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15 Ethical Issues When Working with People of Color

Suzette L. Speight and Michael C. Cadaret

This chapter will engage some of the ethical issues that may arise when conducting therapy with people of color. We will utilize the term "people of color" to reference those of Asian, African, Latina/o, Native American, North African, and Middle Eastern descent. "People of color" does not represent a distinct group of people, but rather refers to communities of people who, by nature of their phenotypic pigmentation of skin color, have been subjugated to practices of exclusion and oppression throughout history. While all forms of discrimination and oppression are horrific and objectionable, the history and conditions of oppression differ across racial and ethnic groups. Even within racial categories, one's experiences of oppression and socialization may be different given sexuality, gender, class, and religion, and thus shape how individuals from these communities negotiate issues of race and ethnicity in U.S. society. Through the lens of cultural competence, this chapter will focus on several topics relevant to ethical practice, including the fluidity of identity, addressing racial/ethnic differences, the utility of an exclusively intrapsychic framework, and understanding the community setting.

Defining Race and Ethnicity

Many practitioners may question where and when racial and ethnic categories are useful and when do they become stereotypes and, therefore, harmful in our conceptualization of persons in clinical work. Markus (2008) argues that for us to AQ1 understand race and ethnicity in psychology, we must understand history and context. The dominant discourse in psychology is largely influenced by northern European and Western thought, which gives primacy to the individual often to the exclusion of one's existence as a social being. Thus, Markus maintains, to truly understand race and ethnicity, psychology needs to reform its model of the person, seeing people not as self-determined, agentic, and stable, but instead as shaped by their relationships with others, their values, and their judgments about the self in relation to society. The definitions of race and ethnicity have a long, hotly contested history within the field of psychology. Ethnicity commonly refers to "a characterization of a group of people who see themselves and are seen by others as having a common ancestry, shared history, shared traditions, and shared cultural traits such as language, beliefs, values, music, dress, and food" (Cokley, 2007, p. 225). Ethnic AQ2 identity, then, is one's subjective sense of belonging to an ethnic group. Ethnic

groups are not fixed but flexible, and ethnic cultural traits are learned and transmitted to others and across generations. Markus (2008) maintains that race and ethnicity are human inventions. Race is often used as a way to uphold social power and does not often typify the groups that it is purported to define. Race refers to a characterization of a group of people believed to share physical characteristics such as skin color, facial features, and other hereditary traits (Cokley, 2007, p. 225). Smedley and Smedley (2005), in their review of the origins of the concept of race, outline how race does not have biological or genetic meaning, but rather represents an ideology, "an invented conception about human differences" (p. 22). Smedley and Smedley claim that race and ethnicity are often used in a sociopolitical context to control or abuse other groups: "Race became an important mechanism for limiting and restring access to privilege, power, and wealth" (p. 22).

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The social construction of race results in the differing opportunities arising from the inequities perpetrated by society's racial ideology. Thus, it is imperative that we view the impact of racial stratification on individuals' daily experiences. The effects of race and racism can be manifest at different levels, from the microsocial to the macrosocial. For instance, individuals may believe the stereotypes about their race (i.e., internalized racism) while also having restricted access to quality public education, employment opportunities, and health care (i.e., institutionalized racism). Consequently, decades of research have documented significant disparities in health care and mental health care between people of color and whites. With regard to mental health care, the Surgeon General's report (U.S. Department of Health and Human Services, 2001) concluded: "Racial and ethnic minorities have less access to mental health services than do whites. They are less likely to receive needed care. When they receive care, it is more likely to be poor in quality" (p. 3). The report identified barriers such as the cost of care, stigma, clinicians' lack of awareness of cultural issues, biases, clients' mistrust, and the effects of racism and discrimination.

