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# Ethics and Culture in Mental Health Care

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This article examines the complex relationship between culture, values, and ethics in mental health care. Cultural competence is a practical, concrete demonstration of the ethical principles of *respect for persons*, *beneficence* (doing good), *nonmaleficence* (not doing harm), and *justice* (treating people fairly)—the cornerstones of modern ethical codes for the health professions. Five clinical cases are presented to illustrate the range of ethical issues faced by mental health clinicians working in a multicultural environment, including issues of therapeutic boundaries, diagnosis, treatment choice, confidentiality and informed consent, and the just distribution of limited health care resources.

Keywords: culture, ethics, mental health

In mental health care, ethics and culture are intimately intertwined. To practice ethically requires awareness, sensitivity, and empathy for the patient as an individual, including his or her cultural values and beliefs. The culturally nuanced practice of medicine facilitates wider access to care, a more welcoming “patient experience,” and more effective health care delivery, thus advancing the overarching goal of delivering more of the benefits of mental health care to greater numbers of people. In this way, cultural competence is a practical, concrete demonstration of the ethical principles of *respect for persons*, *beneficence* (doing good), *nonmal-*

efficence (not doing harm), and *justice* (treating people fairly)—the cornerstones of modern biomedical ethics.

As theoretical concepts, “ethics” and “culture” are also intertwined. Ethical principles are an expression of moral ideals and values, which are a product of human culture. Because values are culturally mediated, clinicians’ deliberations when faced with ethically challenging clinical situations are thus to some degree a product of their own personal cultural development and cultural heritage and may reflect values not shared by their patients. In addition to their personal cultural heritage, mental health professionals are also immersed in the “health care culture,” the traditions and attitudes that pervade contemporary mental health practice (Tseng, 2004). This culture also plays an important role in shaping a clinician’s ethical values, and it is to some degree foreign to many patients.

This article is an introduction to the complex relationship between culture, values, and ethics in mental health care. After briefly describing the concepts of multiculturalism, cultural competence, and ethical theory, we present five clinical cases to illustrate the range of ethical issues faced by mental health clinicians working in a multicultural environment, including issues of therapeutic boundaries, diagnosis, treatment choice, confidentiality and informed consent, and the just distribution of limited health care resources. Although this is far from an exhaustive survey of the myriad ethical issues that arise in the mental health treatment of diverse populations, it should provide the reader with an appreciation of their ethical complexities, challenges, and opportunities.

## MULTICULTURALISM AND CULTURAL COMPETENCE IN MENTAL HEALTH CARE

Culture encompasses the symbols and conventions human beings construct to understand and interact in the world, and cultural variety thus lends extraordinary plasticity and diversity to human behavior (Barrett, 1984). North America is already culturally and ethnically diverse, and current demographic trends (together with more immigration) are likely to bring about even greater diversity in the future (Kavanagh, 1999). By the middle of the 21st century, the majority of U.S. citizens will be of Hispanic, African, Asian, or Arabic descent, not White European (Henry, 1990). Moreover, although the first Industrial Revolution involved only one third of the world’s population, the new economic-industrial revolution is global in its scope, and the combined economic output of the world’s emerging economies (India, China, and others) already accounts for more than half of the world’s gross domestic product (“The New Titans,” 2006). In a globalized economy, markets, people, and the world’s cultures come together as never before.

In such an environment, cross-cultural health care, particularly in psychiatry and psychology, can no longer be relegated to “exotic” status, limited to knowledge of culture-bound syndromes such as Koro (fear that one’s genitals are shrink-

ing), Amok (a dissociative experience of rage and attacking others), or Susto (“fright sickness”). These are curiosities in cultural anthropology, not very relevant to everyday clinical practice. Cultural competence in the modern mental health care environment requires far more knowledge and sophistication on the part of the professional. In the near future, with an ever-increasing movement of people around the globe, a U.S. clinician who speaks with her patients in terms of inches, pounds, or degrees Fahrenheit may one day find that she is not communicating effectively with many of those patients. Similarly, in North America, the Western dualistic conception of the self as separate body and mind—accompanied by the “psychologization” of mental illness—may one day become less prevalent than so-called somatization. Moreover, because cultures are dynamic, major shifts can and do occur in a society’s values and attitudes toward the varieties of human behavior—witness the relatively rapid and ongoing evolution of substance abuse in the United States from sin, to crime, to treatable illness (Kleinman, 1988).

