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## **Advanced Ethics for Mental Health Professionals Course # AL16**

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**3 Credits**

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### **Course Overview**

Advanced Ethics for Mental Health Professionals begins with a brief review of ethical theory and principles. Next, ethics of care, an "advanced" ethical theory is explored as it relates to the work of mental health professionals. The course focuses on two major topic areas: ethical issues involving mental health care for children and adolescents, and ethical issues involved in the spiritual dimension of care. Case examples deal with these two topic areas and other general ethical dilemmas encountered by mental health professionals.

### **Syllabus**

Course Overview and Learning Objectives  
Exercise, Introduction, and Review  
Review of Basic Ethics  
Principlism  
Ethics of Care  
Ethics in Caring for Children and Adolescents  
Ethical Issues Concerning Spirituality in Mental Health  
A Closer Look at Religion and Spirituality  
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### **Learning Objectives**

Upon completion of this course, learners should be able to:

- identify an ethical dilemma.
- identify and describe the four principles used in ethical decision-making
- articulate the meaning and relevance of ethics of care for mental health professionals
- identify ethical issues specific to caring for children and adolescents, and describe ethical choices for mental health professionals
- recognize spiritual issues as they arise, and discern appropriate ethical boundaries for providing spiritual care, as well as appropriate spiritual interventions or referrals.

### **Lesson: Exercise, Introduction, and Review**

#### **Topic: Exercise**

Let's begin with an exercise in ethical thinking which helps us begin to think about ethical dilemmas.

Consider each of the following situations in terms of your opinion about the strength of the ethical justification for the action described:

**Amy Adams** has just paid \$1,000 non-refundable deposit on a long-dreamed-of trip around the world when she discovers she is pregnant. If she continues the pregnancy, she will lose out on the

trip and the deposit. Therefore, she is morally justified in having an abortion.

**Brian Braxton** is driving home from his girlfriend's house at 2 AM when he approaches a red light. Visibility is good so he can see that no vehicles are approaching from the cross-street in either direction. Thus he would be morally justified in running the red light.

**Cecily Collins** is an advertising executive who finds that a line or two of cocaine makes her unusually creative and productive. She is careful to limit her use to times when it is extremely important to her job to liberate these abilities; and she never uses this or any other drug recreationally. Therefore she is morally justified in using cocaine under these conditions.

**David Devon's** family has not had anything to eat for two days and he has no money to buy food since he has been unable to find work or qualify for welfare. There are no resources in his town to provide emergency help. Therefore, he would be morally justified in stealing food from a supermarket.

**Emily East** has worked out a foolproof scheme for embezzling money from clients at the bank where she works. She is virtually certain that she will never be caught, and no one is really harmed since she takes only a small amount of money from each account. Therefore she is morally justified in carrying out her scheme.

**Frank Friendly, MD,** is asked by the wife of a patient who has just died what his final words were. In fact, what he said was to tell his mistress that he loved her and only her. Therefore a lie to the wife would be a morally justified response.

**Gabrielle Green** has a pre-viable pregnancy which is developing in one of her fallopian tubes (ectopic pregnancy). If an operation is not performed to remove the fetus or remove the tube containing the fetus, she may die from a spontaneous tubal abortion or rupture. The operation will result in the death of the fetus, but it is extremely unlikely the fetus could survive in any event. Therefore she is morally justified in having the surgery.

**Howard Hale** knows that his brother-in-law's construction company is in violation of the building codes. But it is only a minor "technical" violation, and the regulation it violates is one that Howard doesn't think has any point anyway. Howard has the authority to approve the plans, so he would be morally justified in doing so, and saving his brother-in-law the cost of having a modified design drawn up.

**Irene Ice's** boss will yell at her if she answers truthfully the question just asked, but she thinks of a lie that will avoid this result and her boss would never be the wiser. Therefore she is morally justified in responding with the lie.

**Jonathan Jones** finds that the nausea caused by the chemotherapy he is taking can be relieved markedly if he smokes a joint of marijuana, which is illegal in his state. Therefore, he is morally justified in using an illegal drug under these circumstances.

(This exercise was created by Dr. Glenn Graber of the Center for Applied Ethics at the University of Tennessee at Knoxville. Used by permission.)

## **Lesson: Exercise, Introduction, and Review**

### **Topic: Comments**

Many people find these situations don't require a lot of prolonged consideration. People often find they can pretty easily and quickly respond with what they believe to be the morally correct course of action. At the same time, we may find that among a group of people, responses differ substantially. We bring our values, our beliefs, our experience in moral decision making to this simple exercise. Often we have a quick response which comes from our intuition, our "gut" telling

us what we believe to be right and wrong. Remember, in these scenarios there are no “right” or “wrong” answers.

Let’s look more closely at our responses, and consider the ethical dilemmas posed by the situations.

## **Lesson: Exercise, Introduction, and Review**

### **Topic: Responses**

#### Ethical Issue: Abortion

Consider your opinion for **Amy**. Very few people consider an abortion under these circumstances to be acceptable. Now look at how you responded to **Gabrielle’s** situation. Often people believe that Amy should not have a procedure which would end her pregnancy because her reason seems somewhat frivolous and selfish. But most people believe that it is justified for Gabrielle because of the high probability of fetal demise and the risk to the mother. Many people find that their views about abortion lead to varying responses in these two situations because they take into consideration the various factors involved. Most people do not give “consistent” responses to Amy and Gabrielle, though of course there are people who are adamantly opposed to terminating pregnancy under any circumstances.

#### Ethical Issue: Keeping rules

**Brian’s** running a red light may not seem like a serious moral issue. But the real moral question concerns whether or not to obey the law. While he may have made a perfectly safe choice in running the light, the fact remains that in doing so he breaks the law. So the ethical question centers around whether it is ever right to break a law. Look at how you responded to Howard’s dilemma. He too is considering breaking a law, but we may find that we feel differently about these two situations. Brian’s law-breaking puts no one other than himself at risk in terms of safety (provided there are no other vehicles around); while **Howard’s** decision may lead to risk for others. Many people find their responses differ concerning keeping rules.

#### Ethical Issue: Drugs

Consider **Cecily’s** use of cocaine. While some folks believe it is acceptable, many people find her practice worrisome. Not only is she breaking the law, she may be risking an escalation of her drug use that could create enormous problems. Compare your response to what you think about Jonathan’s use of marijuana to help with a medical condition. Many people who would believe that Cecily’s use of cocaine is not morally justified believe that **Jonathan’s** use of marijuana is acceptable, and strongly agree that it is justified. Another factor affecting how we respond to moral issues about drug use involves our views about keeping or breaking laws.

#### Ethical Issue: Stealing

Consider **David Devon’s** family. Many people respond by thinking up creative ways to find food so that David won’t be forced to steal. However, to confront the ethical question of stealing, we need to assume that there is no other way to feed his family but stealing from the store. Very few people would tell David he should not steal to feed his family. We might think differently if David were stealing just for himself. Now look at your response to **Emily’s** theft at the bank. Though she is stealing small amounts, most people believe her action to be wrong. Even if we complicate the story by suggesting she is stealing to provide for her aged and ill parent, few people would find her theft justifiable. So is stealing right or wrong? We see, once again, that the ethical issue isn’t always simple.

## Ethical Issue: Truth-telling

Compare your opinions for **Frank** and **Irene**. Frank's decision about answering the wife's question is important to the wife's well-being. He has the potential to do good, or do harm. He has the power to cause immense suffering for the wife, or the power to do good in the form of providing comfort if he is willing to tell a lie. Many people say that Frank is morally justified in lying to the patient's wife. Interestingly, when asked if they would want to be lied to in such a situation, people often say yes. On the other hand Irene's lie feels very different. If she is justified in lying, it is to prevent harm to herself; it is a selfish lie. Whereas Frank's lie may be to prevent harm to another person. There may not always be simple right and wrong ways to think about truth-telling.

Often people are surprised to find their responses inconsistent on each of these ethical issues. It is not that we are ethically inconsistent, or have no real moral values. Rather we find that we have the capacity to take into account circumstances, and how moral decisions can create good or prevent harm for those involved.

## **Lesson: Review of Basic Ethics**

### **Topic: Review of Ethical Theory and Principles**

Ethics concerns how we make moral decisions. What is right and what is wrong? Ethical dilemmas occur when we are faced with two (or more) choices, neither of which is really a good choice. If we find a problem, and the appropriate course of action is easy and obvious, we don't have an ethical dilemma. The scenarios in the exercise just completed illustrate why dilemmas are dilemmas. If there were black-and-white answers, it would not be a dilemma.

If we are sitting with a group of friends, and someone bursts into the room with a gun, we don't stop to ponder whether it is right or wrong for him to shoot someone. We know right away that it is wrong. This kind of situation is not an ethical dilemma.

An ethical dilemma occurs when we are forced to choose between two different actions, and choosing one action will mean that another good is sacrificed. For example, I promised my friend that I would go with her to her appointment with her oncologist. The morning of her appointment I get a call that my sister is seriously injured in an auto crash, and I need to go to the hospital to be with her. This dilemma may seem quite easy; of course I will go to my sister. But I may feel torn between these two obligations. Perhaps the friend is very dear to me, and she is facing a potentially life-threatening illness. And it is possible that my sister and I aren't really very close, and there are two other sisters who could go to the hospital. Various factors may influence the story. However when we analyze the situation we realize that going to the hospital means we are breaking a promise, and even if we know the friend will understand, the fact remains that I have made a choice between keeping a promise (a moral good) and being available to care for my sister (a moral good). I cannot do both; I must choose between competing moral claims.

One of the first questions we encounter in thinking about ethics concerns how we make the decision. Often we decide intuitively; if it is personal choice we can usually just think about the issue, weigh in our minds the goods and the potential harm each option may present, and we choose how to proceed. Much of the time we don't need to stop and think it through. We often "go with our gut" and make perfectly good choices.

However we may be considering a professional situation, or a situation in which others are involved. Our decision may affect our professional practice, or may touch other people. In making professional ethical decisions, we are accountable professionally, and legally at times. So we need to be more deliberate in how we think through the issues and make a decision.

Ethical theory helps us communicate with others. We can discuss issues with others, and hear their

perspectives using a common language. The great French philosopher Voltaire said, "If you wish to converse with me, define your terms."

## **Lesson: Review of Basic Ethics**

### **Topic: Theories**

There are four broad categories of ethical theory, with many variations.

#### 1. Consequentialist Theories (Teleological)

This type of ethical thinking concerns the result of an action, the consequences of a choice. Instead of looking at the proposed act itself, we consider what happens as a result of the act. Utilitarian theory is one type of consequentialism; it seeks the promotion of the most good for the most people.

An example of the usefulness of consequentialist theory might concern a client who is suicidal. You may be quite worried about him, and know that he will be very angry if you take steps toward a hospital commitment. However you know that he will be safe in the hospital even though he will be very upset with you. The dilemma involves honoring his wishes vs. concern for his safety. Your action to initiate commitment is based on what you believe to be the best action in the long run, as you examine the benefits and burdens of each choice.

#### 2. Rule-Based Ethics (Deontological)

This theory examines the action you are considering. It is based on the notion of duty and rules. Some actions are always right; some are always wrong. It is our duty to choose, and act on, the good. For example, I must always tell the truth even if doing so may lead to harm. Strict interpretations of deontology are difficult to carry out; we can all think of times that telling the truth (honoring the duty of always telling the truth) may not be the best choice. Think of Frank Friendly, in the exercise you did recently. Many people find his telling a lie justified as it will cause great harm to tell the truth.

#### 3. Agent-Focused Theories (Virtue Ethics, Feminist Ethics, Ethics of Care)

We will consider ethics of care in more depth later. These theories are among the broadly defined theories which focus on the person making the choice. Aristotle articulated a virtue ethics in ancient Greece, noting the importance of compassion, justice, and other virtues.

These types of theories tend to take into account a extensive range of concerns and issues in considering a dilemma. There is attention to relationships and context.

#### 4. Principlism

Some philosophers include the notion of working with principles as a kind of ethical theory. In medical ethics four basic principles serve well to provide a framework to think about balancing the concerns in an ethical dilemma. Briefly the four principles are:

### **Autonomy**

Respect for persons means that they be allowed to make their own decisions about issues which affect them. There must not be undue influence; the person must be capable of understanding the options; his or her choice must be respected; and there is protection for persons unable to make or communicate their own decisions. Respect for autonomy means that we do not interfere if a person genuinely has the capacity to decide.

## **Beneficence**

Promoting the welfare of another, acting in the best interest of another.

