in the program.” The learning atmosphere was “so bad that she ended up just trying to maneuver through the system the best way she could.”

At the time of the interview, Marlene did not have any patients who she considered to be from a different culture than hers, but she expressed that she had practiced in Alaska early on in her career and “had seen patients who were from another culture when she practiced there.” She described her participation in the APA as “minimal.” She stated that she “pays her dues” though she did not elaborate. Curious about her response, I inquired further. She explained that she was “committed to adhering to the Principles in the Ethics Code, but did not feel that Standard 3.05 was helpful because it did not consider the nuances of multiple relationships in small towns.” I noticed that her voice lowered at this point and she quietly re-stated that she “was committed to following the Principles,” but omitted including the Standards even though they were a central piece of the interview.

**The Interview.** The in-person interview took place at Marlene’s home. When I arrived, she greeted me and welcomed me into her home. I noticed that it smelled like freshly brewed coffee and my attention was drawn toward a beautiful tree outside her kitchen window. The furnishings in her home appeared simple, uncluttered and adorned in neutral pastels. As we chatted over coffee she commented that she had been thinking about the interview all morning and was feeling “anxious and nervous about talking to me about her clinical cases.” Then when we sat down to start the interview process, she noticed that there was a typo on my Informed Consent, drew my attention to it by circling the error with her pen. I felt a little embarrassed by this, but I tried to keep moving. We had gotten through about half of the Interview Schedule at our first meeting, but we were both experiencing some interview fatigue so, I thought it might be good for us to finish at another time. We met again about a month later.

Before the second interview took place, Marlene had contacted me the morning of the interview. She informed me that she might have to cancel our meeting because she was

scheduled to have a root canal that morning. We discussed the possibility of rescheduling however, both of us had decided to proceed as planned. When I arrived at her home, she was polite, but appeared tired and distracted. Noticing this, I had wondered if I should have rescheduled the interview and offered to do so, but she insisted that she was up for it. The second portion of the interview questions were largely about Standard 3.05. Prior to beginning the interview, Marlene commented that she had reviewed the Standard prior to our meeting and was “prepared to answer the questions” almost as if she were preparing to take a test. This time seemed different than our last meeting when she was more open and talkative. I got the impression that she just wanted to get through the interview and be done. Similar to what occurred during the last interview, Marlene stated that she had been thinking about her responses from the last time and felt “anxious about what she already shared.” She explained that she was worried that she might be perceived as having acted unethically. When I inquired further, she commented that she knew that she had engaged in multiple relationships and even though she had read the Standard and “felt relieved to see that she had not been unethical because she had not caused harm or exploitation.” Though she seemed worried about the possibility of incurring negative repercussions for talking about her clinical cases with me. While I thought she able to talk about her clinical work in a way that was authentic to her, throughout the interview her responses seemed cautious, contradictory, and at times even scripted.

As we moved through questions about the Standard and her interpretations of what multiple relationships were and how to address them, Marlene seemed uncomfortable. For example, following a moment when she had discussed a multiple relationship that she had regretted getting involved with, she commented that “this stuff was exhausting and difficult to talk about.” But then in other instances, she would talk in extensive detail about her cases. Her

worry and concern about being judged by others and likely me, never seemed to wane throughout our time together. Sometimes, the fear and anxiety would be quite intense and during those moments, even though she would make her best effort to respond, if I asked additional questions I noticed that she would pull back from the conversation and defend herself. Almost as if she were protecting herself from an attack or criticism. When this would happen, I noticed that I also felt little anxious and worried that she felt so uncomfortable. One way I would try to negotiate this was to try to encourage her in her responses, or accommodate her discomfort by avoiding asking her any more questions that might elevate the anxiety. There were also times when I felt irritated by what felt like patronizing statements that seemed directed at me, responded in ways that gave the impression she was annoyed with my questions, or when she deflected and avoided them entirely. The dynamic between us was shrouded in politeness, which reminded me of the way my own family expresses their discomfort. It is often difficult to determine if they really want to talk to you, because the tendency is to say yes, even if they do not want to say yes. True feelings are often disguised, but even if we try to mask them the source of what is behind whatever we are trying to conceal will manifest. This seemed to be the case Marlene and me. Our way of relating felt so familiar to me, I did not think to explore some of my impressions about this dynamic with her.

One of the most prominent sources of Marlene's angst about Standard 3.05 was the fact that she could not avoid multiple relationships in her small town. "It just wasn't possible or practical." However, her general interpretation of the Standard seemed to be that she should avoid them. This notion was reinforced when she attended APA sponsored ethics training events and would consult with her peers and colleagues. In a more abstract way, she also seemed confused about what constituted a boundary violation. For example, there was a point in the

interview, where we were talking about boundaries, but Marlene thought we were talking about multiple relationships. Or on another occasion, when she discussed Standard 3.05 and the more difficult complex aspects of her cases, most of her concerns seemed about whether she had crossed boundaries or her own fears of her patients crossing boundaries. She seemed confident that multiple relationships were not unethical, yet she was worried and concerned about others' perceptions that they were. She struggled to find ways to discuss this at trainings and more mainstream conferences because, in her experience most of her colleagues were not open to trying to understand her point of view. Those experiences also contributed to an increase in self-doubt about her clinical decisions. Clinical decisions about multiple relationships that she made on a case by case basis depending on the needs of her patients. I started to realize why she did not want to think about this "stuff or talk about it" with me. Because when she thinks about this "stuff" she's worried about being judged or criticized for doing something wrong and that was distressing for her. One way she coped with that distress was to withdraw, "as long as nobody's, looking I'm fine." This understanding about Marlene's lived experience also helped to me become more sympathetic to why she might want to rely on procedures like the Standards to explain or justify her actions. For example, when she responded that "if the APA did not have a Standard or Code that indicated how important it was to be wary of and avoid multiple relationships, then it would be easy for people to say that it's not a big deal and people would not be so thoughtful about them." At the same time, I thought Marlene had courage. When she felt there were situations and moments with her patients when caring about them and for them also meant that she may have become "involved" in their lives (e.g., advocating with their families and support systems for more patience on her patients' behalf, or checking in on patients when they were in crisis or she had not heard from them in a while). Actions that she took at the time

because she felt like it was the right thing to do was inspiring to hear. She cared enough to resist outside pressure despite the projections of others who because of their own discomfort led them to project categorical labels that sought to define her and her patients' experiences—without seeking to understand the circumstances. We all have our reasons for doing what we do, and Marlene certainly had hers, the tragedy in my mind was that she did not feel safe or free to say what her reasons were because she was (and for good reasons) frightened of how others would respond.

Private practice can be a relatively lone endeavor. Clinicians are on their own and may need to rely on their own judgments in determining where the spheres of personal and professional are. In large institutions, the separation between professional and personal life are seemingly “clear” which creates the illusion that the task of trying to delineate where the lines are as being “easier and safer to do.” However, Marlene talked about how in her private practice, those lines were not as clearly defined and often put her in the position of having to make her own decisions about when her personal life overlapped with her professional life. Even though she lived in a small town and it was understood that she would run into her patients outside of the therapy hour, this also fostered a feeling for Marlene that she needed to be “professional” all the time. At church, in the barber shop choir, with friends of her patients and her friends. If she wanted to be “silly or goofy” she assumed that that would be unprofessional. She stated that her assumption was based on the profession's interpretation of ethics and professionalism—our personal values and/or lives need to be separated from our professional life. The trouble with this notion, as Marlene articulated, is that it is not possible to do that in small towns. But, she tries to do that because the Ethics Code implies that it is necessary, and that adds to the level of anxiety

she feels when she is out in her community. How can she enjoy her life if she's constantly having to think about and monitor her behavior?

I did not tell Marlene that I was Korean prior to our meeting in person. At one point during the interview, multicultural competency came up. I got the impression that Marlene was uncomfortable. Likewise, her response as a White woman and my experience of that response as an Asian woman made me feel uncomfortable. However, this experience shed light on how difficult it is to talk about difference in real-time, face-to-face and honestly. In response to my questions about multiculturalism, Marlene noted that she thought it was important to take the person's culture into consideration and rejecting different ways of being within a therapy session because she (the therapist) did not feel like it was supposed to be there also "didn't seem quite right." Therefore, the therapist would "have to know in advance the culture of the people they were working with and what those gestures or experiences that the client might refer to might mean to them." I noticed my own disquiet when I heard this response. It was a response that I heard often in my own clinical training experiences and from peers and colleagues regarding issues of multicultural competency. It was a good example of how the taken-for-granted assumptions about what constitutes multicultural competency in mainstream theory and practice also reinforce the notion that a categorical approach to understanding culture and other ways of being are informed by predominantly Western individualistic assumptions about difference. Somehow, if the clinician studies the person's culture then the assumption is that they will also be culturally competent because they have knowledge about the individual's culture. My reaction to Marlene's response coupled with her discomfort reminded me of how difficult it is to engage in dialogue about those underlying assumptions. Neither one of us seemed to want to explore that during the interview. I imagine in part, because we were fearful of what we might say and did

not want to risk offending each other. A one size fits all approach does not fit when trying to understand moral questions about difference.

**Summary of Marlene.** This topic was difficult to talk about for both of us. Anxiety and fear of being judged, but not fully comprehending where that came from colored our conversation and our interactions throughout the interview. We understood at some level that relationships are complicated, interconnected and multi-dimensional, but we both felt compelled to turn to proceduralism when we talked about uncertainty, complexity and morality. This was whether we talked about the Ethics Code and multiple relationships. Even then, turning to the Code for guidance did not provide help or comfort or understanding. Instead, we became mired in issues about technique rather than deliberation when we tried to think about our values. It was taken for granted that therapists should and can know in advance how to avoid the messiness, and that messiness is thought to be a risk that therapists need to be worried about, fearful of, and causes impaired objectivity. This contradiction was hard to identify because our fears and angst about causing harm, imposing our values onto another hindered us, while at the same time led us to become worried about our own safety. A sense of safety that seemed to hinge on legality, rather than beneficence. This sense of trepidation about safety is not unwarranted. We can be sued, and our licenses revoked or formally sanctioned and perhaps even more insidious, informally sanctioned by our peers and colleagues. Marlene's sense of obligation led her to participate in this study, but at the same time she was terrified, struggled to talk about her experiences, and did not seem comprehend the reasons for those fears. Marlene seemed pulled between her understandings of the good and her need to protect herself from a dangerous world- in this case, a dangerous world of self-righteous proceduralism and her professional life. She seemed to be the personification of mainstream psychology and I imagine that also terrified her.

So, she erected barriers to protect herself and create distance when she felt uncomfortable. When I sensed her discomfort, and responded with compassion she would soften, but when she did not know how to be direct and tell me what she was experiencing, she would try to create distance by getting me to react, for example, she became patronizing, irritated, or frustrated. This caused me to react by shutting down and becoming frustrated and irritated too. This made it hard for us to be more self-reflective and compassionate with each other during the interview. She was in a difficult situation and she was afraid. The way she had learned to protect herself and keep me at a distance was by patronizing me and shutting down the conversation when she did not want to talk about it or go where the questions might have led. In this absence of knowing how to engage in moral discourse about the topic and our reactions and emotions, we struggled to go deep, to talk about our emotional reactions honestly, and to wonder why we were feeling the ways that we did.