Culturally competent mental health care is seen as one key remedy to these mental health disparities. The Surgeon General's report defines culturally competent care as "the delivery of services responsive to the cultural concerns of racial and ethnic minority groups, including their languages, histories, traditions, beliefs, and values" (U.S. Department of Health and Human Services, 2001, p. 36). The delivery of culturally competent services to people of color is, in a word, complex. This complexity is reflected in Lynn Weber's work on intersectionality, she writes:

> "If we are to understand race, class, gender, and sexuality systems, we must be willing to have our stereotypes of subordinate groups challenged and to make the social privilege of dominant groups visible. To do so we must be open to learning information and ways of thinking that may not have been included or validated in our education. We must also be aware that everyone holds stereotypes – that we may even have them about our own groups – and that we can challenge and change them. And because all of these systems operate in our lives at all times, recognizing the complexity in our own multiple statuses helps us to consider the complexity in the lived experiences of others." (p. 218)

Mental health professionals are obliged to deliver services that are responsive to the needs of racial and ethnic minority clients. The Ethical Principles of Psychologists and Code of Conduct (APA, 2010) assert that psychologists should practice within areas of AQ6 their competence, including scientific and professional knowledge that is related to race, ethnicity, and culture (Principle E – Standard 2.01). The overarching principle of "Respect for People's Rights and Dignity" (Principle E) includes special knowledge that takes into considerations the vulnerability of certain communities and practices that are inclusive of awareness and respect for diversity. Furthermore, the Code suggests that psychologists work to eliminate biases that could be harmful to their work (Principle E – Standards 3.01 and 3.03).

Direct guidance for upholding these principles and standards is given within the APA Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (APA, 2002). The guidelines are organized AQ7 into six areas that explain the infusion of multicultural practice in several areas of psychology. The first two guidelines discuss the knowledge of the role of culture within psychology and psychologists themselves (Guideline 1) and the necessity for recognizing race, ethnicity, and culture in the persons that psychologists serve (Guideline 2). Guideline 3 addresses the inclusion of diversity issues in education, while Guideline 4 addresses culturally sensitive research. Guideline 5 directly addresses the application of culturally appropriate skills in clinical practice. The guideline suggests that practitioners be aware of their "client in context"; that is, recognizing that clients (and psychologists) are socialized to understand themselves as racial, ethnic, and cultural beings. Thus, practitioners should appropriately assess for the social, political, and historical factors that may influence a client. In situations involving assessment, psychologists should be aware of the limitations and the cultural validity of such instruments and ensure that their value is adequately explained. Finally, psychologists should be informed in their use of psychological interventions. Specifically, practitioners should take special consideration when conceptualizing clients, especially in cross-cultural encounters. Interventions should be carefully chosen and applied so that they incorporate culture-specific elements. Guideline 6 encourages psychologists to support institutional and organizational change.

Providing mental health services in a culturally informed manner is an ethical imperative (Gallardo, 2009; Ridley, 1985). Ethical practice must extend beyond knowledge and awareness of diversity issues regarding culturally informed practice and be free of bias in order to provide culturally responsive interventions. Such practice seeks to infuse ethical principles of practice (Kitchener, 1984) and multicultural competence, along with responding to the needs of the individual within their community.

(Cultural) Competence

Cultural competence is relevant at the level of the clinician and his/her clinical interactions, to the supervision provided to the clinician-in-training, and at the institutional level of the mental health agency and service delivery system.

The widely accepted framework for delineating the components of cultural competence come from Sue et al. (1982, 1992), who identified cultural awareness and beliefs, cultural knowledge, and cultural skills as the overarching characteristics of a culturally competent therapist. Sue (1998) adds that competence on the clinical level involves being scientifically minded and appropriately and flexibly applying generalized understandings of cultural components with any individual client who may present with a myriad of culturally relevant identities. Competent clinicians utilize culturally specific resources to meet the needs of their clients. Utilizing culture-specific resources may take the form of adding culturally appropriate interventions to existing therapy or, what we will advance later, having knowledge of the cultural practices and resources of the community.

The Council of National Psychological Associations for the Advancement of Ethnic Minority Interests in their brochure titled *Psychological treatment of ethnic minority populations* (2003) cautioned that awareness or knowledge alone are not enough. Clinicians believing that the knowledge gained by reading "is sufficient to make one culturally competent would be the height of naïveté" (p. 3). Competence with people of color requires responsiveness, not just sensitivity and awareness. Thus, as will been seen in the upcoming case of Rachelle, the therapist, Dr. Louis, *asked* about the client's identity and experiences with racism within the predominantly white university. Knowing that in our racialized society an Asian–American woman is likely to have experiences with gendered racism that are detrimental to her self-concept and well-being, a competent therapist would inquire about the client's social context.