## **Nonmaleficence**

Do no harm, act in ways that avoid or prevent harm to another.

## **Justice**

Treating persons fairly and equally.

## **Lesson: Principlism**

### **Topic: Working to a Resolution**

Art Caplan, Director for the Center for Bioethics at the University of Pennsylvania teaches a simple process of asking five questions.

1. What are the facts?
2. What is the dilemma?
3. What principles apply?
4. What are the options for resolution?
5. What will it take to implement the decision?

Collecting information is the essential first step. We need to learn as much as possible about the situation, acknowledging that we will never know everything. Sometimes we have to go with the best we can learn.

But the presence or absence of all the pertinent facts can affect how we proceed. Suppose we are facing a decision involving a prolonged hospitalization for a client. An important fact would be to learn whether she has insurance coverage. If she does not, she may be left with an insurmountable bill which can cause great distress.

As we work through the steps, we are moving toward a resolution which seeks to balance potential benefits and burdens for each possible option. If one choice has a huge burden, and a minimum benefit, we need to keep looking. The best choice will have the maximum benefit with the minimum burden.

The bottom line is balancing goods and harms; benefits and burdens.

## **Lesson: Principlism**

### **Topic: Professional Codes**

It may be helpful to consult a professional Code of Ethics; all mental health professionals work under such codes which provide useful guidelines for ethical conduct and good practice. However few Codes of Ethics are specific and detailed. They may guide us in the right direction; but usually do not provide answers to particular situations.

One issue which comes up at times in ethical decision-making involves keeping the law. There are times we believe an ethical choice to be appropriate, but it involves an act which is illegal. For example we may believe that no one should ever have an abortion. However, with certain

restrictions, abortion is legal. On the other hand, we may believe that recreational use of marijuana is just fine for autonomous adults. But, unless prescribed for medical purposes, the use of marijuana is not legal in most jurisdictions.

The ethical and the legal are of particular interest to mental health professionals because most are bound by state laws (at times federal laws may apply to some situations) regarding certain issues. We are legally bound to honor confidentiality even in circumstances that we believe it may be therapeutically beneficial to share information. We are legally bound to report child abuse even in circumstances where we believe that it could cause more harm than good. We are legally bound to act if a client threatens harm to herself or another person.

We are held legally accountable as well as professionally accountable for many of our ethical choices. While we may believe that the best ethical choice will always be the best therapeutic choice; we may find that the best ethical choice may not, in some cases, be legal. So we are faced with another dimension of ethical decision making: is it ever ethical to break a law, for any reason?

Few of us are likely to be willing to deliberately break a law to promote what we believe to be the best interest of the client. We are bound, first and foremost, as ethical professionals, to keep the law. Only in rare circumstances might we even consider doing otherwise.

## **Lesson: Principalism**

### **Topic: Scenarios which pose Ethical Dilemmas - A**

Let's consider several scenarios which pose ethical dilemmas.

1. You have been called for jury duty in your city. When you arrive on the appointed day you immediately recognize that another potential juror is a former client in the agency where you work. You know this woman well, and you are aware that her judgment is likely to be skewed and her capacity for comprehending complex legal situations may be minimal. Her cognitive capacity is very limited. You cannot imagine that she can responsibly serve on a jury. How do you handle this?

A. You ask the official in charge if you may speak to the judge in private, and explain your concerns to the judge.

B. You speak to the client directly in a quiet corner, suggesting that she may want to ask to be excused from jury duty.

C. You say nothing. You do not approach the client, but when she speaks to you in a friendly manner, you respond politely.

D. You tell everyone in the room that you won't serve on a jury with this person as she is unable to serve.

**Answer: C.** You may not violate her confidentiality. You may not reveal, even to a judge, what you know about this person. Even though you know her abilities to be limited, as long as she is legally competent, and meets local legal requirements to serve on a jury, there is nothing you can do ethically to prevent her serving.

2. You are one of several therapists in an out-patient private practice. You have a receptionist in your office who is competent, friendly, and kind. One of your clients is a young physician who is in residency training at the local hospital. He has found that a few sessions of therapy have helped with his problems. One day, as he is making his next appointment, he asks the receptionist if she would like to meet him for coffee. She would very much like to get to know this young man. She

isn't sure how to handle this, and she turns to you for advice.

A. Tell her it is fine, go ahead.

B. Tell her to use her own judgment; it is not your concern.

C. Tell her that there may be some boundary issues. Even though she is not a therapist, she is a part of the practice, she has access to records; she is bound by confidentiality restraints, and she is expected to behave in a professional manner. You suggest that she follow the rule of thumb that she can date him after two years following the completion of his therapy.

D. Explain to her your concerns about boundaries. Remind her of the need to protect confidentiality. However as she is not one of the clinicians in the office, she is not working under a professional Code of Ethics which would prohibit such contact. You suggest that after the client has completed therapy, which should be within a few weeks, it would be okay to meet him for coffee.

**Answer: D.** Even though she works in your office, she is not a licensed professional and while she is certainly obligated to honor confidentiality in every way, she is not bound by the ethical constraints that would prevent a therapist from dating a client. Suggesting that she wait until he is no longer a client is a wise move. **C is also an acceptable response.** You and the receptionist should talk this issue over carefully and thoroughly.

## **Lesson: Principalism**

### **Topic: Scenarios which Pose Ethical Dilemmas - B**

3. You work in an agency which serves a minority population. You have learned, over the years, to respect the ways and customs of the people you serve. Some issues are particularly sensitive and you have worked hard to be aware of the best way to meet the needs of the clients. One day a client comes in with a gift for you. Her grandmother, who is a skilled craftswoman, has made a clay pot for you. You are aware that her pots sell for hundreds of dollars in the local craft shops. You have provided care for the family for about two years, and they have made great strides. Everyone is doing better, and their future is bright. The gift is their way of expressing appreciation for your work. You know that refusing the gift, even if you explain that there are rules which say you can't accept, will be very hurtful to this family, especially considering cultural norms.

A. You explain as best you can that you are not allowed to accept gifts.

B. You take the gift, say "thank you" and take it home to display.

C. Much as you admire the pot, you know you can't accept it as a personal gift. You express your gratitude for the gift, explaining that you intend to sell it and donate the proceeds to charity..

D. Your knowledge of cultural attitudes for the population you serve causes you to realize that refusing the gift would be seen as very rude. Even explaining that you may not accept the gift would not prevent the client from feeling very upset and hurt. So you talk with her about the gift and how much you appreciate the gesture. You accept the pot, explaining that you want to share it with your co-workers and visitors, and display it in a safe place in the reception area.

**Answer: D** is the best response. Refusing the gift for any reason may not be understood, and may cause great harm. While you may accept it on behalf of the agency, you should not take it home for personal use.

4. You work in a large agency with many therapists. At a party at the home of a friend, you recognize a former client who was seen briefly by one of your colleagues. He is a very attractive

successful businessman, and is very friendly at the party. He flirts with you and before the party breaks up, he mentions he has two tickets to an upcoming play and invites you to join him.

A. You accept graciously, telling him you are looking forward to going. With all those other people around you can't very well tell him why you shouldn't go out with him.

B. You give him your home phone number and tell him to call you later to talk about it. When he calls you, you tell him that it is against ethical practice to go out with him.

C. You quietly explain to him that it is unethical for you to go out with him.

D. You tell him that you can't go, but you have a friend who would probably love to go with him, or you would love to have both tickets.

**Answer: C.** Accepting this invitation would be a clear violation of boundaries and is inappropriate ethically as well as therapeutically. You need to be honest with him about this issue. You should never give him your home phone number.

5. A young woman comes to you for therapy. She is very upset. She reports that she and her former psychotherapist, a well known person in your town, have had sex. She states that he explained to her that her therapy would benefit from such an encounter; that the sex was to help her overcome inhibitions. Soon thereafter she realized she had been coerced, and she feels shame, guilt, and is fearful that no one will believe her. You determine that while she is clearly distressed, her account is credible.

A. You tell her that you want to be helpful, and that her former therapist was only trying to help. You offer to help her work through this issue, noting that nobody wants to be involved in what may become a public scandal.

B. You call the other psychotherapist and confront him, asking him if it is really true that he committed such a clear ethical violation, and demand to know what he intends to do about it.

C. You meet with the other therapist, tell him what you have learned. After your discussion you are not quite sure what may have actually happened, but your concerns are serious enough to report him to the state licensing board for investigation. You inform him that you feel you must do so.

D. You tell the client it really isn't such a big deal; people commit adultery all the time, and no one really cares anymore.

**Answer: C.** While this is an easy and obvious case, the fact remains that in virtually every state the largest number of reports of ethical violations to mental health professional licensing boards concerns violating sexual boundaries. In a court case similar to the situation described, the therapist was held liable for misconduct. (Corgan v. Muehling, 574 N.E.2d 602 [Ill. 1991]) (1) It is never ethically acceptable or appropriate for a therapist to have sex with a client.

(1) Cited in Child Mental Health and the Law Barry Nurcombe and David F Partlett (New York: The Free Press, 1994)196, 522.

## **Lesson: Ethics of Care**

### **Topic: Introduction**

The philosophical theory known as ethics of care has particular relevance for ethical decision making for mental health professionals. It falls under the category of ethical theories which focus

on the agent, ie, the person making the decision. The other two broad categories, utilitarian and deontological are concerned with justice, rights, and duty. They do not, in a formal way, take into account the particulars of a situation such as the relationships or feelings which may be involved.

We can see from a simple case example how this might make a difference. Suppose we are walking down a road one day alongside a raging river. We look over and see two persons about to drown. One is a famous scientist doing important research in curing cancer. The other person is your father, a retired teacher. You know you can only save one. If we were strict utilitarians we would know that we would have to save the scientist because his work can likely lead to saving many lives. Your father, on the other hand, is in his 80s and is no longer able to participate actively in the community. In the long run there is greater benefit to more persons if you save the scientist. But you love your father very much.

Deontology (strictly interpreted) does not permit us to consider saving our father because we love him. Our duty to each person must be considered equally. But we know, instinctively, that we cannot function as detached impartial observers in this kind of situation. We know that we are not radically autonomous individuals, but that our ties to one of the persons in the river is much greater than to the other. Ethics of care encourages us to include our feelings in this kind of case, and include that dimension of our lives in ethical consideration.

## **Lesson: Ethics of Care**

### **Topic: Definitions and Origins**

Ethics of care provides a way to consider, in a more formalized, theoretical fashion, that who we love, and how we care, make a difference in ethical decision-making. Our feelings matter. Our relationships matter. The particular circumstances come into play. Ethical decisions rarely involve just one person. Most often our choices affect a network of persons, whether family or friends. Our decisions are rarely ours alone, and they are rarely made by rational impartial observers.

Ethics of care takes these dimensions of our lives into account as we consider choices and make decisions. In Caplan's process of ethical decision-making, these factors are among the facts we need to know. These factors may complicate how we weigh principles, and see our options, but may well provide for more caring resolutions.

Some theorists trace the formal beginnings of an ethic of care to the work of Carol Gilligan. In the 1970s Gilligan, was a graduate assistant working with Lawrence Kohlberg. Kohlberg was doing important work in observing how people make moral decisions. He did significant research examining how people grow into persons who make responsible decisions. His stages of moral judgment are well known. Gilligan raised a new question. She wondered if there was any difference in the ways boys and girls made moral choices. Does gender matter?

Kohlberg's work involved using cases, imagined situations, to help people think about making moral choices. Gilligan used one of these stories, questioning both boys and girls, and this led to some very interesting findings.

In the story, which is now well-known, a man named Heinz has a very sick wife. The medicine is very expensive, and the druggist won't lower the price. The question: Should Heinz steal the drug?

Gilligan interviewed two 11 year-old children. Jake is clear that Heinz should steal the drug. If there is a conflict between the value of the property (the drug) and the value of a life, logic says the life matters more. Jake says: "For one thing, a human life is worth more than the money, and if the druggist only makes \$1000 he is still going to live, but if Heinz doesn't steal the drug, his wife is going to die."

Jake goes on to say the druggist can get more money later from rich people with cancer, but Heinz

can't get his wife again if she dies. Jake believes the judge will understand and give Heinz a lighter sentence if he is caught. Jake's response rests on the notion that there is a societal consensus around moral values that lets us know what is the right thing to do. He is willing to do what he knows to be a wrong thing in order to save a life; but he knows he must pay the penalty by going to jail.