### **Stevie**

I met Stevie when I was a pre-doctoral intern. A year or so after we had met, she read about my dissertation topic and mentioned that she would like to participate in the study. She worked in a rural community, had experienced being minoritized, and Standard 3.05 had not been helpful to her when it came to multiple relationships. Stevie said she was not a member of the APA and described her commitment to the APA Ethics Code as “complicated.” She explained that the Principles aligned more philosophically with her own values than did the Standards or their application to clinical practice. Prior to the interview, we had attempted to schedule a time to meet, but Stevie had to reschedule on a couple of occasions. This pattern when on for a few months. In our pre-existing professional relationship, the conversations were fluid and unscripted even when we were discussing serious matters, but when we finally met for the interview, we both noticed the awkwardness of the situation.

My initial impressions of Stevie, she reminded me of Colombo, the detective from the 1980s American television series. She was an unassuming, self-effacing, and had a gentle demeanor, while at the same time she exuded an effective toughness. She was patient, inquisitive, and very articulate. We met in her office for the interview. There were piles of paper scattered about and lots of unusual curios in office. She smiled and explained that appearances can be deceiving and despite what appeared to be disorganization, she knew what was in every pile. Her responses to the pre-interview questions gave me a sense that she saw the world from a non-traditional point of reference. Her lived history dictated that she would be minoritized by the dominant ideology. As we had talked about some of her lived experiences, I noticed that many of them felt familiar to my own. She seemed philosophically minded, curious about other perspectives, she seemed well-versed on a variety of topics and engaged when she spoke.

**Background.** Stevie described herself as a “White-skinned/Native-American woman.” She was in her 50s and had been practicing in the mental health for approximately 20 years. She had a Ph.D. in psychology, but had not become a licensed psychologist until approximately six years ago. She stated that “she was already doing what she wanted to do under her LMHC license and did not feel the need to do more to prove her credibility.” At the time of this study, she was the Clinic Director of a small non-profit clinic in rural Washington, but also had a small private practice. Stevie self-identified as Queer with a leaning toward Buddhist/Nature-based spiritually. Her stated theoretical orientation was “Transtheoretical.” She also mentioned that she is feminist-leaning and prefers to use “client” over patient” when talking about her clinical work. At the time of this interview, Stevie stated that she had active clients and supervisees who identified as coming from cultures different from her own.

Stevie noted that she was raised in a “pretty traditional” family. She was the only girl in a household of boys. Her mother was Native-American (registered Choctaw) and her father was Irish-American. She said that they had married when they were very young and divorced when Stevie was four years old, at which time she went to live with her father in Southern California, Orange County/ East L.A. area. Although she had been separated from her mother as a young child, she said she still recalled “riding bareback on horses with her mother over the open plains.” She felt deeply connected to her mother and her mother’s traditions, which were more collectively oriented. Growing up in a White, Western family had been tough for Stevie. She shared that they did not accept her Native American heritage and attempted to “extract that identity” from her. She had to “fight to retain that part of her identity.”

In Stevie’s family, higher education was thought to be “valuable for boys but not for girls.” Her father was “the first person on either side of the family to graduate from college when he was in his 40s.” Stevie left home when she was seventeen and wanted to study journalism. During her studies, she said that had taken an interpersonal psychology course and loved it because it got her “thinking about social justice and individual’s experiences.” She had grown up in East LA. She described the people and community life as “ethnically diverse, vibrant and there was a lot of vitality.” It was common place “for people to speak freely about their opinions and they were open-minded.” Sharing one’s ideas and opinions were expected, “even as a student,” and she felt encouraged by others in her community to do the same. She noted that social justice, advocacy and community involvement were ideals that were embedded in the fabric of the culture there.

Stevie remarked that when she decided to pursue a doctoral degree she knew that those values would be integral in her work. She knew that she wanted to have a “good grounding in

multiple theoretical orientations” and she wanted to attend a graduate program that was committed to community-based psychology. It was a surprise, she commented, to find out that there was such a program in the state of Wyoming. When she arrived with her two young children she said it was a bit of a “culture shock.” The community there was predominately “conservative and traditional,” which was a departure from her more liberal, nontraditional notions. People there tended to express their discomfort with and disdain for her values and lifestyle. Still, Stevie remarked that her values were so different from theirs she could see why they might feel threatened by those differences. It was not easy, but she noted that she did develop relationships there during her graduate training and felt part of the community by the time she graduated.

The community suffered a profound tragedy while she was in graduate school there. A young man was brutally murdered because of his sexual orientation. Stevie stated that she had been deeply impacted by this trauma and it was important to her to be part of the healing process. She began working collaboratively with a multi-disciplinary team to develop a community mental health clinic in town. It was just the kind of work she had hoped to do, and she noted it was a rewarding experience even though there had been profound heartbreak.

Stevie stated that she felt she had “received excellent clinical training and supervision” in her program. The class sizes were small, and she felt supported by most of the faculty. She noted that she left her program feeling that she had gained vital experience. Experiences that had helped her to develop as a clinician, mentor, and community advocate. However, while those aspects of her graduate training were great, she remarked that there were also parts that were “difficult and oppressive.” Stevie explained, that her program was an APA-accredited doctoral program based on the scientist-practitioner model. She had felt that the tradition of an

“authoritarian and fear-based” approach cultivated a climate where students were expected to conform to the program’s agenda, even if those practices were “detrimental to their mental health and well-being.” For example, Stevie described how “the rigor of the program made it feel like we were running through a gauntlet” that was designed “to weed out the people who couldn’t make it.” Those who survived often interpreted their achievement as a “rite of passage.” Student workloads and attempts by some faculty and administration to silence students who spoke in opposition to the experience, created a terrible climate:

There were high attrition rates, and people were decompensating because of the extreme pressure. ... We were putting in 60 to 80 hours a week just to get through classes and assessments and then also doing our research and teaching classes or running the clinic. And When I would try to talk with them about how this is impacting students there was this very authoritarian response to that was very difficult to manage.

Being from a culture where it was common for people to ask questions and challenge the status quo, Stevie was understandably upset by what she had witnessed and endured. She wondered “how it was that they could continue doing it in this way when it seemed to cause damage to the students.” Stevie noted that when she had brought these issues and concerns to the attention of the faculty and administration the responses she received were disheartening, unsympathetic and dismissive. The implied message from the faculty and the administration to the students Stevie commented, was to just “get over it.” Though strong, and strong willed, Stevie did not escape the program without some wounding. The “harsh and competitive environment” was a source of disillusionment for Stevie. She commented that she left the program feeling less inclined to speak out or say anything. By the end, Stevie noted, she was just trying to “exist, survive and make it through the rest of the program.” She had noticed that her

confidence and enthusiasm had been impacted, and seemed saddened by this recollection. However, she also remarked that if it were not for the support and encouragement from her dissertation Chair and a few faculty members she probably wouldn't have finished.

**The Interview.** The in-person interview took place at Stevie's office, and occurred over two separate meetings. As we moved through the interview questions, I noticed that Stevie was extremely articulate, quick witted, and thoughtful. She was well-versed in ethics, philosophy, social justice, multiculturalism, and psychological theory and practice, and seemed to possess knowledge from other perspectives that understood human being and change from a more spiritually inclined framework. It did not seem difficult for her to talk openly about her ideas and experiences with multiple relationships and the Ethics Code. Stevie commented that in role as a Clinic Director running a nonprofit therapy program, she had felt conflicted about the pressure to demonstrate "evidence-based treatment models and protocols" to potential grant funders, regardless of whether those approaches were helpful to the clients and their therapists. In her experience, the rigid approach that many of those models promoted did not align with her understanding of what constituted effective therapy for many of the cases and clinicians that she had supervised. These models, Stevie remarked, are pressuring clinicians to demonstrate "fidelity to the model" rather than considering the individual differences and multiple potential outcomes that could transpire in therapy and the therapeutic relationship. She also expressed concern about the domination of these model and noted that resources and funding for services were harder to find in general, but even harder to obtain for clinics that would not and could not "prove they were using evidence-based practices." She stated that she preferred to use the term "evidence-led." It was not just the demand for a commitment to use evidence-based practices that disturbed her, but the idea that there was an expectation that everyone used them with little exception and

in place of other treatment approaches. In her area of expertise (trauma), she had witnessed how a one-size-fits-all mentality effectively re-capitulated the trauma for many of the clients and clinicians she worked with. Stevie noted that she felt such models “often are not effective in measuring what might be considered therapeutic and in some cases, requiring that clinicians use these models with their clients has caused harm.” She explained that in her experience, many clients may not be able to process their trauma in a sequential, linear way and mainstream models do not recognize or value the individual and interpersonal dimensions of the therapeutic relationship and process.

She also remarked that in her experience, she had observed how the pressure on clinicians and clients to comply with approaches that did not necessarily align with their values and cultures can cause harm and diminish the power of therapy. Stevie seemed worried about this ethical dilemma and struggled with how to fight for the preservation of the rights of clinicians and clients to practice in ways that were evidence-led, and culturally appropriate. One of Stevie’s greatest concerns was that she would do harm or be part of causing harm, but she stated, “according to the Ethics Code, determining what constituted harm was complicated and difficult to determine.” When we moved into questions about specific cases with multiple relationships, I noticed Stevie seem hesitant to go into detail about any one case. She said she noticed that she was feeling anxious about discussing specific cases because she wanted to be sure that she was honoring her clients’ privacy. Her solution to this dilemma was to talk about her own experiences with multiple relationships.

Stevie stated she had a lot of experience with multiple relationships. Not only did she identify as being a member of an LGBTQ culture that is problematized by the dominant paradigm in which heteronormative is viewed as binary and straight, she also identified with her

mother's Choctaw heritage. For Stevie, multiple relationships were common in her everyday lived experience. Because of her identity she is a marginalized person existing in a paradigm that forces the institutionalization of a structure that categorizes people who are not of the dominant class as less than. A notion that is deeply pejorative, derogatory and historically rooted in the fabric of the belief in the supremacy of Whiteness in American society. On the whole, Stevie believed that multiple relationships were beneficial, at the same time she had also observed that choosing to engage in them was frowned upon by others in the profession. She commented that the perception of multiple relationships as types of relationships that clinicians should avoid or be wary of, was perplexing and worrisome to her. Being from a collective culture, the thought of denying or avoiding multiple relationships because they might pose a risk, did not align with her own understandings or beliefs. However, she also recognized that it was important to have professional standards. As a psychologist, she wanted to abide by the Ethics Code, when possible, but it had not been a helpful guide on how to navigate the complexities of her multiple relationships in clinical practice. Her attempts to challenge some of those underlying assumptions were often countered with the implication that she was "rationalizing her decisions because that was what people who break the Code do—they rationalize their behavior." I noticed that she seemed very vigilant of the need to be self-aware. At times during the interviews her vigilance seemed to lead her into obsession about the paradigm almost to the point of no return. She appeared to be quite aware of her inclination to over-intellectualize and described her tendency towards this thought process as "falling into the rabbit hole." She noted that she would often have to pause and remind herself of what she was doing. I had the impression that Stevie's anxiety and worry also caused her to feel she needed to censure herself during the interview. For example, at one point during the interview she commented:

Even my own self can feel my self-closing in and [wondering] what is this about? And so then, I am watching that [process] happen to me. Even talking about the codes and whether I am following them and if I'm not why not? And am I just rationalizing? Does that mean I'm unethical? ... Which then if you get totally into self-preservation then even perceptions of being unethical like your own fears for your own self [the legal liability of your practice] that can interfere with making the best informed or more flexible decisions and are not so rigid. Because if you go from completely rigid, then your decision will all be made from fear, or I'll speak for myself, my decisions can be made around fear.