"Treatment as usual" can have a deleterious result for those with whom it is intended to serve, as traditional ethnocentric treatments have rarely taken into account the cultural values of people of color. Sue (2003) states that "rather than feeling that they have been provided benefits, clients often feel invalidated, abused, misunderstood, and oppressed by their providers" (p. 5). Cultural competence, therefore, demands that clinicians have knowledge of general applications of treatment, along with those that are specific to the cultures and communities within which they work. Clinicians are socialized into the worldview of the dominant groups; bringing this unchallenged worldview into practice, with its assumptions about treatment processes, goals, boundaries, and expectations, can hinder the development of an effective working relationship.

Sue (2003) suggests that for clinicians to become culturally competent they must be aware of their own culture and worldview and the cultures and worldviews of their clients and become flexible in their helping role in order to meet the goals and needs of culturally diverse populations. Perhaps fundamental to cultural competence is the therapist's "way of being" with the client or their general perspective on issues of diversity (Hook, Davis, Owen, Worthington, & Utsey, 2013). Cultural humility is a lifelong commitment to self-evaluation and self-critique, to redressing power imbalances within helping relationships, and to developing partnerships with communities to advocate for system change (Tervalon & Murray-Garcia, 1998). Beyond the ability to perform a task, clinicians must possess an attitude of openness and curiosity about their clients. Culturally humble therapists are motivated to

understand their clients' cultural backgrounds (Hook et al., 2013). Consequently, cultural humility as a philosophy or a virtue represents an essential quality that enables clinicians to be other-oriented and to approach the client's cultural background with respect.

The conversation surrounding how to best deliver mental health services to people of color has a rich history that is beyond the scope of this chapter. Therefore, the following case examples seek to illustrate the importance of various aspects of cultural competence in terms of knowledge, awareness, and skills built on a foundation of cultural humility. It is our hope that these cases and their analysis represent some key concerns of ethical practice with people of color and help the reader to discern the best course of ethical practice.

The Case of Dr. Louis, Cultural Knowledge, and Boundary Crossing

Rachelle is a 20-year-old Filipino–American woman who is attending her second year at college. Rachelle has stopped attending classes and has become distracted from school work, and last semester was put on academic probation. Her roommates encouraged Rachelle to attend counseling after she became very upset and ran out of their residence hall. The roommates were concerned and called campus safety. Rachelle was found walking alone, crying, and talking to herself. The campus police took her to psychiatric emergency services, fearing she may harm herself. She was released with no follow-up other than a verbal agreement to attend counseling. At intake, Rachelle requested a male counselor, indicating that she did not have any racial or ethnic preferences. She was assigned to Dr. Louis, a multiracial male licensed psychologist in his thirties. Rachelle was not forthcoming with her difficulties and appeared embarrassed to discuss the incident that led to her hospitalization. She minimized the reaction of her roommates and believed that her academic performance would no longer suffer, as she had addressed this with her parents and has "recommitted" to attending classes and doing her work. Rachelle readily agreed to a safety plan.

Dr. Louis was curious about the impact of Rachelle's race and gender on her experiences at a predominantly white campus. Rachelle shared that she had grown up in a predominantly white, middle-class, suburban community and attended predominantly white schools. Rachelle said that she was "used to" being a "minority" at school and that "it really didn't bother me too much anymore." Rachelle said that she gets along well with white males, but often feels "snubbed" by white women peers. This is why she requested a male counselor because she was fearful of being paired with a "blonde, blue-eyed female" counselor who she would have resentment toward. Rachelle connected her struggles in school to her anxiety about her relationship with Gabe, a white male student. Rachelle was "terrified" of losing him, although they seemed to really like each other and had been dating for almost six months. Rachelle had seen pictures of his previous girlfriends, most of whom were "skinny, white, blonde-haired cheerleader types," and that compared to them she was

not attractive. Rachelle felt that others were always looking at her and judging her, questioning, "Why would he even be with someone like me?"

Dr. Louis and Rachelle discussed the socialization process by which she developed her standards of beauty. Dr. Louis did some reading on colorism and gendered racism among Asian–American women in preparation (Hall, 1995; Lee & Thai, 2015). Rachelle explored her own stereotypes of Asian women as they discussed internalized standards of beauty, body type, facial and physical features, and skin color. Rachelle and Dr. Louis processed topics that Rachelle said she had "never talked about out loud before," even though she did write poetry about this in her journal. In fact, after about four months of therapy, Rachelle invites Dr. Louis to attend a poetry slam at an off-campus coffeehouse to hear her read a few pieces. Dr. Louis' first instinct is not to attend, but he tells Rachelle that he will think more about it.