Amy sees the situation differently. When asked if Heinz should steal, she replies, "Well, I don't think so. I think there might be other ways besides stealing it, like if he could borrow the money or make a loan, but he really shouldn't steal the drug, but his wife shouldn't die either."

When asked why he shouldn't steal the drug, Amy doesn't think in terms of property or what the law says. She thinks in terms of the relationship between Heinz and his wife. "If he stole the drug, he might save his wife, then, but if he did, he might have to go to jail, and then his wife might get sicker again, and he couldn't get more of the drug. . . so they should really just talk it out and find some other way to make the money." (2)

Notice that both children approach the situation with a great sense of compassion and concern. But their ways of describing and expressing their concern differ. Gilligan's work points toward basic differences, broadly speaking, between how men and women think about moral issues and make decisions. She found that, in general, males tend to approach morality with concern for individual basic rights and the need to respect the rights of others. Morality imposes rules, or restrictions on what you can do, and cannot do.

Females, on the other hand, see morality as concerned with the responsibilities persons have toward one another. Morality should lead us to find ways to care for others which may take precedence over rule-keeping.

Gilligan's way of summary is to say that male morality has a justice orientation, an ethic of rights, and female morality has a responsibility orientation, an ethic of care. Of course neither men or women think strictly in these categories. Women are perfectly capable of thinking in terms of rights and justice; men are perfectly capable of thinking about ethical dilemmas from a caring perspective. But the differences are worth noting.

(2) Carol Gilligan, *In a Different Voice: Psychological Theory and Women's Development* (Cambridge: Harvard University Press, 1982) 27ff.

## **Lesson: Ethics of Care**

### **Topic: Characteristics of Ethics of Care**

Gilligan's work has contributed to the development of an ethic of care. It is not just "ethics for women" but is a way of delineating an ethical theory which takes into account factors beyond laws and rules. Other contributors to this work have included a number of feminist philosophers who have examined many dimensions of what it means to be human and make moral choices.

We can site some differences between traditional Western ethics and ethics of care. (3) First, ethics of care is particularized. We take into account the details of a situation. We do not work simply with abstract principles, but we note specifics and circumstances which make this situation different from similar situations. It matters that people love each other, that feelings play a role, and that there are no two identical dilemmas from which we can abstract principles and make decisions.

The care approach to ethics acknowledges that we are interconnected with other human beings, and even to the universe. Our decisions affect not only ourselves but other people. Autonomy rarely creates a radical separation between one individual and others. We are, unavoidably, involved with others. We make moral choices out of love, empathy, and sensitivity to a situation.

Ethics of care does not demand that we put aside our feelings about the people and the issue involved. We are not simply creatures of reason. Philosophers have known this since the days of Plato in ancient Athens, but sometimes philosophers have functioned as though reason were the only dimension which should be involved in moral choice. An ethic of care acknowledges that we rely on a blending of reason, emotion, and action to make ethical decisions.

(3) This section about ethics of care is informed by the work of Peter Allmark and Gwen Adshead in *The Cambridge Medical Ethics Workbook: Case Studies, Commentaries and Activities*, ed. Michael Parker and Donna Dickenson (Cambridge: Cambridge University Press, 2001) 184ff.

## **Lesson: Ethics of Care**

### **Topic: Ethics of Care in Mental Health Treatment**

An ethic of care is particularly relevant to mental health care and treatment, where the therapeutic relationship itself may be an important part of the treatment. Gwen Adshead notes that in psychiatry, the dominant discourse has been focused on an ethic of justice and rights. Certainly concern for the rights of people made vulnerable by mental illness is appropriate. However looking solely at principles "cannot address the complexity of the lives of individuals, and the relationships in which they are embedded, both in the past and in the present. A rights/principles account that does not consider the patient within a matrix of relationships runs a risk of over-simplifying the patient's autonomy, and thus not doing justice (an appropriate word) to the complexity of the dilemma for this person." (4)

Strict notions of autonomy which focus exclusively on an individual and fail to acknowledge the complexities of relationships may not offer the best way to think about ethical choices in mental health care. We need a more sophisticated notion of autonomy which addresses the independence, as well as the inter-dependence of persons.

Margaret Farley notes that we need to move beyond debates about autonomy versus beneficence, self-determination versus well-being, rights versus responsibilities, or principles versus contexts. She proposes what she calls "compassionate respect" as a way of caring ethically. (5)

Farley states: "To respect a person as a person, .....is to respect her fundamental capacities for relationship as well as the relationships that are part of her concrete reality here and now. To care for a person adequately and genuinely as a person is to care for her in relation—in the context of the story of her relationships, past, present and future." (6) Farley's notion of compassionate respect offers a way to re-think what autonomy means in the context of an ethic of care.

This kind of ethic may well be the most appropriate for mental health care-givers to consider when faced with ethical dilemmas. Many times our clients may be functioning with compromised capacity; their ability to exercise their autonomy may be diminished. Someone who is suffering from depression, or any number of other disorders, is not at her best in thinking through possible treatments and making a genuinely informed choice. The very nature of the illness causes impaired decision-making capacities. Hence the compassionate piece of respect for autonomy comes into play. Caring for a mentally ill client who is not really at her best in terms of decision-making may mean that we offer support and guidance with compassion rather than presenting options for treatment and then leaving decisions to be made alone by people who are ill.

Relationships are important in mental health. Good relationships with others are a significant component of well-being. Often it is problems in relationships that bring people to seek help. And the relationship with the clinician is key to good therapeutic work.

Parker and Dickenson note that relationships in the mental health field have several significant features. The client and the clinician are involved in an on-going relationship over time, in which the therapist may need to manage the client's dependence, while working toward his independence. The illness itself may influence the relationships the client is involved in, with the

clinician as well as friends or family.

The client's capacity to make and maintain relationships may be affected by his illness. The contribution of the clinician and his relationship with the client may be as important as any other aspect of treatment. (7)

(4) Adshead, in Parker and Dickenson, 185..

(5) Margaret A. Farley *Compassionate Respect: A Feminist Approach to Medical Ethics and Other Questions* (New York: Paulist Press, 2002) 23.

(6) *Ibid.*, 37-38.

(7) Parker and Dickenson, 188-189.

## **Lesson: Ethics of Care**

### **Topic: Examples of Ethics of Care - A**

Let's examine some cases in which an ethic of care comes into play. (8)

1. You have lunch regularly with a close friend who is a psychotherapist in your town. You have known each other for many years, have a good relationship, and trust one another. Sometimes you share cases with each other, in a kind of informal mutual supervision. Names of clients are never mentioned. While you know that strictly speaking this may not be appropriate, you mean no harm, and often find useful guidance.

One day your friend begins to describe a case; you immediately recognize that he is talking about a client who is currently an in-patient in the hospital where you work. He reveals that many years ago the client committed a capital crime, and was never caught. You say nothing to your friend; you do not acknowledge that you recognize this story. Later you remember that a few days ago the psychiatrist, in a team meeting, mentioned that he couldn't quite get a handle on this case; something seemed to be missing. Now you realize what the "missing piece" may be. What do you do?

A. You immediately contact the psychiatrist and describe what you have learned. You do not reveal the source of your information. You realize you are violating confidentiality but you believe the best interest of the client is at stake.

B. You speak to the client the next morning, informing him that you have learned what he did years ago. You urge him to tell the doctor.

C. You say nothing. You realize you have already moved into a grey area regarding this client's confidentiality by hearing his story from another psychotherapist. If you reveal to the client what you learned, or tell the psychiatrist, your violation of confidentiality becomes even more serious. Furthermore, you realize that the crime can never be proven after all these years; hence there will be nothing that law enforcement could actually do.

D. You call the police immediately, and report what you have learned about the crime.

**Answer: C.** You may say nothing about this situation. While you may believe that the psychiatrist would benefit from having this information, you may not violate the confidentiality of the psychotherapist who spoke with you as you and he have an understanding that your conversations about clients are always confidential. Your relationship with him is significant and may be at stake. Relationships with colleagues are valuable, and may indeed be taken into account in ethical decision-making. Nor may you speak with any staff at the hospital about what you learned. You may choose to interact with the client in ways that would provide an opportunity for him to tell you what happened, but you should not tell him what you know.

His trust in the people involved in caring for him is at risk, as well as maintaining confidentiality. If you told the client, you may well undermine the relationships with his care-givers.

2. A young woman named Audrey suffers from borderline personality disorder. As a child she was abused by her father. She suffers from depression and intermittent feelings of loathing towards her own body. Sometimes she harms herself; and starves herself. She has a long-standing relationship with her therapist who is very concerned about her. She is currently hospitalized and her weight has dropped dangerously. She refuses to eat, or agree to any kind of feeding. Her doctor is considering force-feeding to save her life

A. After doing your best to help her see the value of treatment, you respect her autonomous right to refuse treatment. After all she is 22 years old, and legally able to make her own decisions about health care.

B. You work with Audrey on the complex issues involved such as control, body image, and her relationships with others. While maintaining respect for her autonomy, you realize it may well be compromised, so you press her to accept treatment. You give her a choice between agreeing to treatment, or if she insists on refusal, you inform her that you are prepared to take whatever measures may be necessary to save her life.

C. You know what is best for her; that your choice to force-feed will save her life, and some day she will thank you. In the long run she will be better off.

D. You are very concerned about the tensions which have developed between Audrey and the staff who care for her. They are having hard time accepting her decision not to have any kind of treatment. So out of respect for their feelings, you order that she be fed.

**Answer: B** is the best response. Audrey appears unable to function with complete autonomy. Though she has not been declared incompetent; and thus remains legally competent, her capacity to understand fully what is going on appears to be greatly diminished. One may remain legally competent while lacking capacity. The caring response may seem to take away her autonomy, but her ability to act autonomously is already seriously impaired. Additionally, the complexities of relationships, past and present, come into play in her case. Compassionate respect in this case leans more toward compassion in this situation.

(8) Cases # 2 and # 3 are adapted from Parker and Dickenson, 185-189.

## **Lesson: Ethics of Care**

### **Topic: Examples of Ethics of Care - B**

3. Bart is 21. At age 10 he was injured by a truck, leaving him disabled. There was a generous financial settlement. His disability provides a caring role for his mother. She does many things for him which he could do for himself. She supports his reluctance to go out and encourages him to remain at home, even discouraging him from seeking rehabilitation which the physician suggested could help. The entire family revolves around Bart, catering to him in many ways. The family physician, who is concerned about his well-being, refers him to you. How do you manage the ethical issues posed?

A. You do your best to get Bart out of the house; encourage his independence, assist him in arranging for living elsewhere. You encourage him to see his family as "holding him back." His autonomy and his opportunity to exercise his own choices has been stifled long enough.

B. You see that helping Bart become independent is indeed a benefit; however you realize that there may be harm involved for other family members who are invested in Bart's situation. While

Bart may be able physically to move out, the emotional ties, and the complex dynamics of this family are at stake. A physical benefit (moving out) needs to be balanced with the possible emotional harm (loss) which needs to be handled carefully. You realize that while you are treating Bart, the entire family, especially the mother, needs to be taken into consideration.

C. You suggest that the mother see another therapist in your practice in order to deal with her unhealthy connection with her son. You don't think Bart can ever pull away from her until she undergoes significant personal change.

D. You offer to take Bart to live in your home. After all, he will be good company for your elderly grandmother who lives with you.

**Answer: C.** Bart cannot be understood apart from the family he is part of. The various family members are connected in complicated ways. Helping Bart, with no attention to the family situation, could well be counterproductive. Good ethical care requires a complex response attentive to the particulars of the situation.

4. You are employed by the state social services department. Mark has been declared incompetent and is a ward of the state. He has a girlfriend, Maggie, who is legally competent. Even so, you are aware that her capacity for caring for herself is limited. Now she is pregnant, and Mark and Maggie intend to raise the child together. He has a history of not following through with plans, and he is impulsive. Both Mark and Maggie will receive assistance in the form of home support and case management. But you are very concerned that with the presence of a baby in their home, the stress level will increase and you worry about Mark and Maggie's ability to care for the child. You wonder what to recommend.

A. You realize that Maggie is legally competent. While you believe the infant may be at risk, until there is a reason to substantiate harm to the child you can do nothing. But you are concerned that a "wait and see" attitude may lead to great harm for the child.

B. You counsel Mark and Maggie, discussing your concerns, trying to help them see that raising a child is more demanding than they think. You realize that while your agency is responsible only for Mark, you are dealing with the well-being of two other persons. You work to provide the maximum support you can to enable them to live together and raise the child.