Another dilemma Stevie described was that she did “not want to impose those values onto her clients and others,” because it can create the perception that something was wrong with them for not seeing, understanding or labeling their struggles in the same way that the profession tends to do. Because of her own values which were eclectic and reflected her mother's ethnic heritage, from Stevie's vantage point, the concept of community and relationship were understood as just part of everyday living. Though, the rules and approaches that emerge from mainstream psychology and the Ethics Code did not fit with the complexity of human interaction and community. In fact, she stated “some of the very values that are aspirational values of the Code seem to come into direct conflict for her.” She explained that in her opinion:

The profession need to honor not only their own values, but also the values of the people that they serve. The fact that the Code is there, and we study it and are taught to abide by it is certainly a small piece, but it's just a small piece because it doesn't nearly cover the complications.

The Standards Stevie commented, do not adequately address how she might conduct herself in an ethical manner in those relationships and/or groups. Rather than following those

aspirations and applying them to our ethics and practice in psychology, Stevie remarked, the focus seemed to be on whether people were disobeying the codes (Standards) and using the Standards to “guard against liabilities that were not always in the best interest of all those involved.” At this point, she paused to attend to the irony of this dilemma and the anxiety that it produced for many clinicians who worried about multiple relationships. In her experience, she had observed that whenever “there was a multiple relationship, she was more anxious about it than her clients tended to be.” But the anxiety, Stevie remarked was powerful:

See the anxiety in talking about it [the Code], and wanting to be more- broad minded and thoughtful, be even in that approach to thinking and what I just said to you [the interviewer], I have this sense that I need to watch out. ... The way that the Ethics Code and the Standards are implemented is fear based and that can be stultifying. And then, where do the aspirations go? We can't really aspire if we feel scared and guilty about even aspiring. I can feel this oppression like, who am I to say that? To talk about aspirations and disobeying the code.

The ethical training models from Stevie's perspective, had adopted a “medical model response” that perpetuated the assumption that “there's something wrong with the client if they wanted to know about their therapist's life or desired to see and interact with their therapist in another situation or context.” This seemed odd to her because from her perspective:

Therapy is interpersonal (relational) work the client's desire to know about me or want to become involved in any other way in my life other than the four walls of the therapeutic room seemed to be a very natural response. Though it is implied in the Standard and mainstream psychology that there's something wrong with them for wanting to explore that.

Another issue of concern with Standard 3.05 that Stevie noticed, was related to the idea of how clinicians are supposed to anticipate harm. She explained that, “what constitutes harm was a really hard thing to know because of the ongoing nature of the therapeutic relationship.” Yet, the implication in the Standard and that was reinforced by mainstream theory and practice, seemed to be that as the therapist she should be able to foresee what will happen before it happens. She talked about a situation when she and her client discovered that there was a multiple relationship several months into their work together. Stevie noted, that if she stayed true to her own values, ending the therapy relationship because there was a multiple relationship would not necessarily be helpful or beneficial to the course of treatment. She wanted her clients to know that she understood the effort and courage it takes for clients to even begin the therapy and the process of facing their trauma histories. Honoring the welfare of the therapeutic relationship was important to her. Conversely, she also recognized that it was a multiple relationship and she wanted to be sure that she did not cause harm. From her vantage point, there were multiple ways she could manage the relationship without causing harm that she did not consider to be unethical and that were not addressed by Standard 3.05. She remarked, if “I followed the Standard, I would be abandoning my client and that goes against my own ethics and the Code’s Principles.” Then, there were also unique circumstances that weren’t “in the books or the Code, but created a dilemma.” Stevie provided the example of when a colleague had passed away suddenly. The clinicians were shocked. Everyone was trying to figure out how to support the clients and continue services while grieving their loss and attending a funeral together. Stevie commented, “that would constitute a dual relationship, an interesting one, but it’s still a dual relationship.” I notice Stevie paused before saying:

I almost wonder sometimes if the aspirations are more of... they're more of the values, and philosophy, broad based inclusive... you know it does feel like the language in the aspirations and I can't remember them perfectly, but it does almost feels more collective. Like we care about society and goodness and contributing those kinds of things and doing good; social justice I think it is in there, I hope that it's in there. I might just be misremembering but I think that that's in there. [Researcher: they put it in there. They added it in]. I like those and my memory that serves me, I like the aspirations and agree with most of what I read in that. Then to me it's like the Standards are Euro-centric, and when liability and rules and regulations are used to control people. ... That authoritarianism and fear steps in and then separates the code from the aspiration. That's kind of how it feels to me. ... but it's the broad and open and allows for us to really consider what we're doing and why we're doing it. And the other – the Standard tells us or tries to tell us. But then it's still squishy and weird. It tries to be a rule but then isn't. It allows for discipline. It's a way to discipline so that's why there's so much fear around it. It's a way to discipline... and I've had some cases where clinicians have done harm and the Ethics code has been a tool to stop that harm, but it's also a tool that has been used to do a lot of harm... it paralyzes people and moves them away from the aspirations to fear. Which is sad to me because most people are drawn into this work because of the aspirations not because of the rules that may or may not protect people.

The Code and the Standards, seemed to her to be more about “covering our ass” than being ethical, which then becomes “less of moral guide and more of a set of rules that clinicians are told they must obey and fear:

The Code is not real. It's not something that we can use as clinicians. It's more of something that we know that we must at least present as if we are doing it the way mainstream expects us to practice so that we're not going to be conducting ourselves in a harmful way. But that doesn't really mean that, it's just a perception... because the harm I see in actual multiple relationships doesn't really fall very well under that. So, I don't feel, personally, I don't feel like it's something that is a helpful tool at all in that I can regurgitate it when I need to.

Stevie seemed to have a strong sense of obligation to be morally responsible. She understood the influential position associated with the role of psychologists. She believed that because of the influential nature of her position, as psychologist, she felt strongly about taking on the responsibility of making sure she was "really aware of where those multiple relationships might exist and how they might be impacting the people she worked with." It was evident that she took this obligation seriously, so much so, that at times during the interview it seemed to be immobilizing, or as she might say, *stultifying*, which was a term that she used to illustrate how the Code invokes a fear-based mentality. Despite her understanding and use of the language and terminology often used in mainstream psychological ethics models, she remained vigilant and in a strange way this seemed to heighten her felt sense of being surveilled.

It appeared that Stevie coped with her discomfort by compartmentalizing and over-intellectualizing her felt experience. For example, she seemed very adept at drawing distinct boundaries between her personal and professional values, and very careful to make clear that she was separating what was personal and professional. Though she recognized that she did this, it escaped our notice that the assumption that a clinician would need to compartmentalize and/or think of their personal values as separate from their professional values, was ironically, a

reflection of professionalism. There were moments during the interview when Stevie would emphasize technique and rely on a more technical approach when the Code did not align with her own ethical positions. I got the impression that finding the middle ground for Stevie depended on her ability to “manage the multiple relationships and monitor” her conduct in them. She conveyed that she often felt constrained by the “Western Eurocentric” values of the dominant class. She explained that, the assumptions in the Ethics Code emerged from a cultural framework that privileged individualism and seemed less inclusive of nontraditional practices and approaches to therapy that do work in more collective communities. Being embedded in a Western paradigm also meant that she felt adhering to the Code and that meant she had to practice in ways that felt inauthentic and contrived at times. This seemed perplexing for Stevie. She stated that from her standpoint:

Broad and open and allows for us to really consider what we’re doing and why we’re doing it. And the other, the Standard tells us, or tries to tell us what to do. But even then, it’s still squishy and weird because it tries to be a rule but then it isn’t. It [is a rule that] allows for discipline. I’ve had some cases where clinicians have done harm and the Ethics Code has been a tool to stop that harm. But it also paralyzes people and moves them away from the aspirations. It makes them afraid. This is sad to me because most people are drawn into this work because of the aspirations not because of the rules that may or may not protect people.

**Summary of Stevie.** Although Stevie did not seem to be worried about sharing her views and talking about multiple relationships and ethics based on her own experiences, she was anxious and concerned about how the Code was implemented and seemed to cultivate a climate of fear. Though she seemed comfortable with moral ambiguity, she also struggled to remain

philosophically minded when her anxiety was heightened. It was evident in Stevie's responses that it was worthwhile to her to challenge those mechanisms of "power, control and oppression." Yet, feeling as though she had to adhere to a model of ethics that "recapitulated some of those oppressive paradigms that created the trauma her clients and clinicians experienced to begin with" made it harder for her to openly follow the Principles that drew her to the profession. Stevie observed that the profession's stance towards different ways that clinicians and clients understand their struggles and find relief seemed to have made it "more difficult for clinicians to be open about their boundary crossings and ethical challenges because they fear of repercussions from the APA."

### **Summary of Case Studies**

It was striking to see how much fear of negative consequences, anxiety, and confusion about multiple relationships, Standard 3.05, and mainstream theory and practices had infused the experiences of these two participants. Both seemed to struggle with thinking and talking about their concerns with the Standard and their interpretation of it as it related to their clinical practice.

For Stevie, the prominent themes seemed to be tied to conflicts related to concerns about the absence of different cultural practices and ways of being that honored her values and the values of her community. For instance, the Code did not consider a way of being that embodied a more collective cultural understanding of relationships and how those are established, maintained, and function for the good of the community. Her biggest fear seemed to be related to the emphasis of the individualism that is privileged in a Western paradigm. An emphasis that from her viewpoint, undermined and caused harm to people who were from collective cultures or cultures that were not White. She was worried, anxious, and conflicted about how to implement a

Code and follow a Standard that directed her to act in ways that were contrary to what she and her community valued and honored.

These same concerns were present for Marlene, but in a different way. Marlene seemed to be worried and anxious about whether she would incur negative professional consequences for not adhering to the Standard and/or following the rules, policies and procedures set forth by the profession. For example, she talked about her fear of losing her license because she had engaged in multiple relationships, and believed that if she discussed the details of her clinical decisions—even those she regretted, would be perceived as mishandling her cases and feared negative consequences from regulating bodies (e.g., the APA, CPS, the State board).

Both Stevie and Marlene were anxious and fearful of being judged and criticized by their colleagues for engaging in multiple relationships, in part, because they had been! When they had tried to talk with supervisors, colleagues, teachers, and instructors about their ethical dilemmas and the challenges the Standard posed for those working in rural and minority communities, other cultures that were not of the dominant class, the responses they received were unhelpful, unsupportive and disrespectful of their experiences. It did not feel safe to be thoughtful or philosophical about the Code and the Standards with their colleagues and/or in the public professional realm. This resulted in a sense of separation and isolation from the professional community and the Code itself.

There was anxiety about practicing in a way that disagreed with the APA and the Standard. Though both participants' "believed in the Principles of the Ethics Code," they did not find the Standards to be helpful. This seemed to cause them to doubt their values and question if they were handling their multiple relationships in ways that they should. When they went to the Code for help it was not an adequate guide. Instead, the Standard felt rigid, authoritarian and was

perceived to be a tool to discipline and punish rather than guide them in the ethics of their practice.