Discussion of the Ethical Dilemmas and Associated Professional Standards

Dr. Louis effectively utilized his cultural knowledge about race, racism, and racial identity in his work with Rachelle. The American Psychological Association (APA) Multicultural Guideline 1 (2003) addresses the need for culturally specific knowledge: "Psychologists are encouraged to recognize the importance of multicultural sensitivity/responsiveness to, knowledge of, and understanding about ethnically and racially different individuals" (p. 385). Dr. Louis demonstrated cultural competence due to his facility in processing Rachelle's multiple identities in light of her minority status in the predominantly white social contexts where she grew up and now attends university. The hegemony of the dominant society's standards of beauty was internalized by Rachelle and accepted as true. Thus, Rachelle saw herself as unattractive, inferior, and unworthy of her white partner, Gabe. Dr. Louis is upholding Principle E: Respect for People's Rights and Dignity (APA, 2010). It is critical that clinicians understand the social construction of race, the meaning of race, and racial identity within society. Race, as we know, is not biologically significant; rather, it is socially meaningful. Due to racism and white privilege, people of color often experience marginalization, discrimination, and violence in our society. The case of Rachelle and Dr. Louis represents the importance of cultural humility. Dr. Louis recognized that Rachelle was an expert on her own experience and was open to helping her to explore her cultural background and experiences.

Now, Dr. Louis has to consider if he should cross a boundary and attend the poetry slam. According to the APA Codes (2010), 3.05 Multiple Relationships encourages psychologists to refrain from entering into a multiple relationship if it could impair one's objectivity, competence, or effectiveness, but on the other hand, it indicates that those multiple relationships that are not expected "to cause impairment or risk exploitation or harm are not unethical" (p. 6). Would attending the poetry slam create a potentially harmful multiple relationship? It appears that attending the poetry slam would not be a harmful or exploitative multiple relationship. Speight (2012) urged a culturally attuned approach to the placement and management of therapy boundaries rather than the predominant risk-avoidance approach to boundaries. Dr. Louis

could make a good argument that attending the poetry slam would be a positive boundary crossing that would enhance the therapy relationship and even extend the therapy gains that Rachelle has made (e.g., Glass, 2003). Dr. Louis would be able to support his client as she ventures out and shares her experiences with her community. This is precisely the type of culturally responsive treatment that a culturally competent therapist should consider. A key determination is the appropriateness of the therapist's behavior in light of the client's best interest. The best service Dr. Louis can provide to Rachelle might be to attend her social event and witness her public self-expression. This boundary crossing moves beyond the "therapeutic status quo" to provide Rachelle with culturally competent care (Gallardo, 2009).

Recommendations

1. Like Dr. Louis, clinicians must have knowledge of racial and ethnic groups' histories and experiences, within-group differences, and the intersection of multiple identities in our stratified society, and they must possess the cultural humility to enter into open dialogue about clients' experiences surrounding their cultural identity.
2. Race and ethnicity are but two aspects of identity, and in this case Rachelle's experience as a Filipino–American female was key. Age, sex, sexual/affectional orientation, visible and invisible disabilities, socioeconomic status, gender identity and expression, and religious and spiritual orientation are all important aspects of identity that frame experience within a nation, a region, and a community and shape worldview.
3. Therapists can establish culturally congruent boundaries that are flexible and provide opportunities to personalize the therapeutic relationship based on the needs of the client in a manner that is culturally congruent.

The Case of Sarah and Self-Awareness

Sarah is a practicum student at a college counseling center, her first external practicum. On her caseload she has Ignacio, a Latino male who is struggling with the stress of being a senior accounting major (honors student), is about to graduate, and is looking for a job. Ignacio has talked about being disappointed in not getting any job offers after having what he thought were some good interviews. He is seeking counseling for help with stress management and career options. In their initial few sessions, Sarah has given Ignacio several stress management techniques and she feels he has shown some engagement, but he still reports high stress. Sarah feels somewhat helpless as to what to do next and is considering giving Ignacio some career inventories.