C. You arrange to have the state take custody of the child immediately after birth, knowing that there is no way Mark and Maggie can take proper care of the baby.

D. You know that as Maggie is legally competent, she has the right, as an autonomous adult, to make her own decisions. She has chosen to live with Mark; she has chosen to have a baby with him; and she has the right to choose to raise the child without interference from the state. Honoring her autonomy takes precedence over any other concern.

**Answer: B** is the best response. You may, in some jurisdictions, be constrained in how much you can do to help since Maggie remains competent. But the wisdom of working for the well-being of all those involved leads to B.

## **Lesson: Ethics of Care**

### **Topic: Summary**

Working with an ethic of care will likely not lead to entirely different ethical decisions when faced with dilemmas. It does not radically alter the meaning of right and wrong. It does, however, offer a way to enlarge our thinking, to encompass more of the story in the situations we encounter.

An ethic of care, which acknowledges the importance of context, particulars, and relationships is a

particularly helpful theoretical framework for ethics in mental health. However, rather than relying on our intuition, or our feelings solely in ethical decision-making in clinical practice, we may best think in terms of tempering principles with an ethic of care. Strictly objective consideration of principles may not be an adequate way to account for the complicated lives our clients live. An awareness of another approach can lead to better, more caring, ethical choices. A careful balance between principles and care can lead to responsible decisions.

## **Lesson: Ethics in Caring for Children and Adolescents**

### **Topic: Introduction**

*The United Nations has proclaimed that childhood is entitled to special care and assistance, convinced that the family, as the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community, recognizing that the child, for the full and harmonious development of his or her personality, should grow up in a family environment, an atmosphere of happiness, love, and understanding. . . . recognizing that the child by reason of his physical and mental immaturity, needs special safeguards and care, . . . . .*

---The United Nations Convention on The Rights of the Child

Childhood and adolescence cover a period of about 20 years, and are marked by dramatic changes in physical, cognitive, and social-emotional abilities. "Mental health in childhood and adolescence is defined by the achievement of expected developmental cognitive, social, and emotional milestones and by secure attachments, satisfying social relationships, and effective coping skills. Mentally healthy children and adolescents enjoy a positive quality of life; function well at home, in school, and in their communities; are free of disabling symptoms of psychopathology." (9)

Our role as mental health professionals is to promote these goals, to assist our young clients in moving toward healthy and productive lives. As we work toward these goals we will inevitably encounter ethical dilemmas, sometimes with legal dimensions as well.

Mental health care for children and adolescents is particularly complicated because these young clients are not independent individuals. They reside in families, or family-like living arrangements. Hence we rarely treat just one individual child or adolescent; we consider families and other caregivers. Furthermore there are specific legal requirements and protections concerning caring for children. Therefore ethical considerations are, in some sense, more complex than other areas of professional mental health care.

(9) Mental Health: A Report of the Surgeon General, Chapter 3.

## **Lesson: Ethics in Caring for Children and Adolescents**

### **Topic: Fundamental Ethical Questions**

American views and attitudes concerning childhood and adolescence are constantly evolving, and are by no means uniform. On the one hand, we have witnessed a rise in the number of admissions to psychiatric hospitals over the past two decades. At the same time we have seen the numbers of juvenile offenders placed in institutions decrease. So while fewer kids may be labeled offenders in terms of legal action, more kids are diagnosed with psychiatric disorders.

This raises a fundamental ethical concern about how we think about and name particular behavior. Are we medicalizing behavior which 50 years ago we would have considered just naughty, or perhaps criminal? Are we hospitalizing teens who behave in certain ways rather than routing them

through a legal system? Is it ethically more appropriate to diagnose a teen with a type of psychiatric disorder, than to send her through a juvenile court system? What are the long-term implications of either course of action? What actions constitute working for the well-being of the client, both in the present, and over the long term?

Ethicist H Tristram Engelhardt points out that it is important to decide how we will understand a problem. "In deciding where to place a problem, one changes the frame of reference for interventions." If we medicalize a problem we may "relieve afflicted individuals of one set of disvaluations and encumber them with another." We are reminded of the shift we have seen from viewing drug addicts or alcoholics as immoral to seeing them as diseased. Engelhardt adds: "Within different social contexts, the same person can consider another as sick, diseased, criminal, or sinful." (10)

There are basic questions about how our society thinks about and responds to particular behaviors or problems we see in young people. While there is no right or wrong response, these issues bear careful and thoughtful consideration for they undergird how we think about, respond to, and care for kids. As a society we don't have consensus about how we see young people. Public attitudes in response to the recent explosion of violence among young people vary. Easy access to firearms has contributed to shootings in schools and other public places. There have been, in many jurisdictions, attempts to try in court very young teens as adults. There have been legal challenges to executing young people who have been convicted of crimes were committed prior to age 18. These trends continue in spite of the fact that a huge majority of teens in a South Carolina study were found to "lack sufficient understanding for meaningful participation in their trials." (11)

As a society, we have not resolved how to understand, care for, and treat children and adolescents with problems. Attending to social ills which contribute to these problems is another issue in need of careful attention.

(10) H. Tristram Engelhardt, Jr. *The Foundations of Bioethics: Second Edition* (New York: Oxford University Press, 1996) 224.

(11) Parker and Dickenson, 210.

Lesson: Ethics in Caring for Children and Adolescents

### **Topic: Brief History of Childhood and Adolescence**

The evolution of children's rights in America saw radical changes from the 17-18th centuries when children were regarded as the property of their fathers. This notion came from English common law, reflecting an agrarian society. The 19th century saw greater industrialization and the rise of urban problems leading to laws to protect children. Since that time there have been increasingly complex legal structures to provide for the protection and care of children. (12)

Custody disputes have seen a major shift in the presumption that the father was responsible for the care of his children since they were considered his property. In the event of a divorce, the children were his. The preference for the father actually originated in Roman law and was seen to be an expression of natural and divine law. Not until the time of Henry VIII do we find the idea that custody included protection of children as well as the transfer of property.

The presumption favoring the father began to break down in the 19th century, notably around a famous case in England, *Shelley v. Westbrook*. The poet, Percy Bysshe Shelley's wife had died, and he became engaged in a dispute with her parents about the custody of the children. Shelley was charged with "irreligious and immoral" behavior, and the court was horrified that he might educate his children according to his aesthetic beliefs. (13)

How children are perceived is a fundamental ethical consideration. Whether they are seen as a father's property, or viewed as worthy of legal and moral protections as individuals with basic

rights, is a fundamental ethical concern. Of course we should never assume that every father is abusive; certainly many fathers are kind and caring parents, but the assumption of ownership leads to a particular ethical stance.

(12) Nurcombe and Partlett, 42.

(13) Ibid. 90.

## **Lesson: Ethics in Caring for Children and Adolescents**

### **Topic: Legal Considerations**

As minors, children and adolescents, are subject to laws which both restrict and protect. There are laws which require reporting of suspected cases of child abuse. There are, as well, laws which prevent children and adolescents from consenting to medical care on their own behalf.

In caring for children and adolescents, we find ourselves "bumping up against" the law in ways we may not in other areas of mental health. These laws can make it more complicated, or easier, to provide good care. We may be concerned about issues around confidentiality when a teen discloses information he does not want his parents to know. On the other hand we may be empowered to hospitalize a reluctant child when her parent consents.

When we are faced with ethical dilemmas in caring for kids, we find ourselves bound by two major guidelines. First we must obey the law. We are also professionally bound to act in ethical ways. Often this presents no problem, but there may well be times when the legal course of action conflicts with what we see to be the ethical course of action.

State laws vary, but generally speaking, mental health professionals, along with other persons who have care-taking responsibilities for children and adolescents, are required to report to authorities concerning some situations. You may be required to report instances of suspected child abuse, sexually transmitted diseases, or knowledge of other dangerous activity. There may be legal provisions for hospitalizing clients who are threatening harm to themselves or another. You need to be familiar with your state laws in these matters.

## **Lesson: Ethics in Caring for Children and Adolescents**

### **Topic: Age of Minority and Majority; Legal exceptions**

The legal age of minority vs. majority varies. In most states, the legal age of majority is 18, that is, upon turning 18 persons are permitted to enter into binding contracts, enter military service, and consent for their own medical treatment, including mental health treatment. The corresponding right to refuse medical treatment is also attained at majority.

Therefore we are legally bound to respect the laws concerning age of consent. The legal presumption is that minors are not competent to consent because they lack maturity and the capacity to understand and agree to treatment. Hence a surrogate decision-maker is empowered to consent on behalf of the minor.

The surrogate is, most often, the parent, but may be a legally appointed guardian. There are, however, exceptions. Depending on state law, some minors may be permitted to function as adults in some situations. If adolescents under age 18 fall under the following categories, they may be allowed to speak for themselves:

- Married or legally emancipated;
- Emergency medical situation;
- Pregnancy prevention;

Pregnancy treatment;  
Sexually transmitted diseases;  
Abortion;  
Alcohol or drug treatment; and  
Mental health treatment.

Consulting your state laws regarding exceptions to the legal age of majority will enable you to know precisely what situations in your state are covered. It is vital that you be aware of these regulations in order to provide appropriate, and legal, care.

Emancipation, a common law doctrine, severs the mutual rights and obligations of the parent-child relationship. The parental right to control the child is terminated, as well as the parental obligation to provide for the child. Most of the time emancipated minors have been given independence by their parents. However, emancipation may be legally challenged. A legal determination will likely be based on the agreement of those involved, marriage, military service, living independently, paying debts, owning property. Common law emancipation affords a youth the right to consent, but does not permit full adult responsibility such as drinking alcohol legally or voting. (14) Emancipated minors may legally consent to medical treatment or health services for themselves or their child.

Another issue concerns communication between the clinician and the parent of minors. Minors who are not emancipated are under the care and supervision of their parents who have a legal right to information concerning their children. However what is legally permissible may not be the best clinical or ethical choice. Clinicians will need to handle such possible conflicts with a great deal of skill.

(14) Ibid., 40.

## **Lesson: Ethics in Caring for Children and Adolescents**

### **Topic: Substance Abuse Treatment for Minors**

With regard to substance abuse, federal law states that a minor patient, acting alone, has the legal capacity under the applicable state law to apply for and obtain alcohol or drug abuse treatment. Written consent for disclosure of information may be given only by the minor patient. In other words, the parent of a minor under treatment for alcohol or drug abuse may not obtain information about the minor in this situation, unless the minor gives her consent. This restriction includes, but is not limited to, disclosing patient information for purposes of financial reimbursement.

Of course a minor may consent to have her parents informed about what is happening in treatment. But the presumption is that such information is confidential even though the client is under age 18.

If a minor is in treatment for substance abuse, and there may be a threat to the life or well-being of any individual involved, a responsible clinician may disclose to the parent if the clinician judges that the minor lacks the capacity, due to extreme youth, or a mental or physical condition which may impair decision-making ability.

The process of discernment in these kinds of situations can be tricky, and call for careful consideration of the law as well as astute clinical assessment. Ethical guidelines which call for constant attention to the well-being of the client are helpful. It is advisable, in such situations, to get consent in writing, to take care that consent is voluntary, specific, and informed. It may be a good idea to consult with another clinician for concurrence.

## **Lesson: Ethics in Caring for Children and Adolescents**

## **Topic: Confidentiality**

The Mental Health Report of the Surgeon General states:

*"Effective psychotherapy. . .depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears. Because of the sensitive nature of the problems for which individuals consult psychotherapists, disclosure of confidential communications during counseling sessions may cause embarrassment or disgrace. For this reason, the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment." (15)*

We may encounter conflict in treating children and adolescents when we seek to honor the young client's confidentiality, and at the same time obey the law in terms of parental rights to information. This is probably more of a concern with adolescents than with younger children. Certainly we want the best possible outcome for the client, and her parents likely share this desire.

The best ethical approach is to be open and honest from the beginning with the client, and her parents. Unless the client feels she can trust you, she may not disclose important information. She may fear her parent's response to learning about her behavior. She may be embarrassed or ashamed of her behavior. On the other hand, the parents have a legal right to her medical information.

A carefully negotiated plan for treatment may include talking to the adolescent, informing her that you will do your best to honor her confidentiality. However, you must inform her, as you would any client, that there may be legal considerations. For example, if she reveals abuse, you are compelled to report that to authorities. If you believe she is in danger of harming herself or another person, you are ethically bound to take action. You may choose to talk to your client in terms of safety; there may be information you need to share if her safety is at risk. You may also need to remind her that there may be information that her parents need to have. For example, if she reveals to you that she is pregnant, at some point, her parents will likely need to know.