Accordingly, the notion of “cultural competence” in clinical practice is increasingly recognized as a key component of medical professionalism. Guidelines of the Accreditation Council for Graduate Medical Education (Accreditation Council for Graduate Medical Education Outcomes Project, 1999), the American Psychological Association (2002, 2003), and the National Association of Social Workers (1999) all include sensitivity to cultural issues as important features of professional behavior and practice. Among the various definitions of cultural competence, Tseng and Streltzer’s (2004) is comprehensive in its scope and particularly appropriate for the mental health setting because of its attention to the impact of cultural issues in psychotherapy. According to this definition, cultural competence is demonstrated by the attainment of three qualities and their use in the service of therapeutic goals. The first quality is *cultural sensitivity*, an awareness and appreciation of human cultural diversity. The second quality is *cultural knowledge*, the factual understanding of basic anthropological knowledge about cultural variation. Cultural knowledge can be obtained through reading, consultation with experts, or meaningful interactions with individuals of diverse backgrounds. The third quality is *cultural empathy*, the ability to connect emotionally with the patient’s cultural perspective. To achieve cultural competence, a clinician uses these three qualities therapeutically by being aware of how cultural issues affect the therapeutic role and relationships, including transference and countertransference. The culturally competent clinician is also able to provide what Tseng and Streltzer termed *cultural guidance*, by assessing whether and how a patient’s problems are related to cultural factors and suggesting therapeutic interventions that are based on cultural insight.

## BIOETHICS AND ITS CULTURAL UNDERPINNINGS

The conceptual framework for Western bioethics was founded primarily on two contrasting philosophical theories: *Kantianism* and *Utilitarianism*. The work of

the Prussian philosopher Immanuel Kant (1724–1804) is the basis for Kantianism. Kantianism, also known as deontological or duty-based ethics, posits that the rightness or wrongness of an action is not based on the consequences resulting from that action but rather the duty, obligation, and intention of the actor. According to this doctrine, some behaviors, such as telling the truth, are viewed as morally obligatory in almost all circumstances. The writings of the British philosophers David Hume (1711–1776), Jeremy Bentham (1748–1832), and John Stewart Mill (1806–1873) provide the intellectual foundation for Utilitarianism, which proposes that the overriding ethical goal is to maximize happiness, pleasure, or well-being (“utility”). Utilitarianism emphasizes the importance of the consequences of one’s actions and the need to bring about the greatest possible good for the greatest number as a guiding moral value.

*Principle-based ethics* is a contemporary theoretical framework for moral judgment and decision making that is widely used in modern bioethics. As described by the American ethicists Thomas Beauchamp and James Childress (2001), principle-based ethics involves identifying and balancing the conflicting moral principles that create ethical dilemmas. These principles emerged from “considered judgments” in the common morality and medical tradition. According to this framework, the most important ethical principles are nonmaleficence, beneficence, respect for autonomy, and justice. Additional, but less elemental, principles in contemporary bioethics include *veracity*, or truth telling; *fidelity*, or faithfulness to the role of healer; and *confidentiality*, the guarding of patients’ privacy (Beauchamp & Childress 2001). These moral principles have been translated into the aspirational principles of many professional practice codes related to mental health care, including those of the American Medical Association (2006) and the American Psychological Association (2002).

Many of the cultural customs that give rise to these ethics principles are standards for interpersonal behavior that most cultures would endorse (Gbadegesin, 1998). Beneficence and nonmaleficence are based on values shared by people from diverse cultures. One of the tenets of the Eastern philosophy of Confucianism, for example, is benevolence in the treatment of others (Norton, 1999). However, the concept of “doing good” may have a more particular meaning in Western society, where there is also a deeply held belief in the malleability of the future and the importance of acting rather than simply being (Bossman, 2000; White, 2000). In a culture characterized by a passive acceptance of the way things are, assertive action to do good may be less highly prized.

Of all the principles elucidated by Beauchamp and Childress, *respect for autonomy* may be most clearly tied to Western cultural values, and particularly the value placed on human beings as individuals rather than members of a group (Bossman, 2000; Fan, 1997; Kitchener, 2000; White, 2000). In societies such as the United States, the individual is viewed as unique, independent, active, and in charge of his or her own destiny (Bossman, 2000; Gbadegesin, 1998; White, 2000). Self-awareness, self-determination, self-actualization, and self-improvement are thus impor-

tant goals (Landrine, 1992). The Western medical culture also prizes individualism as one of its core values (Tseng, 2004). In other societies, including Mediterranean-European ones, the notion of respect for autonomy may be discordant with the value placed on family and community (Gbadegesin, 1998).

It is important to acknowledge the wide range of intracultural variation within the Western cultural group. For example, differences in ethnicity, religion, gender, and class influence individuals within a particular culture. Non-Whites and women may be less vested in the individualist stance and see life more in terms of group or family membership (Hall & Barongan, 2002). Feminist and other alternative philosophical approaches to the study of bioethics have been described, and some may be more congruent with the cultural values of non-Whites and women. For example, *communitarian ethics* defines morality based on social ideals and traditions (Etzioni, 1993). *Relationship ethics* or *ethics of care* views commitments and relationships to others as the basis of ethical life (Gilligan, 1982).