Sarah brings this case to her group supervision, where her peers and practicum instructor ask about the dynamic between Sarah and her client in regard to diversity. Sarah is a 25-year-old, white, upper-middle-class, feminist, heterosexual woman

who identifies as atheist. Her client, Ignacio, is a 22-year-old, Puerto Rican, working-class, heterosexual male who identifies as a practicing Catholic. Unfortunately, Sarah did not have many answers to her peers' questions about Ignacio's ethnicity. In fact, Sarah said, "I didn't really even notice that Ignacio was different except for his name and a slight accent." Her classmates and faculty supervisor challenged her color-blind statement and Sarah became tearful and defensive – she wanted to run out of the classroom. Later that evening, Sarah posted some negative comments on social media about being "so tired" and "confused" by all of the controversy around race and ethnicity. Sarah said she was furious at being unfairly accused of being racist when she is "not being prejudiced at all." Several of her classmates read her posts and are wondering if they should mention Sarah's comments to their faculty instructor.

Discussion of the Ethical Dilemmas and Associated Professional Considerations

A key ethical issue here is Sarah's lack of competence in discussing race and ethnicity, apparently due to her own anxiety owing to a lack of self-awareness and experience in discussing race, ethnicity, and culture. As Sue (2013) described, racial dialogue can be difficult for some whites due to fears about appearing racist or realizing their own racism and reluctance to combat racism. Sarah's white privilege has insulated her from engaging in issues of race and ethnicity, and thus she has had very little experience of discussing such topics. The APA Multicultural Guideline 1 (2003) speaks directly to Sarah's difficulty: "Psychologists are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interaction with individuals who are ethnically and racially different from themselves" (p. 382). Sarah seems to have difficulty examining her own biases, assumptions, and worldview. Sarah could be jeopardizing the quality of the clinical services she offers by not being open to reflect on her own background and biases. In research with counselors-in-training, Knox et al. (2003) found that white students feel they are not given opportunities or instruction to explore bias and involve themselves in cross-cultural dialogues. Even so, there is the possibility that it is fear that inhibits action toward multicultural competence. Research has shown that clinicians who attend to issues concerning clients' cultural identity, appreciate clients' cultures, and understand how clients' presenting concerns can be framed in a cultural context demonstrate better outcomes with clients of color (Atkinson, Casas, & Abreu, 1992). Sue et al. (2007) state that clinicians need to be aware of their biases, seek to involve themselves in situations where their empathy will increase for others, and move toward becoming allies. Yet, even if well-intentioned persons who view themselves as egalitarian have this knowledge, there can still be resistance to engaging in issues of diversity. AQ12

For instance, Shelton, West, and Trail (2010) studied a group of roommate pairs to examine the relationships between white students and students of color. Due to the fear of being perceived as prejudiced, white students reported increased anxiety on a daily basis. This increased anxiety resulted in participants of color viewing their

white roommates in a less favorable light. The implications for clinicians is that the fear of appearing prejudiced could decrease the likelihood of addressing aspects of a racial/ethnic minority client's identity. This fear is often manifested as avoiding such awkward and uncomfortable conversations. Thus, clinicians' anxieties over saying the wrong thing or appearing racist may actually fracture the client's trust in the relationship and hinder the development of a therapeutic alliance.

Sarah's unwillingness to engage in issues of race and ethnicity seems fueled by a lack of self-reflection of her own positionality, privilege, and cultural identity. Sarah appears to be operating within a color-blind racial ideology where she utilizes color evasion and emphasizes sameness. According to the APA (1997), "treating different people differently and celebrating their cultural uniqueness appears to be a more equitable way to achieve social justice than attempting to adopt a colorblind stance" (p. 8). Sarah's color-blind approach is antithetical to multicultural competence. It is surprising and disappointing that Sarah has reached such a point in her training that she is working with clients from a color-blind perspective. Sarah's supervisor at the counseling center (and at her academic program prior to her beginning practicum) have not adequately prepared her to explore her own social identities or those of her clients. Sarah needs a supervisor who is open, aware, discusses culture, and focuses on race and ethnicity in case conceptualization to facilitate her development (Inman & Ladany, 2014).