Discussion with the parents may need to inform them that the best outcome may include their willingness to forgo knowing every detail of the treatment for their child. Honoring the child's confidentiality may create some conflict for some parents, however a clear and carefully articulated position concerning the best course of treatment, and the best way to help the child may enable the parents to agree to not knowing every detail of treatment.

There are usually ways to negotiate the complexities of confidentiality for children and adolescents which do not violate either legal or ethical guidelines. However, when one is placed in a no-win situation, obeying the law must always come first.

(15) Mental Health: A Report of the Surgeon General, Chapter 7.

## **Lesson: Ethics in Caring for Children and Adolescents**

### **Topic: The Voice of the Child**

Professional codes of ethics for health care providers always point to the importance of placing the well-being of the client at the center of our concern. One of the ways we carry out this ethical mandate is to listen to the client's voice, even the voice of a minor child. Article 12 of the UN Convention on the Rights of the Child remind us that "the child shall in particular have the opportunity to be heard in any judicial and administrative proceedings affecting the child. . ."

At times the notion of assent has been advocated as a way to include the child in conversation about medical care and treatment. According to this view, we should always discuss proposed interventions with the child, explaining what we are planning, and how treatment will proceed. The

goal is for the child to assent to treatment, acknowledging that legal consent lies in the hands of the parent or other legal surrogate.

One may question the validity of the concept of assent. It is virtually always desirable to inform a child or adolescent of any impending treatment. We should certainly discuss what is going on with the client, answering questions and explaining details as best we can. But unless we are willing to forgo that treatment if a child refuses assent, the concept is really meaningless.

Questions about the voice of the child, and the best interest of the child, raise issues about therapist's responsibility. To whom are we responsible? In treating children and adolescents, are we responsible to the child, or the parents, or the society at large? Children and adolescents are not independent; they live enmeshed in families or other care settings. Our therapeutic interventions may affect several persons. There are no easy answers for these basic ethical questions involved in caring for children.

## **Lesson: Ethics in Caring for Children and Adolescents**

### **Topic: Mature Minors**

Every practitioner is well aware that adolescents do not suddenly become mature and capable of independence on the day they turn 18. Maturity varies greatly; in fact most of us know people well beyond the age of 18 who are not mature enough to make responsible decisions. We may know 15 year-olds who can make mature decisions much of the time.

Responsible ethical thinking takes into account that some adolescents are perfectly capable of good decision-making. Ignoring the voice of the capable teen is neither clinically or ethically appropriate.

The notion of the mature minor is important ethically. English common law has for centuries recognized that the age of accountability did not happen all at once. For instance, at the beginning of the 19th century, children under the age of seven were considered incapable of committing a crime. Children from age seven to fourteen might well know they were acting wrongly, but could not be held legally responsible. Adolescents over age fourteen were considered fully responsible. (16) The concept of "mature minor" is widespread, but is vague and ill-defined legally. State formulations differ.

Maturity may be defined according to laws, may apply only to adolescents fifteen or older, and may depend on the issue involved. For example, a particular adolescent may be considered mature enough to consent to surgery, but not mature enough to drink alcohol legally.

At least one authority (Weithorn) recommends that at fourteen years, minors should be presumed competent to give informed consent to medical treatment unless they clearly lack the capacity to do so. Between the ages of ten and fourteen, minors should be evaluated for competency on a case-by-case basis. Regardless of age, children should be involved in treatment decisions, and kept informed about treatment. (17)

In evaluating competency for minors clinicians should take the following issues into account:

- Knowledge - Does the child have enough information about treatment?
- Educability - Can the child learn what she needs to know?
- Cognitive capacity - Is she capable of understanding options, risks, etc?
- Capacity for self-determination - Is she free of coercion?
- Emotional freedom - Is there any impairment? (18)

If we are able to establish that we are dealing with a mature minor, capable of making a thoughtful informed decision, we are ethically bound to pay attention to that voice. While we may be legally bound to do as the parent wishes, the voice of a mature minor deserves our notice and care. The

best ethical resolution is to arrive at consensus among clinician, minor client, and parents.

(16) Nurcombe and Partlett, 73.

(17) Weithorn, in Nurcombe and Partlett, 69.

(18) Nurcombe and Partlett, 69-70.

## **Lesson: Ethics in Caring for Children and Adolescents**

### **Topic: Cases - A**

Let's examine several cases concerning children and adolescents in order to practice thinking ethically in these situations.

1. You meet with a married couple who have a two-year old daughter. They are both eager for help for their family. They recently discovered that a relative caring for their daughter had engaged in questionable behavior. They are very upset about this, they want help for themselves in dealing with this issue, and they ask for a referral for their child so that she can receive whatever help she may need. They have severed all ties with this relative, and are determined that he never see their child again. They are aware of reporting laws, and ask you not to report this incident.

A. You tell them that you have no choice but to obey the law. You explain that investigators are well-trained, kind and sensitive people, but that this relative must not be left to harm other children. You offer your support and assistance in this matter.

B. You realize that reporting can lead to an investigation and may cause further emotional harm to this child. You also are aware that the incident was not explicit abuse, though the relative's behavior was certainly inappropriate. You trust the parents who insist that the relative will never see their daughter again. You decide that there is no future danger, so in the interest of helping this family heal and move on, you decide to forgo reporting.

C. You tell the parents to wait in your office, you go to another area and phone the proper authorities to make the report. Then you return to the parents and let them know you have made the call.

D. You have your initial session with the parents, and tell them you are still thinking about whether you should report. You may need to consult a colleague or two about this decision. You give them an appointment for next week.

**Answer: This situation is ethically very difficult.** Strictly speaking, A is the best answer, however your clinical judgment may lead you to choose B in rare circumstances if you have doubts that there was actual abuse, and you trust the parents to keep the child safe. You cannot take lightly the legal requirements about reporting, but if your judgment leads you to conclude that the child truly is no longer at risk, you may choose B.

2. You receive a referral from a surgeon who wants your evaluation. His patient is a 16 year old girl who wants breast implants, has worked at an after-school job, and saved enough money to pay for the surgery. She seems to be a good surgical candidate, but he wants your assessment about her psychological state regarding this surgery.

A. You meet with the girl, and in your assessment you realize that she has some significant illusions about what the surgery will accomplish. She has low self-esteem, and believes that big breasts will make her popular. She giggles a lot, and dismisses your concerns about the serious nature of the surgery. You report to the surgeon that she is not a good candidate for cosmetic surgery.

B. You meet with the young girl, discussing her situation, probing carefully to assess her motivation, support systems, etc. You report to the surgeon that you believe the patient is mature enough to consent to surgery, and it is appropriate to perform this surgery.

C. You meet with the girl, discussing her situation, assessing her motivation, etc. You also ask to meet with her parents to assess their role in supporting their daughter, determine their views about the situation. The family is supportive, and agreeable to the surgery. They told her she could have the surgery if she saved up enough money. You report to the surgeon that the patient is mature enough to make this decision, and that the surgery is appropriate.

D. You meet with the girl and inform her clearly of the risks of surgery. You tell her about the problems women have had in the past with breast implants. You tell her you would hate to see her go through with this.

**Answer: This could go either way.** If the young woman should not be having this surgery, the ethical response would be A. However, a 16 year old may well be mature enough to make this kind of decision, in which case, C is the best choice. Meeting with her parents is advisable as she will need their care and support.

## **Lesson: Ethics in Caring for Children and Adolescents**

### **Topic: Cases - B**

3. An eight year old boy is brought to your office for treatment. He has been acting out at school, causing problems at home. He has hurt his baby sister several times; he has hurt the neighbor's pets and seems out of control much of the time. His parents recently separated, and the custody arrangements are still unsettled, and there is no court order. The mother brings the child, but you get a call later that day from the father saying he does not want his child treated by a therapist. Can you treat this child with only the mother's consent?

A. You consult state laws, and they seem somewhat murky to you concerning custody and consent. You call the mother and tell her that unfortunately you will not be able to see the child because of the unsettled custody issue.

B. You consult state laws about seeing the child in this situation. It may be that state laws will permit you to see the child in the absence of a custody agreement. If the child is residing with the mother, and she has "physical custody" that may be construed as appropriate to consent. As the best interest of the child is at stake, you want to pursue the best legal way to protect yourself, and provide good care for the child.

C. You consult a lawyer, and decide that you must be very careful. You refer the child to another clinician because you don't want to risk the anger of the father.

D. You consult state laws and decide that the vague nature of the situation poses some risk to you. You realize that caring for the child is important, but until the custody is settled you tell the mother you cannot see the child.

**Answer: B is the best choice, depending, of course, on your state laws.** Honoring the law takes precedence, but if there is a legal way to treat the child with only the mother's consent, you need to take seriously the ethical mandate to focus on the well-being of the child as foremost.

4. You are seeing a 14 year old girl. You have carefully explained to her and her single mother the parameters of confidentiality, explaining to the girl that you will do your best to keep her confidences, however there may be times you have to tell. Her mother agrees that in the girl's best interest she will not insist on knowing everything. The girl comes for her regular visit, and tells you

she is 8 weeks pregnant.

A. You go to the waiting room, call the mom to come into your office where her daughter is sitting and say to the mom, "Your daughter has some news for you" turn to the girl, and say, "Now, tell your mom what you just told me."

B. You discuss with the girl her need to inform her mother right away, so they can think about decisions for the best course of action. You tell her that you will be right there with her, and help her, but she really needs to tell her mother herself.

C. You call the mother later that day and tell her that her daughter is pregnant, and you are recommending an immediate abortion.

D. You ask the girl who the father is, she tells you, and you call the boy's parents and inform them they need to come to your office tomorrow to discuss an important matter. You ask the girl's mother to be there at the same time.

**Answer: B is the best choice.** You hope to avoid actually violating her confidentiality, and you want to retain her trust in you. Your offer of support is a good clinical, as well as ethical, choice.

### **Lesson: Ethics in Caring for Children and Adolescents**

#### **Topic: Cases - C**

5. The parents of a 12 year old boy bring their son to you. He has told them that the youth pastor at his church has abused him, along with several other boys, at a church camp. He is very upset, confused, and scared. He is afraid that if he tells, the popular youth pastor will lose his job, but he is unable to stop crying.

A. You call immediately and report the abuse. You then proceed to work with the family to help them deal with this, including helping the boy prepare for the questions of the officials who will be investigating.

B. You call the senior minister at the church and tell him what you have heard. You suggest he call a meeting of all the young boys and their parents to find out just what has been going on. You insist that the youth pastor be fired immediately.

C. You report the abuse to the proper authorities. You also call the senior minister and inform him that you have done so.

D. You call the authorities to report the abuse and also report the minister to his denominational officials.

**Answer: While you may want to warn everybody who may become a victim, your best response is A.** You are violating the confidentiality of your young client and his family if you inform anyone beyond the proper authorities. The other victims, the pastor, and others involved will know soon enough when the investigation begins.

6. You are treating a young woman for an eating disorder. She is 17, and turns 18 in less than two months. At that time she will be legally empowered to refuse treatment. She is dangerously ill, her physical health is at risk, possibly her life. Her parents have tried for years to help her, and they are very worried that once she turns 18 she will leave treatment.

A. You do your best to persuade her to stay in treatment past her birthday. But you inform her parents that if she refuses treatment, there is nothing you can do.

B. Your assessment of her is that her illness has caused significant loss of capacity for decision-making. In other words, you believe she is not actually competent to make the decision to refuse treatment. Therefore you urge her parents to begin proceedings to have her declared legally incompetent upon her 18th birthday, and petition for her legal guardianship. You will be able to continue to treat her.

C. You suggest that the parents be prepared to have her committed on her birthday so that she will be in the hospital and you can continue treating her.

D. You remind her of the responsibilities of being an adult. You remind her how much her parents love her, and she should behave as an adult.

**Answer:** The best interest of the patient must always take precedence. While you want to honor the autonomy of an adult, you realize that her capacity to exercise her autonomy is compromised by her illness. Hence B is the best course of action. However, depending on family and other circumstances, C may be an acceptable choice as well.

## **Lesson: Ethics in Caring for Children and Adolescents**

### **Topic: Cases - D**

7. You receive a call from a physician in town. He has been treating a 17 year old boy for a serious illness. The boy and his family are Jehovah's Witnesses, and believe that blood transfusions imperil their salvation. The family is thoughtful, responsible, and devout. The boy needs transfusions, and is refusing to accept blood. While the courts have ruled that children of Jehovah's Witnesses may be treated with blood over the parent's objections, the physician is reluctant to do so as the boy is highly intelligent, deeply religious, and seems capable of making this decision for himself.