Both participants also reacted to or protected themselves from the distress of having to rely on themselves more than the Ethics Code. For instance, Stevie tended to compartmentalize and over-intellectualize the apparent contradictions. Marlene mitigated the contradictions by deflecting and avoiding discussions about ethics and her practice. She responded to the perceived inconsistencies by minimizing and even denying at times that she had a problem with the Standard. Even though she had described occasions in her clinical cases that indicated she did have a problem with the Standard. Stevie tended to go inward when she felt uncomfortable in the sense that she became hyper-vigilant about her self-awareness and seemed to take on personal responsibility for not re-capitulating the oppressive aspects of the Code. Marlene tended to lash outward when she was uncomfortable, which was reflected in her patronizing statements to me and her attempts to deflect or avoid having to talk about the conflicts she had with the Standard and APA mainstream theory and practices. In addition, both seemed to want to make clear that they were separating their personal and professional identities. For Stevie, this separation seemed to be more unsettling to her because she presented an understanding of the multiple identities she embodied. These identities were interconnected, fluid and could occur simultaneously. Marlene seemed to struggle with the notion of multiple identities and I noticed that she talked about herself in a way that sought to reduce what she felt into disparate aspects of her experience in order to arrive at a more linear, logical interpretation of her identity.

## **Discussion**

The two participants in this study bravely attempted to articulate their values and clinical encounters with multiple relationships and the problems they experienced when they tried to

apply Standard 3.05 in their practice. It was a difficult conversation. The aura of deception about being uncertain with what might occur if they revealed themselves and their vulnerabilities led both the interviewer and participants to react. The participants struggled to understand how to talk about their disagreements with the Code and locate their standpoint within the ethical positions that mattered to them. Avoidance, obsession, anxiety, and fear filled the space. They coped by trying to protect and defend against the conflicts that emerged by attempting to minimize their discomfort with ambiguity and relied on procedures to explain or answer the impossible contradictions the Standard posed. This was especially the case when their lived experiences with multiple relationships did not fit with interpretations of Standard 3.05. As a means of creating distance and mitigating the discomfort, it seemed easier to patronize, deflect, compartmentalize, and over-intellectualize the issues of concern; to allow something and/or someone else to explain, justify, and provide answers to questions and problems that we struggled to understand, let alone solve in substantive and meaningful ways.

### **Findings and Implications**

There were three prominent themes (and several sub-themes within each) that were uncovered in this study through an interpretive analysis of the interviews: Participants' reactions; Problems with the Ethics Code; and Defenses. By abstracting from the themes and case studies, two broad conclusions emerged. First, the authors and interpreters of the APA Ethics Code seem to have understated the influences of other cultures, the lived experiences and histories of individuals and communities that are not of the dominant class, and various ethnic understandings that run counter to Western ideas about individualism and communalism, and small town/rural life. And second, the interviews contained material that indicated that the

proceduralism<sup>1</sup> present in mainstream psychology is an impediment to a better understanding of moral issues, relational processes, and thus ethical outcomes in the work of psychologists.

**Values, Rules and Competence.** What principles do psychologists rely upon to understand the choices that we make and what do they do when working with patients and colleagues whose traditions and moral understandings differ from theirs? Is Standard 3.05 a helpful guide for clinicians who because of circumstances and cultural understandings might choose to become involved in multiple relationships?

Chang (2010) commented that from his perspective, he did not consider “the results of his study to be merely findings, rather he had been transformed by his interactions with his research participants” (p. 28). I resonate with this observation and can see in my own research process how deeply affected I have been by my participant’s stories. The demonstration of their humanity through the expression of their emotional reactions, struggles, and attempts to cope with and defend against the pressures they experienced with the Ethics Code and their efforts to find ways to practice that were meaningful to them and their patients was remarkable. It is true that the kind of dialogue of which Gadamer (1989) speaks is difficult to practice, but if one can be open to the possibility of what might emerge from engaging in such a demanding task, a new understanding might appear and slightly shift one’s perspective. The journey is not an easy one, nor does it promise peace, but it does hold the hope of comprehending something in a deeper way and offering the opportunity to change if we choose to take the risk. As a profession what have we chosen thus far? Do our stated values reflect what we really believe, or have we sold our soul for an empty and dangerous illusion that a prescriptive Code, rules and procedures will offer protection and safety from ambiguity, the messiness of social entanglements and the pains and

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<sup>1</sup> Reliance upon stated policies and procedures to address one’s moral dilemmas.

joys of living? What do we understand about ethical and professional competence? Being proficient in these domains is important and is something most psychologists try to achieve to the best of their ability. Most psychologists want to be ethical. However, the kinds of skills clinicians being taught to value: do they include freedom of thought, responsibility of self, confidence in one's own judgement, speaking freely if one disagrees with the standards, and moral deliberation so that changing course becomes possible?

Strong guiding values are what help us to not be at the mercy of dangerous situations. But, being mired in angst and fear of speaking out, or following one's own course as opposed to what others prescribe, is also a dangerous situation. One that might lead us to misperceive that becoming emotionally walled off and disengaged from what occurs around us and happens to us is what is needed and valued. Have clinician's been taught that the separation of personal and professional spheres is necessary to be ethical? As a culture, I wonder if we have really come to believe that there is a difference in the way we conduct ourselves in our personal relationships from the way we conduct ourselves in our professional relationships. When we accept this view, what are we communicating to our patients, students, and each other about honesty, authenticity, adversity and the value of honoring other ways of living?

Therapy is a paradox (Casement, 1991). As such our notions of what is considered to be therapeutic emerge from and exist within this frame. There are a dizzying array of psychoanalytic/dynamic approaches to therapy. General consensus, however, within these persuasions is the assertion that there is no universal "technique" that one must employ. There are, however, universal beliefs and attitudes that undergird the effort to apply philosophical principles in terms of framing and understanding the growth of another person (McWilliams, 2004, p. 28). Relational psychoanalysts Mitchell and Black (1995) describe these attitudes as

including deference for the “complexity of the mind, the importance of the unconscious mental processes, and the value of sustained inquiry into the subjective experience” (p. 206). Jessica Benjamin (2002) beautifully articulates a psychoanalytic/relational and dynamic attitude as being one that is concerned to the “truth, freedom, and compassion for our mutual vulnerability” (p. 44). Lothane (2002) sees the [psychoanalytic] patient as one who seeks the “Socratic goal of the examined life, both of learning and to know himself or herself... and to grow as a moral agent who lives his or her life responsibly rather than impulsively” (p. 577). Additionally, Schneider (1998) noted that the [psychoanalytic] tradition is an “expression of the more ‘romantic’ (affective, intuitive, holistic) sensibility in Western thought, as opposed to the hypothetical-deductive-inductive bias that permeates most American academic psychology informed by logical positivistic tradition in general” (McWilliams, 2004, p. 28).

Non-objectivist approaches, I believe, integrate and reflect the philosophical ideas and values of these perspectives and propose an understanding of human being that is deep and broad. As such, identification and orientation toward these approaches is intuitive. This is not necessarily because I always agree with their opinions, but rather, it is because these approaches have seemingly been able to articulate and move towards an emphasis on honesty, authenticity and the quality of dialogue in the context of clinical practice and professional life. I, along with other contemporary authors believe that the quality of engagement in dialogue and the articulation of these ideals within our practice, has deepened and broadened our ability to think creatively and respectfully about our patients and the ways in which we try to describe and understand their struggles (Benjamin, 2002; McWilliams, 2004; Mitchell & Aaron, 1999; Stern, 1991). These approaches call attention to and champion the excitement of the search, the open-ended dialogue and the spiritual dimensions of the quest itself (Stern, 1990, 2010). Clinicians

still need to practice in a way that makes sense to them and expresses their individuality, and this notion remains true for me.

**The Model Isn't Working.** According to the current APA Ethics Code, the General Principles are aspirational goals. These goals reflect the highest ideals that psychologists are to strive toward. Although the Preamble and General Principles are not themselves enforceable rules, and are often not covered in depth in ethics education and training curriculum. Yet, these are the principles that psychologists rely on and consider guiding them. These principles are the foundation from which psychologists draw to help them develop their own strategies. Strategies will be unique to the psychologist, their patients, and their circumstances. On the other hand, the ethical standards set forth by the APA are:

Enforceable rules for conduct as psychologists. ... General Principles, in contrast to Ethical Standards, do not represent obligations and should not be the basis for imposing sanctions. Relying upon General Principles for either of these reasons distorts both their meaning and purpose (APA Ethics Code, 2002, 2010, pp. 2-3).

The severing of the philosophical Principles from enforceable Standards is also reflected in mainstream theory and practice. A split that has made it difficult for many psychologists to talk about their values and the differences they embody when those differences are at variance or in conflict with the Code. Within this framework, questions about ethical dilemmas become questions and concerns that are interpreted as matters of technicality rather than morality. Recall Behnke's (2004) assertion that "the ethical questions about multiple relationships, may be about ethical dilemmas, however the questions and concerns that many clinicians have about how to address multiple relationships is not one of ethics, but of technicality" (p. 66). Many clinicians live and practice in communities where various ethnic and cultural understandings run counter to

Western ideas about individualism and have written about what is problematic with this perspective (Everett et al., 2013; Littleford, 2007; Zur, 2002, 2012). However, the findings of this study convey that clinicians are still struggling to find ways to talk about their concerns and disagreements with Standard 3.05. When they do attempt to ask questions, or challenge the dominant paradigm, they are met with judgement, discounted, dismissed, and even pathologized. Both participants in this study described such difficulties.

Often clinical judgements are based on personal values and political beliefs, but what is the effect when questions about moral values are driven by objectivist methods of inquiry and scientism?

The hermeneutic argument is that scientific method, when applied to questions about moral values, is itself a historical/cultural product of Western, rationalist traditions ... mainstream scientific psychologists do not understand that the findings they believe are the product of objective methods are framed by disguised moral understanding and inevitably result in subtle but important political consequences. (Cushman, in press, personal communication, pp. 23-24)

Relying on set of procedures that will function to guarantee objectivity and thereby unify the profession's values is only one way to address the myriad of complex ethical dilemmas. At the same time, it fails to recognize that there are various good ways to be in the moment, how patients might experience treatment and what the therapeutic endeavor might mean to the clinician and their patient (Hoffman, 2009). Hoffman (2009) stated, "the moment by moment choices that we make will always be influenced by sociopolitical mind-set, personal values, countertransference and factors that are never fully known" (p. 1043). The proceduralization and manipulation of a shared set of values (e.g., Principles) can also result in the destabilization and

fragmentation of those shared values. When values that are then interpreted as separate from the enforceable rules that psychologists are expected to obey, the Code becomes an exhaustive set of rules rather than a substantive guide clinicians might use to help them assess their clinical judgements and develop responses to perceived ethical dilemmas. When the clinician is worried about following procedures or fearful of being punished, the focus of the therapeutic relationship shifts away from being about the welfare of the relationship between the clinician and their patient to an emphasis on the relationship between clinician and the regulations. In practice, this can undermine the authenticity of the therapeutic relationship and effectively exclude the individuality of both the clinician and the patient, which in turn leads the clinician to doubt their own capacity to arrive at creative solutions to the dilemmas they face.

The process of therapy and the therapeutic relationship should not be driven by fear of incurring negative consequences for deviating from the ethical standards. Rather, it should embrace and promote the value of moral deliberation, which necessarily must include trusting one's clinical judgment, the capacity to be open to the unknown, and trusting in one's ability to make clinical decisions in the realm of the unknown (Hoffman, 2009; Stern, 2013). This is not to say that procedures are unhelpful, however, proceduralism can cultivate a climate of fear and anxiety. It was the fear and anxiety that I noticed and was so palpable throughout the interviews in this study. Even when the participants' believed their clinical judgements and decisions were beneficial to the course of treatment for the patients, it was hard for them to talk openly about it because they felt that they had failed to follow Standard 3.05 and that would incite judgment and criticism. There was no question that multiple relationships posed challenges and require special consideration on the part of the psychologist. At the same time, the question of how psychologists might act ethically and do the best they can in the moment and under varied

circumstances seemed to be unanswered by the Standard. The underlying assumption about Standard 3.05 was that the clinician can and should be objective and anticipate what their patient might do in therapy before it happened. At a very basic level it created pressure that led them think that they ought to have known beforehand what they should have done to address the multiple relationship(s) that emerged-- an unreasonable expectation at best.