Contemporary bioethics also demonstrates its ties to Western culture through the subject of its empirical and conceptual research (Gbadegesin, 1998). Much ethics scholarship in the past 20 years has focused on the use of emerging technologies in the health care setting—including the appropriate use of life-support technologies, organ transplantation, assisted reproduction, and genetic engineering. Because these technologies are financially out of reach for a sizeable portion of the world's population, research in these areas is currently irrelevant for many. More pressing, though far less thoroughly researched, ethical issues worldwide concern justice in access to basic forms of health care, such as immunization, primary care, and sanitation (Gbadegesin, 1998).

## ETHICAL CHALLENGES AND OPPORTUNITIES IN TREATING DIVERSE PATIENTS

In mental health treatment, ethical dilemmas may arise because of differences between a clinician's personal values and beliefs and those of the patient, even when both individuals have the same cultural heritage. Patients and clinicians often differ in the meaning they attach to psychiatric diagnoses, for example, and in their beliefs about the utility of psychotropic medication and/or psychotherapy. These differences are seemingly amplified and extended when the doctor-patient relationship occurs within a cross-cultural setting. The following five clinical scenarios describe situations in which the interplay of culture and ethics create dilemmas and opportunities for the clinician. Discussions after each case highlight general strategies that can be applied to other ethical/cultural dilemmas.

### Case 1: Maintaining Therapeutic Boundaries

A White male psychology intern was called to a hospital emergency room to talk with Ms. K., who was contemplating suicide. During the intern's evaluation,

he learned that Ms. K., an attractive woman who had recently emigrated from Japan, was despondent over the unexpected death of her father. The intern provided support and empathy and recommended that Ms. K. be admitted to the inpatient psychiatry unit for observation. The intern continued to work with Ms. K. after admission, and a strong therapeutic alliance began to form. The intern had little knowledge of or experience with Japanese culture, but this did not seem to hinder the treatment.

On the day of her discharge from the hospital, Ms. K. presented the intern with a beautifully wrapped box, which when opened revealed a pair of jeweled cufflinks. They had belonged to her father, she said. The intern gave Ms. K. his heartfelt thanks for the gift but said he would not be able to accept it. She urged him several times to take the gift, but he continued to refuse. The intern was surprised to see how hurt the patient appeared when she finally realized he was not going to take the gift. He wondered if he was violating a cultural norm. However, he believed it would be a boundary violation to accept the gift, which clearly had more than a nominal monetary and personal value. Furthermore, the intern planned to continue treating Ms. K. after her discharge, and he did not want his acceptance of the valuable gift to complicate their ongoing therapeutic relationship. Ms. K. fell silent despite the intern's attempts to talk with her about the meaning of the gift. She packed the cufflinks in her belongings and left the hospital. She did not show up for her follow-up therapy appointment, and the intern's attempts to contact her failed.

*Discussion.* Accepting expensive gifts from patients is generally considered a violation of therapeutic boundaries. Boundary violations are among the more well-described ethical issues in the psychology literature, especially for clinicians who practice psychodynamic psychotherapy and psychoanalysis (Epstein, 1994; Gabbard & Lester, 1995; Gutheil & Gabbard, 1993; Simon, 1992). Since the 1970s, ethical guidelines and legal prohibitions regarding sexual or romantic boundary violations between therapists and patients have been strengthened (Epstein, 1994). Other types of violations include employing patients to provide labor such as housekeeping. Such situations exploit or threaten to exploit patients for the clinician's personal gain. Because dependency and transference feelings diminish patients' ability to choose freely whether to engage in these activities, clinicians bear the sole responsibility of maintaining boundaries even in the face of provocative behavior on the part of the patient (Epstein & Simon, 1990; Galletly, 2004; Gutheil & Gabbard, 1993; Simon, 1992).

In treating a patient from any culture, exploitation of the patient for the clinician's sexual or financial gain is clearly an ethical (and legal) wrong. The ethical waters start to become murky in cross-cultural treatment when receiving gifts from patients and accepting barter for professional services. Although there is no language specific to gifts in the ethics code of the American Psychological Association, many psychologists make it a practice never to accept gifts (Bailey, 2004).

The American Psychiatric Association Ethics Committee has stated that it is unethical to accept large financial gifts from patients, even if unsolicited, because doing so would tend to exploit and contaminate the treatment relationship (American Psychiatric Association, 2001). On the other hand, some clinicians believe it is ethically and clinically justified to accept gifts of small value from patients at the end of treatment, or from patients with severe and persistent mental illness who are paying little or nothing for their care (Simon, 1992), on the belief that rejecting the gift causes more harm than good. In a similar fashion, it could be argued that accepting gifts from a patient whose culture highly values this type of exchange may be less damaging to the treatment relationship than rejecting the gift. Agreeing to a barter arrangement might also represent the lesser of two evils in treating patients from certain traditional cultures.