A. You refuse to see him for assessment as you think refusing blood is too ridiculous to even contemplate.

B. You meet with the boy, and his family, and determine that indeed he is a mature young man. He is fully aware of the risks involved in refusing blood. He understands that he may even die if he doesn't have the transfusion his physician recommends. You support his right to refuse.

C. You meet with the boy and talk with him at length about what his refusal might mean to him, both in terms of his physical health and his spiritual health. You conclude that while he is intelligent and thoughtful, you cannot stand by and participate in allowing him to make what could be a fatal decision. You recommend to the physician that he obtain a court order for the transfusion, which you believe to be in the boy's best interest.

D. You meet with the local leaders from the Jehovah's Witnesses in order to learn more about the issue. You call the physician and tell him that he should do what the boy wants.

**Answer:** This boy meets the definition of a mature minor. While you may not agree with his choices, respecting his religion and his right to make this decision at age 17 is the best ethical response, hence B is the answer. Your personal religious views may be seriously at odds with his beliefs, however, it is never ethical to impose your own religious views on a client.

8. A young mother brings her four year old daughter to see you as the child is having behavior problems. She is divorced from the child's father. According to custody arrangements, the child is allowed to spend one night each week with her father. The mother believes that these visits with the father are the cause of the child's problems. She wants you to support her petition to terminate the child's visits with the father. In your opinion the child's visits with the father are not the source

of the problem and that the child's relationship with the father is important, but the mother says she is terminating therapy if you don't support her in stopping the visits.

A. You don't want to discontinue therapy with this child as you believe it is helpful. The mother's threat to discontinue therapy worries you, and as you have the child's best interest at heart, you go along with the mother in order to continue treating the child.

B. You and the mother have differing views about what constitutes the child's best interest. You feel that your function is to act as the child's advocate, and it is your opinion that visiting her father does no harm. You regret losing the opportunity to help the child, so you reluctantly tell the mother you are sorry she will not be bringing the child again, but you cannot support her petition.

C. You invite the father into your office for a consultation, explaining to him what is going on from your point of view. You invite his input, and encourage him to seek therapy for himself and his daughter.

D. You reconsider the possibility that the mother may be right, that visiting the father could cause harm, and you conclude there is enough of a concern to support the mother. After all, you can't help the child if the mother doesn't bring her.

**Answer:** One of the difficulties in making ethical decisions is that we often can't see the whole picture. We don't really know what is going on with the child and her father. However if our best clinical assessment is that the mother is asking us to assist so that she can punish the father, we cannot support her petition. B may be the best response even though it may well mean an end to therapy. You may talk with the mother about terminating therapy, and suggest appropriate referrals for her and the child.

## **Lesson: Ethics in Caring for Children and Adolescents**

### **Topic: Cases - E**

9. You are seeing a woman whose husband has left her. After 15 years of marriage, he announced he has realized he is gay, and he has taken a lover. They have moved in together. There are two young daughters who don't understand what is going on. The mother asks you to see the children, ages 9 and 11, and explain to them what their father is doing.

A. You agree to see the children, you explain to them what "gay" means and that in spite of all the changes in their lives, their mother and their father still love them very much. You answer all their questions about how two men can love each other.

B. You ask to see the father and mother together, and in the best interest of the children, they agree to come in together. You work with them about ways to tell the children what is going on. You offer to see the children if they seem terribly upset.

C. You call the father and tell them he needs to be honest with his daughters about what he is doing. You tell him that he should tell them the whole truth, and arrange for them to meet his lover right away.

D. You realize these children are in the midst of a major change, and their lives are greatly disrupted. You work with the mother to seek a custody arrangement that protects the girls from seeing their father's lover, from any exposure to a homosexual lifestyle until they are older and better prepared to deal with it. You suggest that you continue to see the mother, and refer the girls to another therapist to deal with the divorce.

**Answer:** The appropriate ethical response in this case is closely linked to the appropriate clinical response. You know your clients, and the situation in ways the written summary cannot express. In

some situations B may be the best response; in other situations D may be the best way to proceed. There are a number of factors which may influence your choice, such as maturity of the children, their previous exposure to homosexuality, religious influences, and other issues.

10. You live and work in a small town. You and your spouse have two children, ages 8 and 11. In your practice you sometimes see children. You recently began seeing an 11 year old boy whose behavior has become increasingly violent and dangerous. He has harmed pets, and started fires. Therapy seems to be progressing well. One day your 11 year old son brings home a birthday party invitation he has received at school. You realize he has been invited to a party at the home of your client. What do you do?

A. You tell your son that he must not tell the other kids, but the birthday boy has lots of mental problems, and you will not allow your son to visit his home.

B. You have serious reservations, but you decide you can trust that in a group setting, with adult supervision, your child is at not at risk, so you agree to drive him to the party.

C. You suspect that the client's parents do not realize that your child has been invited to the party as you and your children have different surnames. While you are concerned about boundaries, you ask your spouse to drive your son to the party, so that the boy and his family won't realize that your child is the child of the therapist. You do not say anything about the connection to your child.

D. You offer no explanations, simply tell your son he will not be allowed to attend the party.

**Answer:** Small towns can often create difficult boundary dilemmas. We often find ourselves in dual relationships. In this case we cannot violate the client's confidentiality. If our child really wants to attend the party, C is likely the best response as it serves to protect all those involved.

### **Lesson: Ethics in Caring for Children and Adolescents**

Topic: Conclusion

Treating children and adolescents is particularly fraught with ethical challenges. The primary challenge lies in the fact that our young clients are presumed incompetent, dependent on surrogate decision-makers, and legally unable to make their own decisions. Navigating the path between providing excellent treatment, obeying the law, including parents or other care-givers in the process can generate interesting ethical dilemmas.

This area of mental health care is particularly appropriate for an ethics of care. Considering families, relationships, emotional attachments, and the particular situation of each child enables the practitioner to think broadly about the best ethical response not only to the primary person, that is the child, but also to others involved.

### **Lesson: Ethical Issues Concerning Spirituality in Mental Health**

Topic: Introduction

*We are not human beings having a spiritual experience.  
We are spiritual beings having a human experience.  
-Teilhard de Chardin*

The past few years in American culture have witnessed an ever-increasing interest in spirituality. Though often vague and ill-defined, spirituality has become very much a mainstream topic. There

are retreats, magazine articles, multitudes of books, tapes, CDs, and even television programs with spiritual themes.

There are an abundance of resources available to those who are interested in learning more about spiritual matters, or studying spiritual practices. One may wonder what spirituality or religion have to do with ethics and mental health. Our ethical mandate, stated in all codes of ethics for mental health professionals is to place the well-being of our client at the center of our attention. Good ethical practice means that we are prepared to identify and promote the best possible outcome for our client. That may well include attention to the client's spirituality or religion.

Few people are genuinely neutral when it comes to religion. Most of us have experiences, attitudes and beliefs which shape how we think about, and respond to others and their religious beliefs. Often we have strong feelings, one way or another, about religion and its role in human lives. We may believe that a religious faith or spiritual practice are essential to good mental health. Or we may believe that faith can cause so many psychological and emotional problems that it is detrimental. We need to be aware of these attitudes and beliefs as we think about attention to spiritual matters with our clients.

## **Lesson: Ethical Issues Concerning Spirituality in Mental Health**

### **Topic: Historical Connections: Religion, Mental Illness, and Healing**

Certainly the history of humankind reflects a complicated relationship between religion and healing; between priests and physicians. While the past century has seen an overtly hostile attitude on the part of medicine and psychotherapy toward religion, there has been a complex relationship with important connections in prior centuries.

Samuel Thielman has traced this fascinating story, citing time and places through history in which madness, healing, and religion are deeply intertwined. (19) in Handbook of Religion and Mental Health, ed, Harold G. Koenig (New York: Academic Press, 1998) 3-20. In the ancient world healing generally took place within a religious context. Prior to the Enlightenment and the rise of scientific thinking, the priest was sometimes the only healer available. Concepts of mental illness, or "madness" have evolved in interesting ways.

The 19th century conflict between religion and science, growing, in part, out of Darwin's important work, contributed to the hostile attitudes we find in 20th century views about mental illness and religion. Perhaps the best known example of such attitudes is Freud, who described religion as "the universal obsessional neurosis of humanity."

Albert Ellis wrote: "Devout, orthodox, or dogmatic religion (or what might be called religiosity) is significantly correlated with emotional disturbance. . . . the devoutly religious person tends to be inflexible, closed, intolerant, and unchanging. Religiosity. . . is in many respects equivalent to irrational thinking and emotional disturbance. . ."

Lest we think these attitudes have faded, note that Wendell Watters, wrote a book called Deadly Doctrine, published in 1992. He states: ". . . Christian doctrine and teachings are incompatible with many of the components of sound mental health, notably self-esteem, self-actualization and mastery, good communication skills, related individuation and the establishment of supportive human networks, and the development of healthy sexuality and reproductive responsibility. . . ." (20)

These attitudes are fading in many circles. There has been, in recent decades, a renewed interest in examining the role of spirituality in mental health. It is a complex role. At times religion and spiritual practices may be highly beneficial. At other times, religion and spiritual practices may be problematic.

(19) Samuel Thielman, "Reflections on the Role of Religion in the History of Psychiatry"  
(20) Freud, Ellis, and Watters quoted in Harold G Koenig, Michael E. McCullough, and David B. Larson, Handbook of Religion and Health (New York: Oxford University Press, 2001) 61-63.

## **Lesson: Ethical Issues Concerning Spirituality in Mental Health**

### **Topic: Spirituality and Religion Defined**

There are almost as many definitions of religion and spirituality as there are people who write or talk about them. One of the difficulties in defining terms in this realm lies in the fact that many believers are aware they are attempting to describe things which are beyond words. James Gustafson, a noted scholar in ethics has said: "Mystery is not equivalent to unknown or unknowable, but rather to known (in the sense of experienced) but not fully describable and explainable."

Hence we may have a hard time talking about religion or spirituality. Language gets slippery. However we need to work toward definitions so that we can communicate more clearly. Most writers speak of spirituality in terms of things which give meaning and purpose to life. Spiritual concerns are about things of ultimate importance. The premise is often that every human being is born with a spirit, and the nurture and care of that spirit involves "spirituality."

Religion is often seen as an organized, institutionalized way for human beings to formalize their spiritual yearnings and seek meaning in communal ways. There are, of course, many different religions and ways to be religious. One helpful distinction between spirituality and religion may be to say that we are born spiritual beings, and we choose whether or how we will be religious.

Healthy religion should serve to promote healthy spirituality among its adherents. However, there may be persons who are religious without much serious attention to a personal spiritual journey. There may be persons who are deeply spiritual without a connection to a particular religion.

So when we talk about religion or spirituality, we are talking about things which may be difficult to define or describe. What I refer to when I say something about my own "spirituality" may be very different, carrying different meanings and connotations, from my client when she talks about spirituality. Communication in this area can be a challenge.

## **Lesson: Ethical Issues Concerning Spirituality in Mental Health**

### **Topic: Spirituality in Ethical Care for Clients**

*The undeniable fact that all people have their own sacred landscapes as explicit or implicit context for their lives has been ignored by clinicians. Many patients undergo lengthy psychotherapeutic treatments without ever attending to the beliefs coloring the background of their experiences. (21)*

For too long, too many mental health professionals have failed to take into account the spirituality or religious concerns of clients. Such an omission in clinical practice constitutes a significant ethical failing.

Codes of ethics uniformly place the well-being of the client at center, and when we fail to include this important dimension of human experience, we fail our clients. Polls consistently show that Americans are believers. 85% or more describe themselves as believing in God and praying regularly. While numbers are somewhat lower for attendance at religious services, Americans are clearly people who describe themselves as people of faith.

On the other hand, several studies have demonstrated that, on the whole, mental health

professionals, are less likely to be people of faith. There may be a kind of gap between the population at large, and mental health professionals with regard to faith or spiritual practice. If our life experience does not include spirituality or faith, we may neglect to attend to its importance in the lives of our clients.

Of course we do not have to be believers to provide for spiritual needs. Just as you do not have to be a recovering alcoholic to treat addictions, or a divorced person to treat people with troubled marriages, you do not have to be a person of faith to attend to spiritual concerns in clients.