Having professional standards that are clear and compassionate is important, but even the most well-intentioned standards are susceptible to becoming dogmatic influences, especially when clinicians are taught that they need to follow them because that is what is what's best for all (Edelstein, 2011; Marin, 1979; Singer, 1995). Power differentials are complicated. When you add in multiple roles or sex to the mix, the discernment of the boundaries of the relationship can become very difficult to navigate and problematic because the roles that the clinician must negotiate are simultaneously equal and not equal. As many have experienced, navigating this dynamic in ways that keep those positions clear and where welfare of the patient (or student) and the relationship is always in the forefront is not easy to do in practice. On the other hand, the notion that influence runs two ways, meaning perhaps the power of one's self to say, "I don't agree with your interpretation" or "that's creepy, I'm getting out of here" (Edelstein, 2011, para 4) is understated. There are multiple reasons why patients might end the therapeutic relationship, but many, if not most, do end it. Of course, there are very clear reasons why psychologists do not have sex with their patients (see Standards 10.05; 10.06; 10.07; 10.08) and the APA directive to refrain has been constructive, but is that same approach to multiple relationships helpful? The findings from this study support what others have conveyed about the problems with creating a catch all standard that implies blanket avoidance whenever possible— It is not realistic or helpful

and in some cases for some, it is not ethical (Duran, 2006; Everett et al., 2013; Littleford, 2007; Sue 2001; Zur, 2002, 2012).

We embody the cultural traditions and practices of our time and place. I could not escape the influence of “the modern-era discourses of diagnostic classification and empirically [or rather] evidence-based supported treatments that have a strong hold on our training programs, agencies we work in, and clinics where we practice” (Chang, 2010, p. 28). The choice to conduct a hermeneutic case study was deliberate, but throughout this process I noticed that I found myself distressed about whether I was conducting research the right way. I worried about the how to justify the relevance of the findings because they were not generalizable from the perspective of systematic-empirical research methods that are often used and privileged in scientific psychotherapy research and discourse (Hoffman, 2009, p. 1044). But then again, hermeneutic inquiry after all, is “the work of the heart” (Chang, 2010, p. 28) and these in-depth case studies brought to light a deeper understanding and appreciation for the participants’ histories and their lived experiences. They helped me to recognize more fully how they became who they were and why they reacted to interview questions as they did. By being open to what unfolded in the moment, I was able to shift my perspective in a way that I could understand the degree to which they felt the need to be evasive, pejorative, obsessive etc., during the interview in a different way. I learned to value the interpersonal work, the give-and-take that occurs within an interview session, which also deepened my comprehension of relational processes that occur in a therapy session (e.g., how they affected me and how I was affected by them). This insight increased my understanding of the complexities we as psychologists embody and try to work out in the therapeutic endeavor. It also brought to light that “the result of what we study, can lead us to change our perspective and makes it possible to carry ourselves differently and live

differently” (p. 28). I discovered that I could be more sympathetic of those who turn to procedures for help and guidance even when doing so may not be helpful and in some cases harmful. From a hermeneutic perspective, the absence of something can be as important it’s presence. For instance, throughout the interviews I noticed that there was an absence of positive reasons for the Standard. Like the air that is breathed, it was so obvious that it escaped our notice during the interviews. Sadly, it seemed to reflect how we have been conditioned to be frightened of “ambiguity, complexity, uncertainty, perplexity, mystery, imperfection, and individual variation” in research (Cushman & Gilford, 2000, p. 993). My understanding of hermeneutic inquiry thus far, has taught me about the need to proceed in research and clinical work delicately, wholeheartedly, asking wisdom to let me attend so that I could develop self-awareness about how to conduct myself honorably and respectfully with those who I come into contact in my professional and personal realms.

### **Suggestions for Future Exploration and Discussion**

It seems at present within mainstream psychology, that it is difficult to locate the kind of moral discourse that furthers critical thought and constructive debate regarding the moral issues of our time. Many psychologists seem less inclined to give freely and talk openly about the feelings, lived experiences, and concerns they might have related to the profession and its Ethics Code. This was apparent in the participant interviews. The Ethics Code purports to exist as a clear and measurable understanding about what type of behavior is acceptable within the profession. At the same time, “we breathe life into our ethical engagement by continually being open to new learning and new possibilities while holding on to important teachings from historical contexts and our lived experiences (Everett et al., 2013, p. 18).

**Revision of the Ethics Code: The shepherd not the master.** Might the Ethics Code aim to become like a guiding shepherd rather than a punishing master? Confucius contended that:

Uniformity of a set of standards might produce rule, regulation and laws, but tedious force and brutal law has never led people to [moral] convictions that legitimately resulted in proper conduct. Force only produces alienation and people will transgress secretly that which is public regulation. The passions instead of having to be painfully exterminated, are yoked like snarling tigers to our carriage. Uniformity alone cannot give rise to proper conduct (Wilhelm's interpretation of Confucius as cited by James DeKorne, n.d.).

Like "a shepherd who keeps the sheep calm through the calmness of their own mind lets their sheep find their own preferred kinds of shrubs and grasses, and just sees to it, every moment, that all are safe" (Heyboer, April 2000). In its highest expression, a discipline's code of ethics can reflect values that serve to guide the profession in shared endeavors and unify beliefs while at the same time encouraging its membership to critique its own dictates and engage in moral deliberations about its policies and procedures. The findings from this study indicated that the level of anxiety and discomfort experienced when talking about these issues could be due to an absence of moral and philosophical discourse about ethics. The pressure the participants felt to conform to the Code was powerful and at times felt inescapable. Based on the findings of this study, their sense of freedom and confidence in the way they practiced was impacted by the dominant ideology of mainstream psychological associations (such as the APA) regarding ethics education and training. Standard 3.05 was interpreted as a rigid rule that was distant and disconnected from their own understandings of the principles in the Ethics Code, but they still felt compelled to try to follow it at the risk of incurring negative consequences. This fear had been reinforced by their experiences of being criticized, judged, and shut down by other

colleagues and faculty when their opinions about ethics competency differed from what their APA-accredited programs taught. Such encounters led them to feel ostracized, isolated, and disengaged from the profession's discourse about ethics. They did not feel comfortable talking about what was important to them and the reasons why that might be, and equally important, they did not feel as though their voices were valued by the dominant class.

If clinicians cannot critique the underlying philosophical assumptions that inform the Ethics Code they are expected to obey and enforce, then they will also struggle to comprehend the multiple ways of understanding the good and what the good life might mean for themselves and their patients. The Ethics Code when interpreted as a text that will solve difficult questions about moral values rather than as a guide to help clinicians better understand and attend to the ethical dilemmas they encounter, loses the power to inspire clinicians to enact the profession's highest ethical ideal in their daily lives and professional careers. It becomes a reproduction of what the few who maintain authority prescribe. The Code holds the potential to become a text that draws on the wisdom of multiple perspectives across disciplines and could better serve and prepare clinicians to engage more deeply with the moral quandaries they will inevitably encounter.

**Ethics training and education.** What is the aim of ethics education and training of psychologists? It is unclear what the motivation of the current model of ethics education and the Ethics Code is intended to do. Is the intention to produce psychologists who loyally guard the profession's values in honorable ways, to think creatively and respectfully about those they treat? Or is the aim to train clinicians to become like a master that bears the responsibility to protect, enforce, and impose rules and regulations even when they don't agree with principles psychologists are told they are to abide by? Are graduate training programs equipped to teach

psychologists how to interpret the signs and symptoms that pose dangers? Or are ethics education and training curriculums teaching clinicians to abdicate their right and responsibility to critique, challenge and change the dominant paradigm? The price of being competent within the profession seems to come at a high cost. Obedience to a profession's code seems to be more important than critiquing and deliberating on the values that inform its standards and poses a great risk to the future of the profession. A future that encompasses a sense of betrayal, perpetuates deception and fosters a loss of faith in ourselves and our ability to serve society in ways that are substantive. The findings from this study indicated that the participants and the profession of psychology are embedded in a social landscape that compels clinicians to be reductive, and the profession is struggling to think about our embodied philosophy, understanding morality and findings ways to resist.

It is possible for the profession of psychology in the U. S. to travel on a new road that utilizes its power to change course and reform the Ethics Code and related clinical training programs. However, this will not be easy, but it is worthwhile. The real power comes when can as a collective face who we are with humility and refrain from projecting uncertain images of our own power. In the current cultural political milieu where aggression, posturing, manipulation of others to promote self-serving agendas, and exaggerated self-righteousness seem to rule the day, it is hard to remember that gentleness and a humble attitude also has the power to influence, change and affect others. Psychology as a social institution is not immune to such practices either. There is more to be desired than domination and short-term gratification (e.g., Cognitive Behavioral models of treatment, limited therapy sessions and a 15-minute clinical hour). History has taught humanity that evolution and change within our social institutions requires relentless dedication. In the profession of psychology, perhaps this would mean a commitment to

developing curricula that trains and mentor's clinicians in the practice of moral deliberation and dialogue with the knowledge that our ability to interpret our situations is a necessary and valuable skill (Richardson, Fowers, & Guignon, 1999). In the U. S., it seems to have become even more difficult to stave off what often feels like an impatient world. But then again, if we succumb to that notion, we risk the loss of our capacity to become patient observers of the human condition and the freedom to enact changes that are socially just and worthy of pursuing. It becomes less possible to comprehend what might be the reasons for the dis-ease from which so many of us seek relief. Listening carefully, being thoughtful and philosophical, about the direction of the profession and its policies and procedures are not dangerous endeavors.

“Scientism cannot produce thoughtful moral understandings about ethics when it is severed from “philosophy, moral dialogue, and relationality. Only philosophically sound moral discourse can work toward that goal” (Cushman, in press, p. 21). In other words, there is not going to be a designated savior or a manualized method that will rescue us out of this predicament, only moral sensibility and the development of practical wisdom can pave the way. We are all but mere mortals, ordinary people who have the capacity to develop, shape and make substantive changes in the policies, procedures, and ethics codes within our discipline. It is our responsibility to maintain a questioning stance about our rules and policies if we are to avoid being tyrannized by our own body of knowledge (Anderson, 1997, 2013). Improving our ability to teach and practice dialogue is vital if American psychology is to become a discipline that is politically vibrant and a viable profession.

Relational, hermeneutic, and non-objectivist approaches uphold the therapeutic endeavor as a form of moral discourse. Helping clinicians to be more reflective about ethics, professional standards, and the politics that form and envelope them can move us toward a socio-political,

historical mind-set and methods of inquiry that invite evaluation on its own terms. Ethics education that teaches clinicians how to be able to make their own best assessment based on what they perceive, rather than interpreting the Ethics Code as an exhaustive set of rules regarding what to do under various situations, is important if psychologists are to examine how they might more boldly and compassionately approach the various ethical dilemmas that they will inevitably encounter in their professional lives.