Should professional ethics therefore be modified when treating patients from a culture in which gift giving has a different meaning than in Western culture? One argument against loosening ethical standards is that patients from all cultures deserve the protection that these guidelines provide. For example, Epstein (1994) suggested that accepting a gift rather than dealing with the embarrassment or shame that its refusal may cause will signal to the patient that some emotions are off-limits in therapy. Although culturally competent professionals take context into account, unfortunately there is a lack of empirical research examining how gift acceptance and gift refusal affect treatment in culturally diverse patients.

A second argument against loosening ethical standards in these matters is that minor boundary violations appear to be precursors to more serious ones, according to retrospective analyses of clinical settings in which patients were sexually exploited (Gabbard, 1999). Clinicians who had sex with patients usually violated other types of boundaries first. There may also be a “slippery slope” for boundary violations in cross-cultural psychiatry. If clinicians believe that it is acceptable to discard their normal ethical inhibitions about receiving gifts from patients with certain cultural backgrounds, will it then seem acceptable when treating these patients to relax other ethical prohibitions?

In Case 1, the intern appears to be an empathetic psychologist who was caught between his ethical obligation to maintain professional boundaries regarding receiving gifts and his sensitivity to Ms. K.’s feelings about his rejection of the gift. Because Ms. K. abandoned treatment, it might initially appear that the intern handled the situation incorrectly. However, because the gift was expensive, accepting it unconditionally would have clearly run afoul of standard ethical practice. The intern was justified in thinking that abandoning the usual rules regarding boundaries could complicate the future treatment of this attractive woman—from his perspective if not from hers.

Had the intern realized the cultural importance of gift giving for the patient, he might have been able to treat the matter with more finesse. The best option would have been to be culturally astute enough to anticipate the offering of a gift and ex-

plain to the patient ahead of time that he could not accept gifts or could accept them only if they were of nominal value. Failing that, the intern might have accepted the gift provisionally, explaining the reason for his reluctance to the patient. The intern could thus have “bought time,” which could be used to consult with a knowledgeable supervisor or colleague before deciding whether to return the gift, and if so, how to engage the patient in a helpful dialog about the personal and cultural meanings of the gift and the act of giving. In adopting a neutral and nonjudgmental stance with regards to the gift, the intern would not have missed the opportunity to explore with his patient the stressful issues related to her recent immigration, and negotiating two very different cultures, in a sensitive and culturally competent manner.

### Case 2: Ethical Issues in Diagnosis

A White male psychiatrist who trained in an urban setting accepted a job working for the Public Health Service in the U.S. Southwest. He immediately began learning about Native American culture by reading books and talking with patients about their values and beliefs. After 6 busy months on the job, the psychiatrist was asked by a primary care colleague to evaluate Mr. R., a young Navajo man who reported apparent visual hallucinations. During the psychiatric evaluation, Mr. R. related that for the past 6 months, his deceased father had been appearing before him in “visions” that occurred several times a week. Mr. R. found these experiences comforting, but he felt they were unusual enough to mention to his doctor.

The psychiatrist was moved by the young man’s story. The doctor’s psychiatric training had taught him to create a wide differential diagnosis, which in this case included major depressive disorder with psychotic features, schizophrenia, and psychosis caused by substance use or a general medical condition. He did not dwell on these possibilities or mention them to Mr. R. He felt that to do so would pathologize a phenomenon that his Native American studies had led him to view as a culturally congruent expression of hope and connection to the dead. He was also aware that in Navajo culture, speaking openly of negative things, such as the possible diagnosis of major mental illness, would likely be culturally inappropriate. For both reasons, he felt comfortable giving Mr. R. reassurance that the visions were harmless and sending him on his way.

Six months later, the referring physician mentioned that he had hospitalized Mr. R. after the man had a series of seizures. An MRI scan revealed a parietal-lobe brain tumor, which was most likely responsible for the “visions” as well as the seizures, and was now threatening his life.

*Discussion.* Mental health practitioners have an ethical duty to provide competent care, based on the principles of beneficence and nonmaleficence. For physicians, competent care includes diagnosis as well as treatment of illness. Interest-

ingly, as a field of study, bioethics has paid relatively little attention to the moral questions involving diagnosis (Fulford & Bloch, 2003). An exception is in psychiatry, where the interplay between culture, values, and conceptions of disease is especially complex. Indeed, one of the most bitter and most enduring controversies in the field of mental health concerns the morality of psychiatric diagnosis. Szasz (1960) and other members of the so-called anti-psychiatry movement believe that it is unethical to label as a disease any condition that primarily involves the mind, on the grounds that doing so falsely relieves the individual and/or society from responsibility for the condition. On the other hand, mainstream psychiatry and patient advocacy groups see medical diagnoses as accurately reflecting the biological as well as social and psychological influences on mental disorders (Surgeon General of the United States, 1999).