But good ethical practice requires that we become knowledgeable, and attentive to these concerns. Training programs for mental health professionals have included attention to the spiritual only for about a decade. Many clinicians, therefore, have not been exposed to formal training in ways to identify and care for spiritual concerns. Ethically, we are bound to seek such training if we are lacking. Most programs now are deliberate in their attention to the religious or spiritual as a significant component of assessment of clients.

Note the changes from the DSM-III to the DSM-IV. The DSM-III used religious examples to illustrate cases of serious mental illness. Larson and his colleagues found that the glossary illustrating technical terms had substantial religious content. Illustrations about illogical thinking, incoherence, catatonic posturing, delusional thought, and magical thinking, among others, were illustrated with religious accounts. (22) The obvious assumption was that religion caused, or contributed to, mental problems.

The DSM-IV includes a category called "Religious or Spiritual Problem"

*"This category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of spiritual values that may not be necessarily related to an organized church or religious institution." (23)*

We see a shift in the current DSM in attitudes about religion. It seems apparent that good practice now means we are ethically bound to be able to assess and attend to these kinds of issues as they arise in therapy.

(21) A. Rizzuto, quoted in Nancy Clare Kehoe, "Religion and Mental Health from the Catholic Perspective" in Koenig, 222.

(22) Koenig, McCullough, and Larson, 71

(23) Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition

(Washington, DC, The American Psychiatric Association, 1994) V62.89

## **Lesson: Ethical Issues Concerning Spirituality in Mental Health**

### **Topic: The Importance of Spirituality; The Evidence**

There have been, over the past decades, hundreds of studies examining the role and importance of religion, and spirituality in health care. Many of these studies have focused on physical illness, but a number have examined mental illness.

These studies take many forms. Some measure religious practices, such as church attendance, or participation in spiritual practices. Others ask people to self-assess concerning attitudes and beliefs. Over these past decades, the studies have become increasingly refined and reliable. While a review of literature of these studies is beyond the scope of this course, such information is readily available.

The studies are, admittedly, uneven. For example, a study which shows that elderly women who

attend church often are more likely to be healthy, and exhibit less depression, may fail to take into account that elderly women in poor health, or suffering depression, are far less likely to be able to go to church.

The National Institutes of Health have funded millions of dollars worth of research into the connections between religion, spirituality and health, including mental health. There are more and more reliable studies, and the overall evidence clearly points toward the role of religion and spirituality as having positive impact on people's lives, their coping, their ability to deal with stresses, and their ability to find meaning and purpose.

There may be some geographical variation, but many of us will find that a large number of our clients care about spiritual or religious concerns. These concerns cannot be ignored if we are to provide the best care for those we treat.

## **Lesson: A Closer Look at Religion and Spirituality**

### **Topic: Diversity in Religion and Spirituality**

People are not simply religious or not religious. Being spiritual or religious is by no means an all- or -none proposition. There are different ways to be religious; there are differing degrees of religiosity. There are different forms of being religious. An exhaustive analysis of the ways in which people are religions is beyond the scope of this course.

However a brief overview can be helpful. Gordon Allport's now classic distinction between extrinsic religion and intrinsic religion is a useful place to begin. Extrinsic religion often serves as a means to an end. Extrinsic believers are drawn to religion for the benefits it provides. For example attending church may be a way to increase one's prestige or status. It may be a way to make friends to enhance one's business opportunities. It may be a way to find experiences which make one feel good. This type of religious orientation is considered immature, and is sometimes associated with pathology.

On the other hand, intrinsic religion is more mature. It is concerned with a personal quest for meaning, and includes genuine possibilities for transformation. It often includes concern for caring for others. Such persons go to church for worship rather than to improve business prospects. Whether a particular client's religion is intrinsic or extrinsic obviously makes a great deal of difference.

Even among a particular faith such as Christianity, there are widely divergent ways to believe and practice. And in these differences, we find much diversity in how people believe, how they understand and view mental illness, and how we can best serve spiritual needs.

Newton Malony provides a way to understand Protestant diversity. He proposes a typology based on a continuum. Simply put, at one end are fundamentalist Protestants for whom the Bible is the primary authority. Next are evangelical Protestants which value emotional spiritual experiences in their lives. Traditional Protestant churches rely on historical tradition as authority, and liberal Protestants look to rational thinking as a key component in formulating theology. Each of these groups have differing ways of understanding what constitutes mental health. (24) A familiarity with the differences will help the clinician understand the client better.

Beyond different church affiliations, and different theological positions, there are variations in the degree to which religious connections matter in people's lives. Kehoe, in writing about the Catholic perspective, points out that one can be devout, active, practicing, marginal, or disaffiliated. These categories may fluctuate and certainly are applicable not only to Catholics, but to participants in any kind of religion.

So we need to have some idea of what sort of religion our client is connected with as theological and doctrinal views can make a huge difference in how we offer care. We need to understand whether the client is devoutly and deeply religious, or whether religion really doesn't matter all that much. These are important pieces of the puzzle to understand the role of religion in the client's life.

It is important to approach these topics in an open-minded way. Kehoe quotes what she calls a "blatant example of inappropriate generalization" about treating Catholic patients:

*The dynamics of the patient raised in a traditional Catholic mode present a special challenge to the therapist, due to the patient's powerful superego guilt. Thus the Catholic patient can be misunderstood by most therapists. . . . (25)*

Good clinical practice means that we make no such assumptions. We keep an open mind as we seek to explore the role of religion and spirituality in the lives of our clients.

(24) H. Newton Malony "Religion and Mental Health from the Protestant Perspective," in Koenig, 205. Malony considers each of the four types with regard to mental health treatment.

(25) Nancy Clare Kehoe, "Religion and Mental Health from the Catholic Perspective," in Koenig, 214.

## **Lesson: A Closer Look at Religion and Spirituality**

### **Topic: Religion in Mental Health / Mental Illness**

Let's look more closely at the ways in which religion can be connected to mental health, or in some instances, with mental illness. We can, by no means, assume that every person who describes herself as religious is religious in healthy or beneficial ways.

Religion can, in fact, have negative influences in the lives of some people. This connection is illustrated by a story recently in the news. Dr. Harvey Elder of Loma Linda University Medical Center in California was treating a 37 year old woman. The patient had asthma so severe she had suffered two heart attacks. Dr. Elder asked her why she thought she had asthma. "Because I had an abortion," she replied. The physician was shocked, and talked with the woman about God. As he shared his views of God as loving and caring rather than punishing, the woman found that her symptoms abated. (26)

At times the role of religion is detrimental to the well-being of clients. Excessive devotion to religious practices can be harmful. Time spent at church, doing church work, studying Scripture, praying can all become extreme in ways that are harmful to the person, and her relationships with family and others.

Religion can promote rigid thinking or judgmental attitudes. Religious practices such as repetitive prayer can be ways to conceal obsessive or compulsive actions. Unhealthy religious ideas may hide anger or aggression or may promote a self-righteous attitude.

How people experience and understand the deity makes a difference. A client may believe that her illness is God's punishment for her sins. She may tell you that she has confessed her sins over and over and God has not forgiven her. Distortions in how God is understood and experienced can contribute to pathology.

Religious people may resist treatment by refusing conventional treatments with a professional. At times mental illness may be understood as a moral failing. If a person has been taught that depression is really unconfessed sin, he may not be amenable to seeking professional help. In some religious circles, taking medication may be discouraged.

Research is underway to demonstrate the positive, beneficial role religion may play in the lives of

believers. We should be careful not to underestimate the positive ways religion can help clients cope with stressors, deal with suffering, engage in healthy and meaningful relationships, and find ultimate meaning in life. Healthy religion can provide a basis for self-esteem which does not rely on how productive, monied, or attractive one is. Religion can provide a focus outside oneself to lead one to care for others in significant ways.

Western religious worldviews see the universe as friendly, a basic orientation which promotes mental well-being. Reliance on a higher power can provide comfort and strength. Religious people can find hope and meaning even in the midst of suffering, either personal suffering, or the suffering of humankind on general terms. (27)

So as we consider the place of religion in the lives of our clients, we need some familiarity with what sort of religion and how it is practiced. We do our client a serious injustice by making assumptions about her religion and what it means to her. If a client senses a demeaning attitude when she declares herself a Pentecostal, we may lose an important avenue to provide helpful treatment. If we squirm when our client says she is Catholic, or Buddhist, or Wiccan, she will likely sense our distaste. Some of our clients may arrive with a fear that their faith will not be respected in a therapeutic setting.

Good ethical practices says we need to be open to hearing what our client is offering us in her willingness to share with the clinician that sacred landscape of her life. If a client feels her beliefs are not taken seriously she may experience a sense of rejection. We may actually cause harm, which the ethical principle of nonmaleficence compels us to avoid.

(26) Bettye Wells Miller, "Spiritual Healing" The Asheville Citizen-Times, July 10, 2004, C1.

(27) Koenig, McCullough, and Larson, 225-228.

## **Lesson: A Closer Look at Religion and Spirituality**

### **Topic: Spiritual Assessment**

If we "google" spiritual assessment we find nearly half a million responses. There are all kinds of tools readily available for physicians and other health care providers to make spiritual assessments. The particular kind of tool we use is less important than the fact that we make some effort to assess religion or spirituality in the lives of our clients.

Attention to religious practices or spiritual beliefs is an integral part on our initial assessment, as important as other psychosocial factors we are accustomed to thinking about. If we are not currently including a spiritual assessment, we need to think about how best to do so. We may find it feels somewhat awkward and intrusive, however there is evidence that clients very much appreciate being asked.

Dale Matthews suggests four simple questions:

1. Is religious faith an important part of your life?
2. How has your faith influenced your life, past and present?
3. Are you part of a religious or spiritual community?
4. Are there any spiritual needs that you would like me to address? (28)

These questions are non-threatening, and open the way to discussion. It may well be that the client has no interest in exploring spiritual topics, but the assessment will let you know that you need not focus care in that direction.

If you have a client who declares herself religious or spiritual, a simple way to assess something of the nature of her faith is to ask her for three words which describe God. If she says, "powerful", "distant", and "all-knowing", you can surmise that her faith experience is different from the client

who describes God as “loving”, “forgiving”, and “ever-present”. Images of God are powerful indicators of the nature of faith.

Including a spiritual assessment as part of our general assessment is an integral component of good ethical practice.

How do we provide responsible ethical care in treating clients? Basically there are two paths to ethical action regarding spiritual issues. The first is to provide spiritual interventions. This response assumes that we are knowledgeable and equipped to do so. The second approach is appropriate referral.

(28) Harold G. Koenig and John Pritchett, “Religion and Psychotherapy,” in Koenig, 327.

## **Lesson: A Closer Look at Religion and Spirituality**

### **Topic: An Ethical Clinical Response: Spiritual Interventions**

If we are trained and able, we can certainly meet spiritual needs with appropriate spiritual interventions. We should not attempt such practices unless we are well prepared. Under no circumstances is it appropriate to impose our own beliefs on a client. Such a practice violates an important ethical principle, respect for autonomy.

Listening to a client as she describes how her faith has helped her cope can be helpful to her. Validating that experience can promote healthy reliance on spiritual practices.

Possible spiritual interventions may include suggesting or discussing participation in religious services. This may be helpful for someone who has formerly been involved with a faith group, but has not been participating lately. However sending a client to church because church-goers are healthier is akin to telling clients they should get married because married people are healthier. Such a suggestion is inappropriate clinically or ethically.

There are times when encouraging the use of sacred writings may be helpful. For a client familiar with Scripture, who sees the Bible as authority, there may be passages which offer support, encouragement, and hope. For example, people suffering with depression may find comfort in reading the Psalms in Hebrew Scriptures. Many are prayers which are eloquent descriptions of what depression can feel like.

It may be appropriate to encourage a client to participate in a group which teaches or encourages spiritual practices. Twelve-step groups, with their central spiritual emphasis, may be good place for a client to grow spiritually as well as find support.

As there are a number of studies which demonstrate the benefits of meditative practices, it may be appropriate to suggest that a client join a group, or in some fashion, seek to learn about mindfulness, or other meditative practices. Such practices need not be religiously based, but can be taught as a kind of relaxation.

If we determine that our client’s religious practices are unhealthy, and may be contributing to pathology, we can help reframe in religious language so that we can promote healthier ways of seeing, believing, and coping. Discussing images of God may be a helpful practice in therapy.