Given Sarah's negative social media statements, should her peers "report" Sarah to the faculty supervisor? Often, other students have greater knowledge about their peers' inappropriate behaviors than do faculty. Tirpak and Lee (2012) discuss the importance AQ13 of navigating the multiple relationships that doctoral students experience with their peers and the need for programs to prepare students to ethically manage these relationships. At what point would Sarah's posts alarm her peers enough for them to inform the faculty? The APA Ethics Codes (2010) 1.04 Informal Resolution of Ethical Violation suggests that psychologists should first bring their concerns directly to their colleague. Sarah has not committed an ethical violation, so there is no need for her peers to unduly escalate the situation by "reporting" her to the faculty. However, engaging Sarah to help her to continue dialoging about her positionality with her practicum classmates and faculty supervisor would be very helpful to her own growth. Becoming a culturally competent psychologist will require Sarah to examine her attitudes and biases, which can be a painful process. Sarah's program must provide a learning environment that will both support and challenge her (BEA Virtual Working Group, 2015). Cultural competence is the obligation of all clinicians and is the responsibility of the trainee, the supervisor, and the training program (Inman & Ladany, 2014).

Recommendations

1. Within a therapy encounter between the clinician and the client, each participant comes with separate worldviews, identities, values, and experiences that necessarily shape the process and outcome of that encounter. Thus, clinicians must be willing and able to explore their own social identities, worldviews, and

positionalities in the larger social hierarchy in order to be culturally competent. Sarah needs to access supervision in order to challenge and support her awareness of her own cultural identity and privilege.
2. Sarah must learn about color-blind racial ideology and her own racial privilege.
3. Sarah should make efforts personally and through the support of her program to examine her emotional responses to this and similar incidents. Sarah is likely feeling distress related to white guilt and as a result is distancing herself from engagement in understanding her own privilege (Iyer, Leach, & Pedersen, 2004; Todd, Spainerman, & Aber, 2010).
4. Interaction and discussion from persons of color with Sarah can serve to increase her empathy and broaden her understanding of how racism harms individuals (Spanierman, Todd, & Anderson, 2009)

The Case of Dr. Avery and the Intrapsychic Model

Dr. Nina Avery, an African–American postdoctoral fellow, is in her first job at a local community mental health center. Nina is working for the first time with an urban, poor, primarily African–American clientele. Dr. Avery has been seeing Mia, a 27-year-old, African–American single mother of four- and two-year-old daughters, for six months for issues of depression and a history of significant childhood trauma, including abandonment, physical abuse, and sexual abuse. Prior to beginning therapy, Mia gave temporary custody of her children to their paternal grandmother because she was homeless, had lost her low-wage job, and felt overwhelmed. Consequently, Mia's depression has increased as her financial resources depleted. She feels defeated, frustrated, agitated, and hopeless, with passive suicidal ideation, but her children are good reasons for living. Dr. Avery has been processing her internal reactions to Mia including anger, guilt, and caretaking feelings on her own, but not with her supervisor. Given her caseload of 25 clients, Dr. Avery spends time in supervision talking about her other clients and has avoided talking about Mia.

Mia has been staying with friends and living in her car and does not have money for her basic needs. For instance, Mia recently did not have food, laundry detergent, or feminine hygiene products. Christmas is approaching and Mia does not have money to purchase gifts for her children. Given that her children are not currently in her custody, she is not eligible for toy assistance from local charities. Dr. Avery is struggling with the point of therapy given Mia's circumstances and is wondering what good therapy is really doing. Mia expressed the same sentiment in her last therapy session. Dr. Avery wants to help Mia and intends to purchase some items for Mia and her children without discussing this with her supervisor.

Discussion of the Ethical Dilemmas and Associated Professional Considerations

Dr. Avery is feeling discouraged and pessimistic about her ability to aid her client, Mia, through individual psychotherapy. Mia's psychological symptoms have

increased while her circumstances have not improved; in fact, they have deteriorated. Dr. Avery has apparently defined her role as a mental health provider in a narrow manner. Moreover, Dr. Avery is withholding her feelings, reactions, and plan about her client from her supervisor. The APA Multicultural Guideline 4 states, "Psychologists are encouraged to apply culturally appropriate skills in clinical and other applied psychological practices" (2003, p. 390). This guideline asks clinicians to develop skills, practices, and interventions that are consistent with their clients' worldviews and needs, including "nontraditional interventions" (p. 292). Dr. Avery appears to be trapped in a box of her own making. Vera and Speight (2003) encouraged clinicians to "expand their role" in order to provide culturally competent care. Intrapsychic explanations for psychological distress result in interventions that are intrapsychic in nature. Dr. Avery's exclusive focus on Mia's internal issues has not been effective and, in fact, leaves Mia (and Dr. Avery) feeling hopeless and helpless. As Greenleaf and Bryant (2012) explained, "The resultant perception that clients' problems are internally-based or self-caused, and the not result of chronic, environmentally-caused stress, leads individuals to think that their own mental health problems are a result of their own psychological and biological deficiencies" (p. 22). Dr. Avery's purchasing of a few items for Mia might meet a short-term need but does not address the environmental problems contributing to Mia's distress. The gift giving seems motivated predominantly by Dr. Avery's internal feelings. Moreover, giving gifts to the client might set up a relationship dynamic that could prove awkward or even damaging to the therapeutic relationship. Dr. Avery could benefit from the experience of her supervisor, who has been working in community mental health for several years. The supervisor would likely help Dr. Avery to access a range of community resources to aid the client. Unfortunately, Dr. Avery has been avoiding talking with her supervisor, which leaves both of them at risk of providing poor client care.