The anti-psychiatry controversy highlights the fact that diagnosing a patient with a mental disorder can be a powerful act of beneficence or maleficence, and one that carries social repercussions (Corrigan & Watson, 2004; Witztum, Margolin, Bar-On, & Levy, 1992). Once diagnosed, an individual becomes eligible for treatment and other services and may be relieved of responsibility for the negative behavioral effects of the illness. The label of insanity may legally absolve an individual of guilt for committing a crime, whereas the diagnosis of major depressive disorder may temporarily excuse a person's inability to hold down a job or meet other social expectations. A psychiatric diagnosis can also be seen as a negative label that dispirits patients and leads to social stigmatization and ostracism (Goffman, 1963; Link, Cullen, Struening, Shrout, & Dohrenwend, 1989). In extreme cases, diagnosis has been used as a state weapon, as was demonstrated in the Soviet Union, where psychiatrists diagnosed political dissidents as suffering from "mental disorders" that led to imprisonment in the form of involuntary hospitalization (Bloch & Reddaway 1984). Similar accusations of psychiatric abuse have recently been made in China (Kahn, 2006).

Cultural issues add another layer of complexity to the ethics of psychiatric diagnosis. In the parlance of medical anthropology, a *disease* is used to describe a condition that is conceptualized and diagnosed by a physician, whereas *illness* refers to the patient's perception of his or her condition (Dyer, 1988; Leighton, 1982; Tseng, 2004). Both the clinician's concepts of disease and the patient's concepts of illness are influenced by their cultural heritage and, in the clinician's case, by the culture and theoretical orientation of his or her training (Tseng, 2004). A cultural mismatch between patient and clinician thus may contribute to a missed diagnosis or overdiagnosis. On one hand, a patient may present a culture-specific syndrome that causes great distress but for which there is no standard Western conceptualization the clinician can use to formulate a diagnosis (Kirmayer & Jarvis, 2006). On the other hand, standard *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR, APA, 2000) diagnostic criteria involving judgments about the quality of a person's emotions, thoughts, and functional status may contain inherent

value judgments that do not pertain to all patients of diverse cultures (Fulford & Bloch, 2003).

Case 2 involves a clinician who perceived himself as having abundant empathy regarding his patient's cultural heritage, including the potentially adverse consequences of psychiatric diagnosis. But the outcome of the case demonstrates how the clinician's perceptions about the negative effects of diagnosing the patient with a mental disorder overrode his ethical duty to provide competent care. Ideally, a timely psychiatric workup would have suggested brain pathology, and the tumor might have been detected when it was smaller and at a more treatable stage. The psychiatrist's reverent, romanticized view of Navajo culture constitutes a cultural stereotype and does not reflect true cultural knowledge. The psychiatrist overlooked the fact that both the patient and his primary care doctor felt the symptoms merited an evaluation—an important clue that the visions might not be culturally congruent. This case illustrates how inadequate cultural knowledge can lead to stereotyping and substandard treatment, just as overt racism does (Leighton, 1982). If Mr. R. had not been Navajo, the psychiatrist would probably not have abandoned his standard mode of working up new-onset psychosis.

Cultural sensitivity—including self-awareness regarding possible biases, stereotypes, and limits to our understanding of the Other—avoids arrogance and enhances clinical competence in cross-cultural encounters. In this case, the psychiatrist could have paused, deferred making any diagnosis, but begun a medical and psychiatric workup “just in case.” He might have consulted with a colleague with more experience in treating Navajo individuals to determine how culturally congruent the patient's symptoms were and how best to communicate negative news about diagnosis without violating cultural norms. At a minimum, the psychiatrist should have scheduled a follow-up appointment to see whether the patient's symptoms had progressed or were causing more distress over time.

### Case 3: Ethical Issues in Treatment Choice

Mr. L., a young man who had recently immigrated to North America from China to begin graduate school, was referred to a female psychiatrist for pharmacotherapy and individual psychotherapy. Mr. L. had sought medical attention after suffering numerous somatic complaints, including back pain, fatigue, and constipation. A thorough medical assessment had suggested that a depressive syndrome was most likely the cause of these complaints. The psychiatrist prescribed an antidepressant medication and began weekly supportive therapy. Despite some initial communication difficulties, a therapeutic alliance was quickly formed.

After a few weeks of treatment, Mr. L. told the psychiatrist he had sought the advice of an herbalist recommended by another Chinese student. He had begun taking a mixture of herbs, the names of which he provided the psychiatrist. She was unfamiliar with the herbs and was surprised by her patient's decision to see an-

other practitioner. After the session, the psychiatrist began to feel uneasy about being engaged in a form of “split treatment” with an unknown herbalist whose methods and competence she knew nothing about. She also worried about the legal responsibility she would bear if Mr. L. had an adverse event from taking the herbal concoction along with the medication she had prescribed.

At the next appointment, the psychiatrist strongly urged Mr. L. to stop taking the herbal remedies. He seemed perplexed but agreed to follow her recommendation. Over the next few weeks, he began to miss appointments, however, and eventually dropped out of treatment.