One of the most powerful, and most controversial, interventions is prayer. Studies purporting to demonstrate the efficacy of prayer are problematic. Actually praying with the client is fraught with potential problems. If a client asks you to pray with her, you may wish to discuss what that means, and how it might be helpful. You may choose to tell the client that she may pray, and you will listen. At times there may be magical thinking concerning the prayer of an authority figure. One must proceed with caution in praying with clients. However, there are times it may be a genuinely

beneficial practice.

It is not appropriate to “prescribe” religion. While studies do support the efficacious effects of religion, simply sending someone to church will likely not achieve the desired beneficial results. Telling someone to go to church will probably lead to an extrinsic practice of religion, and promote very little therapeutic benefit.

There are, then, a number of interventions which may be helpful and can be included in therapeutic treatment. Some clinicians, however, do not feel they are equipped to provide such interventions.

## **Lesson: A Closer Look at Religion and Spirituality**

### **Topic: An Ethical Clinical Response: Referral**

Ethical guidelines remind us to know our limits. If we come upon an area of treatment we are not prepared to handle, we should refer the client appropriately. Referrals to deal religious or spiritual matters can be confined to a session or two to focus on just those issues. The client may continue therapy with the primary clinician. But referral raises more questions. To whom do we send our clients? There are several possibilities.

We may know therapists who are trained and prepared to deal with spiritual issues. It is a simple matter to make such a referral. In some areas there may be former clergy who are trained and credentialed to practice therapy.

There may be times it is best to locate a pastoral counselor. These are highly trained individuals, often with seminary training, and extensive training in mental health. Many pastoral counselors hold doctorates, and are well prepared to handle mental illness as well as spiritual concerns.

There may be occasions it is best to refer to a spiritual director. Spiritual direction has a long history in Christianity, however many Protestants may not be familiar with this practice. Spiritual directors are often clergy (not always) who have been trained to assist persons in their spiritual journey. They serve to assist persons in their quest for the holy. You may want to check training and credentials before you refer. It is important for spiritual directors to know their limits and be willing to refer to therapists when appropriate.

You may refer to clergy. There is certainly a wide variation in training and preparation among clergy to deal with spiritual issues among the mentally ill. Some clergy are not trained or equipped to do serious work in these areas. However, it is worth noting that a large portion of persons experiencing distress go first to see clergy before seeking professional mental health care.

Many clergy are, in fact, trained to assist with caring for the mentally ill. A majority (70%) completed a pastoral care and counseling course in seminary. 57% report completing a supervised clinical pastoral education program. Many (40%) were trained beyond seminary in other areas such as marriage and family counseling. (29)

The clinician may need to inquire among colleagues, or in the faith community, to locate clergy who are appropriately trained, and willing to help. Asking to meet with clergy or getting to know local priests and pastors may provide helpful referral resources. You may be able to work out a mutually beneficial arrangement by offering to provide training to local minister’s groups.

If your client is in an inpatient setting there will likely be a chaplain available. She can be an excellent referral resource to respond to spiritual concerns among clients. You can encourage your client to participate in any available spirituality groups or worship services if appropriate.

There may be occasions we will find it helpful to consult someone knowledgeable about certain denominations or religious practices. If we have a client who is a Latter Day Saint, and we don’t know much about her faith, we can certainly be open to learning.

The key to good ethical practice is to be willing to acknowledge the limits of our own knowledge, level of comfort, and abilities in addressing the spiritual needs of our clients. If we fail to provide a referral at times it is needed, we may be guilty of causing harm (nonmaleficence), or failing to do good (beneficence).

(29) Larry VandeCreek, David Carl, and Duane Parker, "The Role of Nonparish Clergy in the Mental Health System," in Koenig, p. 345

## **Lesson: A Closer Look at Religion and Spirituality**

### **Topic: Case Examples - A**

Let's look at some cases involving spirituality and religion. In these cases we will not pose four possible responses. As there are two appropriate ethical paths (treat, or refer) concerning spiritual concerns, we will simply provide a brief discussion of each situation.

1. A client, a single young man, is struggling with sexual identity. He is in the process of a moving toward acknowledging that he is homosexual. He is a member of a conservative Christian church. He brings his Bible to the therapy session, wanting to discuss passages relating to sexual conduct.

**Comment:** Your response will depend on your knowledge of the Bible, and your level of knowledge about Christian views about sexual identity. You may be familiar with more liberal interpretations of Scripture, as well as more liberal congregations in which the young man can find support. You may well be comfortable examining these passages with him. However, many therapists will not feel they are equipped to handle his concerns about Scripture. In this case, it may be best to refer to a clergy person you know to be competent to discuss these concerns in open-minded ways.

2. Your client is religious, very involved in her church. Her faith is an important and meaningful part of her life. The relationships with her pastor and church family are a significant source of support for her in dealing with her mental illness. The client asks you to begin and end each session with prayer. You are agnostic, and are very uncomfortable with prayer.

**Comment:** Your first response may be to discuss this request with her. You may want to explore why it is important to her, and what it means to her. If you determine it is not an unhealthy request, but simply a reflection of her faith, you may choose to tell her that she may pray aloud, but that you would rather not pray. You may agree to a moment of silence at the beginning and end of your time together. This is an area which health care professionals refer to as a conflict of conscience. Your own autonomy is violated if you feel you must pray when you are not a believer.

3. Your client is referred to you for serious depression. She talks a lot about her spiritual journey and wonders aloud if what she is experiencing is a "dark night of the soul." She resists medication, stating that she believes she needs to go through this dark passage for her spiritual growth.

**Comment:** In spiritual writings through the centuries, believers have often written about what St. John of the Cross calls the "dark night of the soul." Such experiences have been eloquently described by many spiritual writers, including the Psalmist of Hebrew Scripture. There are thoughtful clinicians in mental health who wonder if we may be medicating genuine spiritual experiences, and thus causing potential harm to some clients. The Greek writer Nikos Kazantzakis refers to what he calls a "spiritual abortion." If we have genuine concerns about assessing this client's experience, our best course may be to refer her to a competent spiritual director or clergy person. Assessment in this kind of situation is closely linked to her world view, her faith, and her religious or spiritual practice. Respect for her spiritual journey is a serious ethical concern.

4. A couple come to see you in great distress. Their 26 year old daughter is seriously involved with a young man of another faith. The family is very religious, adherents of a strict religion, and are

concerned for their daughter's welfare. In their beliefs, her eternal future will be imperiled if she converts to another religion. Her family may actually disown her. Family conflict has become intense.

**Comment:** Your best response in this case will rely on your skills in treating troubled families. The family conflict is a primary problem, and while your knowledge of the religious issues involved will certainly be helpful, good care does not necessarily demand that you involve clergy. Your primary focus will likely need to be caring for the family. It may be helpful to learn more about the religion involved if you feel you don't fully understand the concerns of the family.

5. Your client is seriously depressed. Prior to the onset of her illness she had been a faithful member of her congregation. Now she tells you she feels that God has abandoned her, that when she reads Scripture she might as well be reading the telephone book, and her prayers feel empty and unanswered.

**Comment:** Depressed patients who have known a meaningful spiritual life prior to illness often experience these feelings. You may talk with her about these feelings of spiritual despair as part of her illness which will improve as treatment helps her depression. In the meantime, you may simply validate her feelings, encourage her to explore other ways to care for herself spiritually (mindfulness, reading other spiritual writings, etc.) These feelings may persist for a while, but if her concern continues to occupy much of her energy, you may decide refer her to another professional, perhaps a competent spiritual director.

6. You live in a small town. After several weeks of therapy a client has decided he would benefit from attending church as he has allowed his spirituality to lapse. He learns what church you attend. He begins to attend your church, and then inquires what Bible study class you attend.

**Comment:** Once again, the dual relationships and boundary issues of small town life come into play. While this client continues in therapy you may need to have a frank discussion about boundaries and your concerns about his attending your study class. You may refer him to another church, particularly if your church is very small. You need not sacrifice attention to his spiritual concerns even if you and he decide another church would be best for him.

## **Lesson: A Closer Look at Religion and Spirituality**

### **Topic: Case Examples - B**

7. A young man whose wife has just died of cancer comes to you for grief counseling. He has two small children, and is overwhelmed by his loss and the responsibilities of raising his children. In your first session with him he asks, over and over, "Why is God doing this to me?"

**Comment:** Most likely this man doesn't actually expect you to provide a lengthy or complicated theological response. His question is existential (though he may not call it that) and his needs are immense. If the theological questions, which are important and valid, continue, you may want to refer him to a clergy person, chaplain, or pastoral counselor. You may certainly continue to provide grief counseling.

8. A client arrives with a magazine article about depression and religion. The article, in a popular magazine, cites a number of studies which show that religious people are less likely to suffer depression. She asks you what religion she should join so that she can get better.

**Comment:** You may wonder that this woman is more serious about feeling better than she is about becoming religious. "Prescribing" a faith group will not likely provide much relief. Good practice suggests a careful discussion of her attitudes about this issue, and your best clinical judgment. Certainly you can tell her that she may want to visit several churches, and explore for

herself where she might find spiritual nurture. But you may want to be clear that attending religious services won't cure her depression.

9. A clergyman has been referred to you by denominational leaders for counseling. Some church leaders have raised questions about behavior which appeared "odd". He discloses to you that he feels terrible about it, but he has been molesting young boys on youth trips.

**Comment:** His behavior is unacceptable, and he has broken the law. You must report this abuse to the appropriate authorities. If there are spiritual concerns which need your attention, you may be able to be helpful and supportive. But the first ethical mandate is the legal requirement to report.

10. A middle-aged woman comes to you for help. In your initial interview with her she reveals that she had an abortion when she was a teenager. She states that she does not believe God can ever forgive her.

**Comment:** Your assessment will help determine what is going on. She may benefit from a referral to someone who can help her with theological issues and her image of God. If her negative views of God are part of the problem, a clergy person may be helpful. Forgiveness has a significant spiritual dimension. Forgiveness may be one of the primary areas you can help her with therapeutically. Often people say God hasn't forgiven them, when in fact the real issue is forgiving oneself. This client may best be served by your clinical help as well as the guidance of a competent clergy person.

11. A middle aged couple come to you. They are very worried about their 22 year old daughter. They tell you that she has joined that strange new religious group, and they believe it is a cult. They want you to see her for treatment.

**Comment:** Joining a new religion, even a cult, is not a reason to offer psychotherapy. You may want to learn something about the new group. But unless the daughter has been coerced or is having problems with the new group, there is no reason for her to come to you. Her parents' distress, however, needs your attention. There may be family issues involved which you can help with.

12. A new client comes for her first appointment. Her first words are, "Are you a Christian therapist?"

**Comment:** There is a "Christian psychiatry" movement, and many clients prefer to see clinicians who practice using specific Christian principles and methods. It can be an appropriate choice as long as the clinician as well as the client are fully informed and understand the premise of the therapeutic relationship. The client may be asking if you are part of that movement. However she may be inquiring in more general terms. Before answering the question directly, you may want to explore what her question means, and her concerns about your own faith, or lack thereof. If it becomes clear that she will have a difficult time being comfortable with you if you are a non-believer, or an adherent of another religion, it may be best to refer.

## **Lesson: A Closer Look at Religion and Spirituality**

### **Topic: Summary and Conclusions**

*Seeking for the Divine. . . has been a major aspiration and force in all cultures and periods of history, yet it has been virtually ignored by traditional psychology. . . Regular people with ordinary problems who are also on a spiritual path. . . are looking for therapists who will honor their seeking for something sacred and who can respect their whole being—in its psychological and spiritual fullness— rather than belittling or minimizing their spiritual seeking, as much of traditional psychotherapy has historically done.*

*-Cortright (30)*

Good practice guidelines, as well as professional codes of ethics, tell us that we are to do our best to care for our clients, seeking to meet their needs in the best possible way to promote good outcomes.

Ethically, we are bound to address the issue of religion and spirituality in some fashion. If we fail to take into account the role of religion and spirituality in the lives of our clients, we fail to meet this ethical mandate. Therefore we need to become aware of the importance of religion and spirituality in human well being. We need to become knowledgeable about religion and spirituality and the ways it can inhibit or promote good mental health. We need to become prepared and able to assess clients regarding religion and spirituality.

We need, furthermore, to be prepared to respond in appropriate ethical ways. Failing to attend to the sacred landscape of our clients is an ethical failing. We need to be able to respond, or able to make appropriate referrals when our clients need or ask for help with spiritual concerns.

To do less is to practice in less than ethical ways.

(30) Quoted in William R. Miller and Carl E Thoresen, "Spirituality and Health" in *Integrating Spirituality into Treatment* ed. William R. Miller (Washington DC: American Psychological Association, 1999) 3.

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