Recommendations

1. Dr. Avery is not meeting her client, Mia, at her need. Simply talking about feeling depressed does not help Mia to find housing, search for a job, find steady income, and regain stability so that she can parent her children again.
2. What resources are available within Mia's community? More importantly, why does Dr. Avery not know about these resources and how to activate the relevant ones? Mia might benefit from shelter care, job readiness training, temporary cash and/or food assistance, and family supportive services through the Department of Children Services or local charities and churches.
3. Dr. Avery must avail herself of the support and experience of her supervisor to help her to navigate this difficult situation. Not talking to her supervisor is potentially putting both of them at risk of providing poor care to the client.

The Case of Rules of Group Therapy at the Arch Street Center

Several clients at the Arch Street Center are on the verge of being terminated from the treatment program due to noncompliance.[1] The clients live on the city's east side and the Arch Street Center in downtown. The mandatory group therapy sessions are held on Tuesday and Thursday mornings from 9:00 a.m. to 11:00 a.m. According to the group therapist, three clients in particular – Maria, a Mexican–American woman; Nadine, a biracial woman; and Tyson, an African–American man – have inconsistent attendance. Each has arrived late three times (sometimes 45 minutes late) to group "without good excuses," which is seen as an indicator of their resistance and lack of commitment. The center director, Ms. Williams, asked to speak with Maria after the group to warn her that she was in danger of being terminated. Maria attempted to explain that they had difficulty getting to the center due to the unpredictable bus schedule – some days the two buses the clients ride run on time, and other days either one or both of the buses is late. Ms. Williams listened impatiently and told Maria, "You, Nadine, and Tyson just need to put more effort in or decide if you really want to be here or not. I would suggest that you work on your time management and organize your kids and your mornings much better. Probably you should get up earlier to give yourself enough time to get here. You have been late too many times, Maria, and it is up to you to do better. I hope you can pull it together!" Maria quietly said, "OK," and left the building. While walking to the bus stop, Maria started to cry, feeling frustrated, misunderstood, and hurt.

Discussion of the Ethical Dilemma and Associated Professional Considerations

The group therapy rules of the Arch Street Center illustrate a lack of cultural competence at the institutional level enacted by the therapists and center director to the detriment of the agency's clients. The attendance policy of the Arch Street Center does not appear to consider the environmental barriers that might hinder clients' ability to access mental health services. The APA Code (2010) 3.01 Unfair Discrimination indicates that psychologists must not engage in unfair discrimination of legally protected socially identities age, race, gender, socioeconomic status, or national origin. Moreover, APA (2003) Guideline 6 – "Psychologists are encouraged to use organizational change processes to support culturally informed organizational (policy) development and practices" (p. 392) – is particularly germane. The mental health professionals at the Arch Street Center, in setting and implementing the attendance policy, apparently lack knowledge of the communities that they serve. Knowing the bus routes and bus schedules would allow the clinicians to develop an attendance policy that better fits the daily lives of their clients. In this situation, the clinicians have not considered the actual barriers that their client's encounter. (Our assumption is that the clinicians lack knowledge. We are loathe to consider a situation where the professionals do have this knowledge but do not care.)

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Maria explained what the obstacle was, but Ms. Williams did not believe Maria and instead implied that Maria was not dedicated and was unorganized and lazy. Ms.