*Discussion.* In Western medicine, the standard treatments for major depression are multimodal, encompassing pharmacotherapy, individual psychotherapy, and/or psychoeducation. A growing body of scientific evidence supports these treatments as beneficial and provides empirical guidance to enable clinicians to fulfill their ethical duty of providing competent care. Historically, the use of native and traditional remedies has been considered unethical, based on the belief that these treatments were unproven and unprofessional (Cohen, Kemper, Stevens, Hashimoto, & Gilmour, 2005). However, as medicine has become more culturally pluralistic, a more complex view of the ethics of using traditional medicines has developed. In its report on complementary and alternative medical therapies (CAM), for example, the Institute of Medicine (2005) at the National Academy of Sciences defined the ethical principle of nonmaleficence to include “respecting divergent cultural beliefs; creating an emotionally safe environment for the discussion of CAM; and appreciating how CAM may fit into a patient’s larger social, familial, or spiritual life” (p. 169).

Adams, Cohen, Eisenberg, and Jonsen’s (2002) ethical framework for evaluating traditional medicine recommends that clinicians take seven factors into account when analyzing the risks and benefits of a complementary or alternative treatment:

1. Severity and acuteness of illness.
2. Curability with conventional treatment.
3. Invasiveness, toxicities, and side effects of conventional treatment.
4. Quality of evidence of safety and efficacy of the complementary or alternative treatment.
5. Degree of understanding of the risks and benefits of the complementary or alternative treatment.
6. Knowledge and voluntary acceptance of those risks by the patient.
7. Persistence of the patient’s intention to use complementary or alternative treatment.

According to this framework, if scientific evidence suggests that an alternative or complementary treatment is safe and efficacious, physicians are on solid legal

and ethical ground to support patients' decisions to use the remedy. On the other hand, if medical evidence is clear that the treatment is unsafe or ineffective, clinicians have a duty to inform patients of this and recommend against the treatment. In the gray zone, where evidence is lacking regarding safety and/or efficacy, clinicians should safeguard patient well-being to the best of their ability. This can be accomplished by informing patients of the lack of data and by monitoring for adverse effects (Cohen et al., 2005). In all scenarios, clinicians should take into account the strength of the patients' desire to use the alternative and complementary treatment. In doing so, clinicians demonstrate respect for the patients' preferences and for the practice of shared decision making (Adams et al., 2002; Cohen et al., 2005; Institute of Medicine, 2005). The emerging ethical ideal is thus for care that is simultaneously scientifically competent and supportive of the patient's traditional concepts of healing (Adams et al., 2002; Cohen et al., 2005; Ernst, Cohen, & Stone, 2004; Institute of Medicine, 2005).

In Case 3, the psychiatrist lacked knowledge of the patient's cultural practices and sensitivity to the cultural differences between herself and her patient. These shortcomings, added to the psychiatrist's own anxieties about liability issues, prevented her from being empathetic with Mr. L.'s desire to use herbal medicines. A traditional treatment could have tremendous psychic importance for a young man attempting to deal simultaneously with culture shock, separation from friends and family, the demands of graduate school, and a depressive syndrome.

A more culturally competent clinician would have responded more empathetically and would have taken steps to educate herself about the particular herbal medicines the patient was using. This could be accomplished by searching the growing scientific literature on complementary and alternative medicines and/or by consulting with a knowledgeable colleague (Adams et al., 2002; Ulbricht, Basch, Weissner & Hackman, 2006). Once the psychiatrist had a better understanding of the data regarding the herbs' safety, efficacy, and potential for drug interactions, she would have been able to inform her patient about the risks and benefits of the herbal medicines and make a recommendation based on scientific evidence. The patient should have also continued to receive supportive therapy and antidepressant treatment. In this way, the clinician would adhere to professional standards of care, provide her patient with appropriate safeguards, and demonstrate a respect for the patient that would likely deepen the therapeutic alliance.

#### Case 4: Confidentiality and Informed Consent

A White female psychologist was referred Mr. S., a young man from a traditional East Indian family who had been diagnosed with dysthymia. The psychologist proposed weekly psychodynamic psychotherapy, and the patient agreed. Mr. S. was somewhat guarded at first, but by the third session he felt comfortable enough to tell the psychologist that he was gay. He appeared greatly relieved by the psycholo-

gist's nonjudgmental response and used the next several sessions to talk about his sexual orientation and his anxiety about its being discovered by his extended family, with whom he lived.