### **Limitations of the Study**

A key limitation to this study was the small number of participants who took part in it. Many of my colleagues and other psychologists expressed interest in this study early on, but only four responded when I reached out, and only two of those were willing to participate in the interview process. Some of the explanations for not participating had to do with the fear of being perceived as having acted unethically, not wanting to comment on their concerns with the APA, and not wanting to give the time participation required. More interviews might have resulted in more diverse pool of data that would have added depth and nuance to the results. Another limitation involved my own capacity and skill. I started this project as a novice in how to conduct hermeneutic interviews and case studies. I struggled to refine my interview style and was afflicted with a lack of confidence in my ability to ask the kinds of questions that would have helped me better understand some of the participants' responses. Although the data generated was rich and helpful, I suspect there may have been more to draw from if I had been able to ask more probing follow up questions after certain responses. Initially I did not realize how difficult and angst-provoking it was for the participants to speak freely and openly about their fears and concerns regarding their clinical experiences with multiple relationships. For instance, both participants noted repeatedly during the interviews that they were worried about protecting the

confidentiality of their patient and/or they were unsure if they could recollect enough details about their cases to be helpful. Furthermore, because the topic was difficult to discuss and think about, there were reactions and defenses that were challenging for me to perceive and negotiate during the in-person interviews.

## **Conclusion**

Several key themes were uncovered in this study through an interpretive analysis of the interactions during and transcripts of interviews conducted with the two participants about their clinical experiences regarding ethical questions related to Standard 3.05 of the APA Ethics Code. The data collected revealed a plethora of personal and professional concerns and dilemmas that the participants faced in trying to uphold the values and expectations implied as the norm for the field of professional psychology. The participants described situations and experiences that seemed to be intended to prevent them for critical thinking or debate regarding the constraints of the Ethics Code in relation to their lived experiences. While their stories highlighted the problems and dilemmas created by the unrealistic expectations of blind compliance with policy and procedure, they also highlighted the need for more dialogue and critical exploration. This dissertation is a step in that direction and I hope it is helpful to others who are interested in the pursuit of such efforts.

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Appendix A  
Foregrounding

### **Foregrounding: The Situated Interpreter**

Human beings are cultural beings. Our interpretations of what is meaningful or valued occur within a particular framework (Taylor, 1988). Although the social practices and the traditions that constitute the everyday activities help us make sense of the cultural terrain, it is also inevitable that we will also be constrained by those interpretations in our everyday activities. (Gadamer, 1989). Therefore, all researchers will come to a particular text with a finite comprehension of what they see there. What the person will see is dependent on a shared understanding of what is considered to be relevant and because meaning is determined by the culture and the era in which it exists (Plager, 1994).

**Culture.** In the role of the researcher, I am situated within a particular culture whose traditions and practices are framed by past and present events, and the situations of this historical era. That I wished to explore and better understand this topic—multiple relationships and ethics in present-day American society—is one example of this. The taken-for-granted focus on relationships in general and the inescapable multiplicity of roles that exist in our relationships is another example. The moral values of American society not only framed my interpretations of the text, but also influenced my interpretations of power, control, domination, and oppression and how these forces are played out in the cultural political landscape of everyday lives and relationships. The focus of this research project was to explore some of the taken-for-granted assumptions about multiple relationships and the APA Ethics Code.

Drawing from the lyrics of Journey (1991), I would situate myself as a small town Asian girl living in what felt like a lonely White world. The formation of my cultural and self-identity has necessitated that I contemplate the social constructs of race, class, gender, and power and the ways in which these constructs have profoundly influenced how I interpret the world into which

I was originally “thrown” (Heidegger, 1962)— a world I would describe as puzzling, ironic and confusing most of the time. In contemplating these influences, I realize now how much of this stems from living in a cultural frame that conceives of both race and family in a particular way. For example, I am from a culture in which the meaning of race, adoption, and family emerge from a Western ideological framework. This framework has generated a cultural definition in which the ideal or normal family household generally consists of a married heterosexual couple with biological children.

Debates about multiculturalism continue to explore the importance of bearing witness and how under problematized these issues seem to be in mainstream professional psychology and practice. To bear witness is to recognize the oppressed and acknowledge the act of oppression by the oppressor (Oliver, 2004). Witnessing in this way draws attention to the afflictions that are embodied by the oppressed. Duran (2006) argued if healing is to occur at the societal and individual level, it is necessary to expose the systemic mechanisms of oppression. At the same time, Takaki (1993) suggested that even this paradigm of understanding presents limitations that seem to perpetuate and reflect the history of the American experience. The social, political and power arrangements position the human experience in ways that split us off from our experience.

As someone who is part of a family constellation that exists outside of this norm, my life story is filled with encounters where people often assumed based on my race, that I was not a member of my own family. Being perceived as a foreigner in my own country was perplexing, at times very painful and sometimes I would feel angry. In part, it was because this was an assumption that directly conflicted with my sense of self. The status of being minoritized sometimes seemed to contradict with my middle-class status, which was confusing and a source

of strife. On the one hand, as a woman of color minoritized by the dominant class, I regularly experienced the oppressive force of racism and sexism. On the other hand, as a member of the upper-middle class I have been afforded a privileged status within social and institutional systems that have led to opportunities others who are minoritized generally do not have.

The construction of racial meanings and racial awareness shape the ways in which we understand ourselves and our interactions with others. They inform the activities of our daily lives as individuals, families, and members of a collective society. They are the social, economic, and political ideological structures that organize a particular formation of a racial order—covertly and overtly—enforce particular interpretations, meanings, and practices that manifest in our relationships with each other and ourselves. The attraction of thinking about race as fundamentally natural and therefore fixed and objective is not only misleading, but also carries with it profound consequences in relation to the formation and understanding of our experiences and/or lack of experiences which compose identity. The cost of oppression inflicted upon those who have been minoritized who have withstood and continue to endure as a result of being categorized as the Other by the dominant ideology is both devastating and inexcusable. It is crucial to realize that social meanings can be changed through political struggle in order to effectively fight against this injustice.

The concept of self-identity as a phenomenon unique to the human species, is the conduit through which we make sense of our world and who we are in relation to others. Its essence is also variable, elusive, and complicated. Formed by our social and cultural world, it is constantly evolving in ways that often transpire outside our conscious awareness. Our identities are socially constructed, strikingly fragile, yet robustly hold the capacity to take on many forms called forth by the variety of contexts and circumstances that structure our lives. However, in a culture that

has assumed a way of knowing necessitated by a need for certainty, identity formation has been emphasized as a singular, concrete, self-contained occurrence regardless of context. This has resulted in an over simplification of something inherently multifaceted, causing more confusion and alienation.

While the formation of my own identity has been riddled with deep ache and conflict, I have encountered moments of truth and met with disillusionment throughout my lived experience. Still, as difficult as it is to achieve, the ability to hold your heart open during such times allowed for an understanding that brought to light and knitted together how these moments and experiences can serve to form a more complete understanding of who I am and the way others perceive and interact with me. The journey has been arduous, puzzling, and unclear at times, but truly worthwhile. Along the way, I have learned the value of living authentically and the importance of remembering what I value and the reasons I have chosen those values. I have come to understand that part of what makes us human is the simultaneous embodiment of what is perceived as the good and the bad in ourselves and others. Prejudice, bias, racism, and the rest of the isms are dark and hurtful, but we are malleable and creative beings capable of broadening our understandings and changing our minds or perspectives in ways that initiate substantive change. Humanity is muddled with paradox and mystery, realities that seem to have no place in the current scientific paradigm. But it is the paradox and mystery that I have come to believe in and are what makes life so intriguing and exquisite.

The exploration of these concepts seemed especially salient to the research I conducted, because it helped to make sense of a lived experience that was inherently oppressive while at the same time also became a catalyst for shifts in comprehension of these notions. I chose to use the language that is customary in U.S. society and a Western ideological worldview, first and

foremost because I am constituted by this framework. However, I also came to the texts with an awareness that there are many cultural conceptualizations that also frame and provide meaningful interpretations of the notions I explored. I also recognize, I have and did use terms without a complete awareness of how terms and labels such as: sub-culture, minority or other (etc.) are deeply pejorative, derogatory. It escaped my notice how in the effort to be respectful in the way that I described the participants and my own experiences, could be simultaneously perpetuating the oppressive mechanism of supremacy — an attitude of supremacy that is deeply rooted in the American cultural and social life. It was regrettable that because of the scope of this project I could not expand on this problem or address more fully the subtle ways that this oppressive dynamic enters the room not only of my lived experience, but also ways in which language can be used overtly and covertly to reinforce oppressive and dehumanizing mechanisms: mechanisms that are embedded in the structures of our social institutions including academia.

**Identity.** I began my life in Seoul, South Korea and was adopted and brought to live in the U.S. at the age of nine days. I was afforded the privilege of having two sets of parents in this lifetime. My Korean parents who brought me into this world, but given the historical and cultural constraints of their era could not afford to provide the kind of life they wanted me to have. They had been college professors and wanted their child to have the opportunity to attend college and have a better life than what they felt they could provide. That's where my American, White, traditionally conservative parents—who raised me with love, privilege, beauty and a dash of anguish—entered the picture. Is it not strange how one can feel a sense of complete helplessness about the circumstances of one's life?

I grew up on a small working farm and lived a rural life. My mother wanted as many animals of varying species as possible. Horses, goats, cats, dogs, turkeys, chickens, pigs, cows, reptiles, and exotic birds were my everyday lived experience. So were pre-dawn chores, scooping poop, death and birth. What a journey. My parents have come a long way in the practices and lessons learned from farm life, but they had no idea what they were doing in the beginning. My father was a rural family doctor, which meant it was not uncommon for his patients to come to our home to talk to the “doc,” share vegetables from their gardens, fish that they had caught, and stories of the day. Thank you cards and notes, phone calls (early in the day or after dark), and lots of practical advice about farming and life were just how things were. Multiple relationships were part of my everyday lived experience.

You might say that being a family physician “addressed” my dad. He described becoming a doctor, a healer of those who were in need, as something that he felt called to. Born in the Midwest to a single and financially strapped mom, he had become accustomed to taking care of himself and being self-sufficient pretty early on in his life. He met my mother during high school and they married when he turned twenty-one. Dearest mom grew up in Oregon and was raised in a traditional conservative family. Her mother was from the Midwest and her father was a Korean War veteran. She grew up in a classically 1950’s style home on the outside and the inside.

My parents were young, married, and poor. My dad put himself through medical school on the good old G.I. Bill. He had dodged the Vietnam bullet, but carried out his duties as a captain in the Army in South Korea. My mother who had not lived away from home or her family until she married my dad, was very brave and travelled with my two-year old brother to join my dad in Korea. When we reminisce about her impressions of Korea and the culture there, she uses her face to express the smells, tastes, sights and sounds of this foreign land. Kim-shee

always makes its way into the narrative account and the way that mothers carried their children on the front of their bodies and not in strollers. She always recalls how beautiful and wonderful it was to be around the Korean people. Culture shock. It can feel exhilarating and terrifying simultaneously. Upon their return to the U.S., my sister was born, and my dad established his family practice in a small town south of Olympia, WA. I grew up in this small town where he is still practicing.

**Multiple Relationships.** Prior to my doctoral pursuit, I had lived some of my life time in what I will loosely describe as a spiritual commune (e.g., a nondenominational Christian mission where youth who were drawn to spiritual matters and possessed a curiosity of what a life lived in service to the poor and meek might mean). I had travelled and worked with nongovernmental organizations in regions of South East Asia, India, Nepal, Mexico, the Tenderloin in San Francisco, and poverty-stricken neighborhoods in Louisiana. The emphasis of my journeys was to better understand the human condition, to learn what help looked like for the groups of people and cultures, and to better understand and what mental health and well-being meant to the people in these cultures. I learned important lessons about who determines what is helpful when others are in need. It is not up to the giver to define what help means, it is the person receiving the help who decides what might be helpful for them. These experiences taught me crucial lessons that aided in the formation of my character and broadened and deepened my perspective about life. A philosophy and way of being that I've carried into my professional life.

When I made the decision to become a psychologist, I deliberately chose a small, clinical psychology program that supported a variety of theoretical orientations and emphasized social justice in its curriculum. It was an academic community in which multiple relationships were not uncommon and were sometimes unavoidable. The program faculty had multiple roles with the

students and administration. They were professors, supervisors, mentors, advisors, and in some cases, they were friends. Eager to learn as much I could, I also welcomed opportunities to collaborate in community organizations (e.g., the student government) and research projects with my professors—activities that involved multiple roles, varied agendas, and conflicting goals. Sometimes it was difficult for parties involved (e.g., faculty and students) to clarify expectations and boundaries. Having the capacity to say no or delineate those boundaries was not always easy or clear. Creating the space to talk about those struggles in those relationships with professors and colleagues was challenging, but achievable.

Contrary to my own comfort level with multiple relationships, I often encountered judgment and criticism from my peers and colleagues who may have been basing their disapproval on their own fears and discomfort. It was disheartening, difficult, and isolating. I understand that multiple relationships can lead to exploitation or harm—even the most well-intentioned teachers can lose their way and misuse their authority or power—however, it was surprising that I was rarely asked about my experience of those multiple relationships or how I perceived my place within them. Instead, assumptions about multiple relationships and ethical behavior were cultural projections that others attempted to impose upon my experience without understanding my experience. These projections were inaccurate, felt disrespectful, and dismissive of the possibility that there are multiple ways of being that exist simultaneously and are equally relevant.

## Appendix B

### Researcher Field Notes

## Marlene

### *Interviewer's Process Comment*

I noticed Marlene seemed to struggle when I asked her questions that she did not want to answer, or it seemed like she did not know what to say. This occurred mostly when questions had to do with unpacking what concepts were. For example, trying to avoid risk, boundaries and the APA. She would pause for long moments and sometimes she would share in way that seemed more open and other times she would respond, but in what felt like closed, maybe guarded and curt responses. I found it interesting that she seemed to interpret the function of the APA IT as a form of protection for the clinician and institutions from risk of legal penalties (e.g., lawsuits), but said nothing about protecting the client. When I asked her to share more about whether she had felt like the APA had effectively kept her safe from risk, she became irritated and edgy.

There was a moment during the interview when Marlene had shared about what it was like growing up in a small town.

Just to let know how it felt in my home town. I had a band director when I was in high school. He was really a nice guy and he was a trombonist and I was a trombonist and so he taught me really well. I got to go to all state ban and he came with me. So, we had become kind of friends in a sense, you know, so that when I was in my first year of graduate school I get this phone call. When I answered and the voice says: is this [Marlene's first name]? And anybody who called me [by my first name], I knew they were from my home town, and it turned out it was my band director. He and his wife were living in Cleveland and one of the first things he said to me: What's a good Christian girl like you doing in psychology."

I noticed that I felt offended by the comment her band director had said to her and had asked Marlene how she felt about that, and she said she just "laughed it off." I could also totally relate to those kinds of interactions and comments from my own experience growing up in a small town. They always felt a little weird and irritated me from time to time, but similar to Marlene's response, laughing those kinds of things off was how I survived. I felt like I could relate to her.

It did not occur to me to tell Marlene that I was Korean-American. Never crossed my mind in fact. But when we met for the first time in person, we did not explicitly talk about the fact that she was White and I was Asian. We just took it for granted that it would not impact color our interactions or trigger instinctual reactions that sometimes play out when one person is White and the other is not. Retrospectively, race did play out in our interactions and we struggled to talk openly about multiculturalism when it came up during the interview. Her response to my questions about working with clients who were from a different culture seemed scripted and reminded me of what I often hear from other clinicians and in mainstream psychology. I felt a little bit sad and disappointed when I heard it. But I also could sympathize with how uncomfortable it might have been for her to speak freely about race, culture and how those play out in therapy with someone who was Asian. Sensing her discomfort and feeling like she did not want to go there, I did what I learned to do in my family when stuff like this would enter the

space. I felt irritated, sad etc. One way I survived as a child in my own family (the internalization of oppression) was to accommodate their discomfort by avoiding addressing remarks that felt racist, prejudiced or offensive. It was strange, confusing and terrifying at times to feel like the Other even in my own family. Many of Marlene's reactions and defenses (e.g., what felt like patronizing comments directed at me, disguised superiority, over politeness, avoidance and deflection) were like the defenses and reactions my family enact. It felt familiar. Marlene felt familiar to me in that sense, and I related to her like I do with my family.

Our communications prior to our first phone call were confusing, but also felt strangely familiar. Her style of writing and tone felt formal and polite, but difficult to tell whether she wanted to participate because she was interested in talking about the topic, or if she felt obligated to help students with their research projects. I noticed that I felt cautious and unsure of how to respond to Marlene's correspondences with me on many occasions. When we finally spoke for the first time on the phone, I immediately felt at ease when I heard her voice. She reminded of my grandmother, who is White and from the Midwest. Her responses to the pre-interview questions also gave me a sense that she saw the world from a White, Western, individualist point of view. Her sense of commitment and duty (e.g., I feel it is my obligation to help students with research) reminded me of my own father, a family "doc" who it seems is always helping others whether it's his patients, students, neighbors and even strangers. There's a kind of generosity and strength that seems less and less a daily occurrence in my generation.

I noticed that when Marlene shared about her graduate training experience and some of her more difficult interactions with colleagues, she would often pause in silence before she talked about them—she seemed vulnerable and the emotion in her voice was apparent. It was as if she was remembering how hurtful those experiences had been. Isolation and survival came to mind when I heard those parts of her story, history. Sometimes, she would pause and disclose what felt like a vulnerable moment in her lived experience, but then she would stop and say something to the effect of, "I don't remember very well." I couldn't tell if she was trying to express that she did not want to talk about it with me, even though it kind of felt that way. There were moments when she would recall her cases in remarkable detail, and then when it came to questions about the APA, or that were more philosophically minded, I felt like she would get annoyed with me. She responded, but they were short answers and in some cases, she would avoid the question all together.

Graduating from an APA accredited program seemed important to her, even though what she experienced in that program was oppressive. In a way, I thought she was telling me, that she had endured a lot of crap in her program, but because it was APA accredited that was something to be proud of. I noticed that she seemed to circle back to this experience when she was reflecting about her self-doubt and lack of confidence in her clinical decisions.

I noticed that when questions about how the participant modified the Standard to fit with their values and practice the idea of having to discuss in any detail the ways that she had changed her practice seemed to cause anxiety. She would create distance by avoiding, deflecting the question or would respond in what felt like patronizing tone to get me to react and back off. Sometimes I also noticed I felt a little demeaned, as if I had asked an inappropriate question. Other times, I noticed her anxiety and wanted to help her to feel more at ease. I would offer

encouragement and note that I did not see that what she had done (in her clinical cases) was inappropriate or wrong. In fact, it seemed to me, that she cared a great deal about her patients and I thought that was cool. She would engage again, but then she would sort of snap back into a defensive posture with me and modify her previous responses. She seemed nervous about what she had said and circled back around those answers with more guarded responses. I sensed that she felt vulnerable in that moment and I wondered if she had been worried about what she had shared and the choices that she made (e.g., not communicating with her client after that encounter). I wondered if she feared that I would criticize her.

I noticed I felt a strong pull to want to help her feel more comfortable and at ease most of the time. Like I needed to take care of her and I questioned if I was being polite enough and appropriate. Growing up, when I would ask questions or be more direct in sharing my opinions and thoughts about something, when people did not feel comfortable with what I was saying, they would project their discomfort onto me by commenting that I was being inappropriate, angry, disrespectful and often I felt as though they would try to put me in my place so to speak. For a long time, I believed that there was something wrong with me and could not understand that it was their discomfort. As I matured and started to understand a bit more what that was, I felt less like I was wrong, and could see that it was just what happens when people feel uncomfortable. In my life, that was usually the case with White people. I wondered if this was what was happening between myself and Marlene. We were triggered by those old ghosts and patterns of relating and reacted in response, even if we could understand some of it intellectually. Although Marlene was more difficult for me to engage with during this process, her courage, strength and sincere efforts to practice in ways that were meaningful and respectful of her patients and others did not escape my notice.

### **Stevie**

#### *Interviewer's Process Comment*

Stevie was less difficult for me in the sense that she reminded me of my Other-ness. We had both experienced what sounded like similar and often oppressive encounters and this seemed to be able to talk about them. I noticed that I felt connected to her in a way that I did not with Marlene. It was easier for me to relate to and with her because she felt more familiar to my lived experience in many ways. There were many similarities between Stevie's experience and my own. For example, we both grew up in families that did not appreciate or understand the experience of being marginalized and the ways in which the dominant class oppress those who are not like them. The taken for granted assumptions of individualism that White culture privileges often conflicted with the collective traditions that informed Stevie's (and my own) values about others, and other ways of being. These aspects illuminated our discussion about the Code and the effect of trying to practice under it. One way that I survived that internalization of oppression in my own family was to compartmentalize and over-intellectualize the apparent contradictions and denials by others of my own experience. Or I would accommodate their supremacy and the inferiority it sought to impose upon me. She reminded me of what it is like to be the Other—minoritized and I felt drawn to her because she articulated that understanding in her dialogue with me during the interview.

Stevie's responses to the pre-interview questions suggested that she had a more collectivist frame of reference and seemed less traditional in her thinking, actions and overall approach to life. She loved horses and animals, spoke in metaphors, had conditioned herself to follow linear time-tables and schedules, but did not interpret the passage of time that way. She was philosophically minded and committed to anti-oppression work. We shared a similar world view and concerns about the profession. Stevie had this buddha calmness about her, this was reflected in her responses and style of giving feedback. For example, if she was noticing that she was anxious, uncomfortable or did not want to answer the questions I asked, she was transparent about her emotional states and would talk about them with me when she noticed them. She seemed direct and spoke to others directly. I appreciated that about her.

I found it interesting that she had her PhD for about 20 years before she decided to get licensed (she became a licensed psychologist about six years ago). She told me that she had been happy practicing under her LMHC, she didn't believe becoming licensed at the doctoral level would change her clinical authority and competence. At the same time, she also was noticing that she could offer more opportunities to students, interns, and supervises if she had her license, which seemed important to her—being of service to others in the best way she could. So, she “bit the bullet” and took the exam.

During the interview, I noticed that when questions about how she addressed multiple relationships in her practice came up there was a tendency to revert to a highly intellectual stance, and even times when she would talk in more procedural terms. She was super vigilant about protecting her own values onto her clients' and wanted to preserve their privacy. This contributed to her to worry about how she could address my questions about multiple relationships in a way that would satisfy this concern. Sometimes to the point of obsession. We both commented on our tendency to “fall into the rabbit hole” especially when our sense of moral responsibility was triggered. There were many times during the interview where I followed her down these rabbit holes and would let her go there even if it took us off point. I did not think to ask us to pause or even to notice out loud what was occurring. I accommodated.