After several weeks of treatment, the psychologist received a phone call from Mr. S.'s mother, who requested a copy of her son's therapy notes. The psychologist explained that she was unable to talk about her patients, much less release their records, without the patients' permission. When the clinician discussed this privately with Mr. S., she was astounded to learn that the young man felt his mother had a right to see the therapy notes. The psychologist had written moderately detailed notes, many of which mentioned the patient's homosexuality and his covert hostility toward his parents. She showed a sample note to Mr. S., explained that he had the right to keep his records private, and suggested that she prepare a treatment summary for the mother that omitted the detail of the therapy notes. Mr. S. agreed that it would be personally devastating to have his sexual orientation revealed at this time, but he also felt that denying his mother's request to see the entirety of the notes was simply not an option. He signed a consent form allowing the release of information to his mother.

The psychologist consulted with several colleagues before taking any action. She felt that releasing the notes would be damaging to the patient and that he was agreeing to the release only because of his enmeshment with his family. Her colleagues pointed out that what she called "enmeshment" was most likely culturally sanctioned and therefore deserved her respect.

After carefully weighing the suggestions of her colleagues, the psychologist decided that she could not ethically release the notes. She offered to provide a specially prepared treatment summary but explained to the patient that she would not release the therapy notes because she felt that the potential harm outweighed the benefit. Mr. S. appeared relieved, and a treatment summary was sent to the mother. Over the following weeks, however, Mr. S.'s mother began pressuring him to drop out of therapy. Eventually, he asked for a referral to another therapist; the psychologist, believing the situation had become untenable for the patient, complied.

*Discussion.* Confidentiality has been a tradition of Western medicine at least since Hippocrates' time. The ethical principles of nonmaleficence and respect for persons support the practice of keeping confidences. In mainstream Western culture, the belief that patient–therapist interactions will be kept private encourages individuals to seek treatment and to discuss intensely personal, often shameful matters, which can then be addressed therapeutically. Clinicians are ethically and legally responsible for maintaining the confidentiality of information about their patients—including the fact that particular individuals are mental health patients—except under limited circumstances. In the United States, clinicians are permitted to reveal health care information without patient consent only in situations of danger to others—suspected child abuse, elder abuse, or when a patient

poses a significant threat to a third party (Smith-Bell & Winslade, 1994). Clinicians may also reveal confidential information when the patients request the release of medical information to a third party such as an insurance company or consultant.

The importance of confidentiality in Western medicine is a reflection of the cultural values emphasizing respect for the individual (Beauchamp & Childress, 2001; Fan, 1997; Meer & VandeCreek, 2002). Patients from a Euro-American cultural tradition are likely to highly prize confidentiality in medical care and avoid treatment if they do not believe it will be private (Sankar, Mora, Merz, & Jones, 2003). In a culture in which the individual is less important than the family or larger group, a premium would not be placed on the privacy of the individual patient, though the privacy of the family or group might be highly prized (Meer & VandeCreek, 2002; Tseng, 2004).

Case 4 also involves the issue of informed consent, another cornerstone of ethical practice in Western medicine. Far from being merely the signing of a consent document, informed consent is ideally an ongoing process of information sharing between clinician and patient that depends upon three elements. Patients must receive adequate information about the matter under discussion; they must be capable of making a decision and communicating it to another; and they must be free to act voluntarily, without coercive influences (Appelbaum & Grisso, 1988; Roberts, 2002).

In Case 4, the psychologist and patient clearly had differing views of the appropriate sphere of confidentiality, stemming from their different cultural backgrounds. The psychologist also believed that the patient's consent for the release of information was compromised. Numerous elements may influence the ability of a person to act voluntarily in the process of giving informed consent, including factors related to the person's psychological maturity, burden of illness, cultural background, and life circumstances (Roberts, 2002). A conundrum in this case is whether Mr. S.'s cultural background's emphasis on the family constrained his ability to protect his privacy—or whether his decision to release the records was a true and authentic expression of his own belief in the primacy of the family. In other words, to what extent were Mr. S.'s personal values synonymous with those of his culture and family? Was there, as his psychologist believed, a separate “individualistic” Mr. S. whose true preferences were being overridden by his family and culture?

The clinician behaved sensibly and ethically by consulting with colleagues about this difficult case. In the end, she chose to adhere to her personal ethical/cultural views regarding the appropriate sphere of confidentiality rather than those of the patient and his mother. Her concerns about the validity of his consent supported this choice. Withholding the notes under these circumstances was not in itself unethical, though it carried some risk to the psychologist, as the patient and his family might have grounds to file an ethics complaint or pursue legal action to obtain the documents.

As we have seen in other cases, this type of ethical dilemma is more easily prevented than solved. A clinician with a more sophisticated understanding of cultural influences on the concept of confidentiality might have clarified the matter with the patient before treatment began. Had she known that the patient believed his family had a right to view his therapy record, the psychologist might have kept less detailed notes, in which incendiary material was excluded.

### Case 5: Justice in the Treatment of Diverse Populations

A social work student at an inner-city tertiary-care medical center was assigned to provide supportive therapy to clients in the psychiatry clinic. Over time, she noticed that her caseload consisted primarily of African American patients with severe and persistent mental illness. Their mental health and social problems were great, and the student often felt her skills and knowledge were not adequate to her patients' needs.