I noticed that I was surprised by her hesitancy in sharing about a clinical case in detail because when we had discussed the focus of the study initially, it seemed clear to both that I would be asking her to talk specific cases and she seemed fine with that request. Retrospectively, I wonder if she held this concern all a long and perhaps our pattern of needing to reschedule the interview was one way we both avoided this discomfort or fear? I noticed that she struggled to find the middle ground. When she would use more procedural language to describe her experience, I felt as was as if there was distance; or maybe she was trying to keep her anxiety at a distance? I was also unsure of how to help her to talk about her clinical cases specifically, and I reacted by avoiding asking her to be more specific.

I remember feeling shocked when she told me she had deliberately moved to Wyoming to go to graduate school. We talked about what it was like for her there. She said, “I know, it's crazy, but they had the kind of program I was looking for.” She shared about some of her own experiences of being targeted and victimized, which I suspected were at times violent because of her way of life and lifestyle. She said on the surface people were polite, but there was a tacit agreement that people like her should blend in with the herd, even if the herd knew that she was

different. If you blended in, she noted that they wouldn't bother you or cause you harm. However, the homophobia there was off the charts and she had known others in that community who had been beaten, tortured and even killed for not being heterosexual and conservative.

Stevie and I tended to be more informal and casual in our approach to most matters, and this one felt different. It was as if we had to talk to each other in a way that we were not accustomed to doing. We both noticed this and laughed about the awkwardness of trying to be in our "participant/researcher" roles. It took me a bit to feel comfortable and at ease in my role as the "researcher" with Stevie in part, because we were in different roles.

It was difficult for me to notice Stevie's anxiety (which came out but in different ways than Marlene's). She was really adept and presenting outwardly with a calm and collected demeanor. She did not seem emotionally reactive, but as the interview progressed I noticed she worried a lot and wondered how much at times because she concealed her worry fairly well. When she talked about these issues during the interview, because she was able to conceal her anxiety, I noticed that I didn't really pay attention to the intensity of her experience until I started to analyze the data.

Appendix C  
Recruitment Letter

## Recruitment Letter and/or Email

Tammera Cooke  
PsyD Doctoral Student at Antioch University Seattle  
Email: [tcooke@antioch.edu](mailto:tcooke@antioch.edu); Phone: [REDACTED]

Dear \_\_\_\_\_,

My name is Tammera Cooke and I am currently involved in the dissertation phase of the PsyD program at Antioch University Seattle, Seattle Washington. I would like psychotherapists such as yourself to participate in my research project and I am writing to you as part of my recruitment effort INSERT NAME HERE thought you might be interested and referred me to you. My particular area of interest is exploring the attitudes, feelings, expectations, assumptions and associations toward Standard 3.05. Multiple Relationships in the APA Ethics Code (2002) and how these have influenced or informed how the clinician practiced in a particular clinical case. The purpose of this research project is aimed at exploring Standard 3.05 of the APA's Ethics Code which addresses multiple relationships—its meaning and controversies—in order to better understand the cultural influences reflected in and the political consequences that emanate from the Ethics Code.

For geographical convenience, I am recruiting participants who live in the Western Washington. I will be conducting audio-recorded interviews that are approximately 2 hours in length, with an additional interview designed to clarify any confusing statements and/or ask additional questions. The interview(s) will be scheduled at a location and time that is convenient for the psychotherapist.

I am looking for therapists who identify as male or female or other and are between 20 to 60+ years old. They must be: 1) practicing in the field of psychology; 2) licensed at the doctoral level; 3) actively practicing in a clinical setting 4) have had or has experience working with patients who are from culture different from their own; 5) working from patients from a rural/remote setting and; 6) willing to describe a clinical case that involved a multiple relationship. Participation is strictly voluntary, and the interview would be confidential.

Participants would be asked to answer a few general questions in order to determine eligibility for this study and complete a brief Participant Demographic Form at the time of the interview. If you are interested and available to participate in my research please feel free to contact me by phone or email (see information listed above). Thank you for your consideration. Sincerely,

Tammera Cooke, MA, PsyD Candidate, Antioch University Seattle

## Appendix D

### Pre-screen Questions

### Pre-Screen Questions

I would like to ask you some questions to determine if you meet the criteria to participate in the study. These include:

1. Are you a licensed psychologist?
  - a. How many years?
2. Are you currently or actively seeing patients
3. Are you working with patients from a culture different than your own?
4. Do you see patients from a rural/remote setting?
5. Are you an active member of APA?
  - a. What is your level of participation?
6. How would you describe your commitment to adhering to the Ethics Code?
  - a. How committed are you to following the code?
7. Are you willing to discuss your experience or a case in handling multiple relationships? (it can be another type of clinical relationships? e.g., supervisor/supervisee etc.; not just traditional therapy).
8. How do you define your cultural identity?

*\*Follow up questions:*

1. Do you identify with any religious affiliations/practices?
2. How do you define gender?

Appendix E  
Informed Consent Form

## INFORMED CONSENT

I \_\_\_\_\_, hereby willingly consent to participate in a research project on therapists' experiences with multiple relationships to be conducted by Tamera Cooke, MA, PsyD Candidate, under the direction of Phillip Cushman, PhD, Dissertation Chair and faculty member in the PsyD program in the School of Applied Psychology, Counseling, and Family Therapy (SAPCFT) at Antioch University Seattle (AUS) and committee members MiNa Chung, PhD, and Mark Russell, PhD, ABPP.

I understand the procedures as follows:

I will be participating in a 2-hour audio recorded interview that will occur in a private, confidential setting to be arranged by myself and the researcher. I will be talking about my clinical work and will be asked to discuss my attitude, feelings, expectations, reactions, assumptions and associations toward Standard 3.05 in the APA Ethics Code (2002) and how these have influenced/informed how I have practiced in a particular case. I will complete a brief Participant Demographic Form.

- 1) My participation in this study will be confidential. I will be asked to select a pseudonym (false name) for the use throughout this study and assigned a code number that will be used on all of the data. All interview information will be securely stored in a locked file, separate from the consent form and other identifying information. Personal information about me will not be shared with anyone other than the dissertation committee (and then only if necessary).
- 2) I understand that only the researcher and her committee will have access to the data. However, in the event that I disclose child, dependent adult, or elder abuse, or a danger to self or others, the researcher is legally bound to report the information to the appropriate authorities.
- 3) I am aware that there is little potential risk for emotional or physical discomfort involved in participating in this study. However, should this happen, I will be able to contact the researcher who will make provisions for me to receive further consultation with a licensed clinician.
- 4) I understand that I may decline to answer certain questions or withdraw from this study at any time without penalty or prejudice and ask to have all the material I have already provided in the study destroyed. I also understand that this study may be published and that my identity will be kept confidential. Pseudonyms may be used but no names or individual identifying information will be used in any oral or written materials. Transcripts from these audio recordings aside from the excerpts being used in the dissertation results and discussion sections, will be destroyed by shredding. The audio recording will be destroyed at the completion of the data analysis.
- 5) I understand that the researcher, Tamera Cooke, will be available to me by telephone [REDACTED] [REDACTED] to answer any questions or to address any comments or concerns that I have about this study. I understand that if I experience a problem or wish to contact someone other than the researcher for further information about the study, I may contact the Chair of the AUS Institutional Review Board [Mrussell@antioch.edu](mailto:Mrussell@antioch.edu), The Human Participants Committee, and/or the Chair of the researchers dissertation committee, Phillip Cushman; [pcushman@antioch.edu](mailto:pcushman@antioch.edu).

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- 6) I have received a copy of this consent form to keep, I understand that I have the option to receive feedback from the results of this study. Send me a summary of the results at the address below.  
 Yes\_\_\_\_\_No\_\_\_\_\_

Your signature below indicates that:

- You understand the purpose of the study and the nature of your participation
- You have had an opportunity to ask questions and receive answers
- You agree to participate in this research

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

Please indicate preferred method of contact: Phone\_\_\_\_ Email\_\_\_\_

### **Researcher's Verification of Explanation**

I, Tammera Cooke certify that I have carefully explained the purpose and nature of this research to \_\_\_\_\_. S/he has had the opportunity to discuss it with me in detail and I have adequately answered his or her questions. S/he has agreed to participate in this dissertation project.

Researcher Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: [REDACTED]

Email: tcooke@antioch.edu

Appendix F  
Interview Schedule

## **Interview Introduction**

Thank you very much for taking the time to assist me with my research. I hope that this will be a useful dialogue for you also.

As mentioned when we spoke before, the purpose of this interview is to facilitate an open dialogue about the therapist's attitudes, feelings, expectations, reactions, assumptions and associations toward Standard 3.05, Multiple Relationships in the APA's Ethic Code and how these have influenced/informed how the clinician practiced in a particular case. I am especially interested in what you have to say about a clinical case that involved a multiple relationship. I will be asking you to share your feelings, beliefs, attitudes, and concerns. Please be assured that there are no right or wrong answers.

You have already signed the Informed Consent Statement advising you of the confidential nature of all the information that you share today, and outlines how that information will be protected. You also have the right not to answer any question or to end your participation in this study. If you decide to end your participation, I will destroy all data already collected. If you wish, I will send you a summary of the completed study when I am finished. Do you have any questions before we proceed?

## **Interview Schedule**

### **Introduction Script**

Before I begin, I want to thank you for your willingness to share your personal values and reactions. I recognize that we will be discussing your clinical work which can be difficult, and I appreciate your generosity.

As you know, this interview will be semi-structured so as to allow participants to fully discuss whatever they feel is relevant or meaningful. I will pose some guiding questions as a method of facilitating an open dialogue about your attitude, feelings, expectations, reactions, assumptions and associations toward Standard 3.05 in the APA Ethics Code (2002) and how these have influenced/informed how you practiced in a particular case.

Each participant will be asked the following questions:

### **Background**

1. Tell me about how you came to be a therapist?
  - a. Where did you grow up?
  - b. Where did you go to school?
  - c. Was education important to you?

- d. Was education an important aspect in your family?

## Guiding Questions

### General Questions

1. Are you currently a member of the APA? If yes, why? If no, why not?
2. In your clinical practice have you worked with patients whose culture (this includes but is not limited to: ethnicity, race, class, religion etc.) is different than your own?
3. Have you worked with patients who live in a rural and/or remote area?
4. What is your understanding of ethics?
5. What is your understanding of multiple relationships?
6. Can you describe some of the problems that you have faced when working with patients whose traditions and/or moral understandings differed from you own?

Have you worked with a patient(s) whose values about multiple relationships differed from your own, what were some of the reactions you encountered?

7. Based upon the APA's definition of multiple relationships in the Ethics Code, can you describe a time where you found yourself conflicted about whether to be involved in a multiple relationship?
8. What happened?
9. What values did you rely upon to understand the choices that you made?
7. What were the benefits and risks of either choosing to become involved or not involved in the multiple relationship?

Is there anything else you would like to add?

## Appendix G

## Participant Demographics Form

**Participant Demographics Form**

Name: \_\_\_\_\_

Contact Information: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Racial / Ethnic Identity: \_\_\_\_\_

What Gender do you identify with (circle one):      Female      Male      Other

Current Age Range (circle one):      20-29    30-39    40-49    50-59    60+

Education Level (circle one):    Doctoral      Post

Current Occupation: \_\_\_\_\_

Location of practice: \_\_\_\_\_

Theoretical Orientation (if relevant): \_\_\_\_\_

Years of Professional Experience: \_\_\_\_\_