The student discussed her concerns with her supervisor and was assured that doing her best was all that was required. However, the student gradually noticed that the experienced social workers in her department had client caseloads that were predominantly White and middle class, whereas the trainees treated mainly poor African Americans. She discussed this seemingly discriminatory practice with her supervisor and was informed that this arrangement had evolved because patients who traveled to the medical center from the suburbs were unwilling to be treated by trainees, but the patients from the local urban area did not seem to mind. The supervisor believed it was a coincidence that the neighborhood patients were African American and the suburban ones were White.

The social work student was uncomfortable with the status quo and contemplated leaving the institution before her training was complete. She felt that if she stayed, she would be complicit in an unethical system; on the other hand, if she left the training program early, she would be abandoning her patients. She met privately with an ethics consultant at the medical center for advice. In the end, she decided to remain but to continue to voice her concerns with her superiors.

*Discussion.* Justice is the ethical principle that describes treating people fairly and according to what they deserve. Unlike the principles of nonmaleficence, beneficence, and respect for autonomy, justice is of greatest importance in matters of public health, especially in situations of scarcity. (In Case 5, the scarce resource is treatment by skilled social workers.) Distributive justice is the ethical principle that social benefits and burdens should be distributed to members of society in an impartial manner, and it is especially relevant to the issue of cultural disparities in health care. In the United States, for example, the identification of pervasive health care disparities among racial and ethnic groups has been identified as

a major public health problem (Groman & Ginsburg, 2004; Institute of Medicine, 2002).

Ethical dilemmas involving distributive justice often hinge on the difficulty of defining what is a fair basis for distributing benefits and burdens. One option is simply to give everyone equal shares. Another is to divide up the materials based on some relevant human property, such as individual need, merit, effort, or contribution made to society (Beauchamp & Childress, 2001). Each of these strategies is to some extent anchored to cultural values. The notion that goods should be distributed based on individual effort and merit resonates deeply with Western values prizing individualism and action (Bossman, 2000; White, 2000). In a collectivist culture, on the other hand, distributing goods according to one's societal contribution might hold more sway.

In Case 5, the social work student discovered that her employer seemed to distribute the benefit of treatment with an experienced social worker (and what some would experience as the burden of treatment with a trainee) based on the race of the patient. The trainee was informed that the relevant property for making the determination was in fact the distance the patient had traveled, a property that was apparently confounded with race. Two ethical issues can be analyzed in this case. First, is the system just? Second, what is the ethical course of action for the social work student?

To definitively answer the first question, it would be necessary to learn whether patients truly are assigned to therapists based solely on the assumption that those who travel from the suburbs will refuse treatment by a student, whereas those from the surrounding urban area will not. If that is the case, it raises the worrisome possibility that those from the suburbs protest because they are more knowledgeable about their treatment options, and that the informed consent process for the urban patients is therefore inadequate. An even greater concern is that the suburban/urban distinction merely covers institutional racial discrimination. Although discrimination according to race (or gender, religion, social status, or caste) may be congruent with the values of some cultures, in modern Western society, it is not ethically justifiable on the grounds that it is unfair to treat people differently because of differences over which they have no control (Beauchamp & Childress, 2001). A far more acceptable approach would be one based on need, with the sicker patients or more complicated cases going to those social workers with greatest expertise. Alternatively, the principle of equality might lead one to assign patients randomly to therapists, based on the order in which they contact the clinic or are first seen. Although such a lottery system does not enable each person to be treated in an equal fashion, each individual will have an equal *chance* at treatment by an experienced social worker (Beauchamp & Childress, 2001).

The second issue in this case is how the trainee should behave, given the situation. Her dilemma is that she feels complicit in a system that is unjust to African American patients as a group, but she also recognizes that she may harm her indi-

vidual patients by quitting before her contracted time is over. Such dilemmas are common for clinicians who work in public institutions in which some aspects of health care are rationed according to values the clinicians may not share (American Psychiatric Association, 2001). In this case, the student appears to have made highly justifiable decisions to consult with an ethics expert; remain at her job, thus avoiding the harm that might befall her patients if she left prematurely; and advocate for a more just allocation of resources.

## CONCLUSION

Cultural differences between patients and clinicians have become a matter of growing importance to mental health care as Western societies have become increasingly diverse. This article has attempted to illustrate how attention to these cultural differences enriches the discussion of ethics in mental health care and how cultural competence enhances the ethical treatment of mental health patients. To be culturally competent, a clinician must be sensitive, knowledgeable, and empathetic about cultural differences—and then make therapeutic use of those capacities. Cultural competence is a concrete, practical expression of bioethics ideals. Mental health providers live out the ethical principles of beneficence, nonmaleficence, justice, and respect for persons in their efforts to understand, appreciate, and empathize with their patients' cultural values and to use those abilities in the service of excellent patient care.

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