Williams added insult to Maria's injury and committed a so-called microaggression with monumental impact. The APA guideline calls for clinicians to utilize "culturally informed organizational policy." Clearly, the Arch Street Center's policy is not culturally informed. Apparently, Ms. Williams and her staff are not aware that the bus route begins at 8:00 a.m. and that if both buses are on time, Maria, Nadine, and Tyson would arrive at the Center at 8:55 a.m. However, as all regular riders of public transportation know, buses can be unreliable. Maria can do everything right and still be 20 minutes late through no fault of her own. It is surprising and disconcerting that the center's staff and director do not know this. Moreover, Ms. Williams' dismissive, patronizing, and disrespectful behavior toward Maria at best indicates a lack of awareness and at worst might indicate a prevailing set of assumptions and biases that the professional staff hold against their clients. Ms. Williams' comments blame Maria for her circumstances. Wrenn (1962) would say that the professionals at the Arch Street Center are culturally encapsulated, being unaware of the social conditions around them. The consequence of this encapsulation has erected a barrier that makes access to mental health services difficult for some clients. This situation could be easily remedied if the staff modified the start time of the group to 9:30 a.m., which would provide a needed cushion for the clients who rely on public transportation. Empathy from the clinicians at the Arch Street Center would be a good first step toward making the necessary changes.

The American Counseling Association's Advocacy Competencies (Lewis, Arnold, House, & Toporek, 2003) might even propel the clinicians to collaborate with existing community organizations in order to address the inequitable distribution of reductions in public transportation whereby certain communities bear the brunt of budget cuts resulting in fewer public transportation options. "When counselors identify systemic factors that act as barriers to their students' or clients' development, they often wish that they could change the environment and prevent some of the problems that they see every day" (Lewis et al., 2003, p. 2). In order to be effective advocates, clinicians must identify those impinging environmental factors, develop community alliances, and listen effectively in order to change the system. "Change is a process that requires vision, persistence, leadership, collaboration, systems analysis, and strong data" (p. 2). Ms. Williams and the staff can begin by changing the time of the group session in order to be more responsive (and less discriminatory) to the needs of the community they serve. In fact, connecting with the local community is a key element of cultural humility (Tervalon, 1997).

Recommendations

1. The staff at the Arch Street Center must learn more about the communities that they serve, perhaps by leaving the office to forge alliances and to gain familiarity with resources and community leaders.
2. The voices of the clients appear to not be heard at the Arch Street Center. Perhaps the center could develop a consumer advisory board that could participate in

developing policy, conducting a needs assessment, and advising on programming.

3. The staff might need additional diversity training to explore their own biases, particularly their positionality and privileges. In particular, Ms. Williams made some assumptions about Maria and committed a microaggression against Maria. The staff might benefit from exploring the stereotypes they hold about various racial and ethnic groups.

Ethical Principles for Culturally Competent Practice

Following the framework of awareness, knowledge, and skills, ethical practice with persons of color can intersect with the ethical principles that guide psychological practice generally. Kitchener (1984) outlined ethical principles for practice: autonomy, nonmaleficence, beneficence, justice, and fidelity. Kitchener explains that the principle of autonomy includes more than respect for individuality. Rather, it is expressed as mutual respect. In our framework, recognizing that cultural differences may lead to differences in values and differences in motivations for decisions from clients. Awareness of how one's biases, stereotypes, and experiences shape reactions can be helpful to ensuring that clinicians are not inadvertently making judgments that do not respect culture, language, and values. Clinicians must understand how institutional and cultural racism impacts people of color. For instance, in the case example at the Arch Street Center, Ms. Williams failed to recognize how her reaction and the center's policy unintentionally disregarded their clients' contextual barriers to treatment, thereby creating an institutional constraint on their access to treatment. It may be unrealistic to expect clients of color to make decisions or to initiate action within social and institutional systems where they do not hold status or power and instead may feel alienated and marginalized. White privilege may enhance a clinician's feeling of entitlement within a given system, which does not necessarily translate to people of color who have been marginalized and discriminated against in these same institutions. From the perspective of cultural humility, autonomy serves both as a process of mutuality in providing care as well as the attribute of egoless (Foronda et al., 2016). AQ18 AQ19

Nonmaleficence, the principle that guides "do no harm," is directly relevant to ethical practice with people of color. Certainly there are guiding practices, such as the decisions that may infringe on one's civil rights or misuse of assessment (as cited by Kitchener), but we would argue that the very nature of addressing racial and cultural differences is part of the ethical responsibility of practitioners. Given the literature reviewed above surrounding the degree of cultural mistrust, as well as the pernicious impact of practice-as-usual that does not attend to the culture-specific worldviews and experiences of clients of color, it may follow that when clinicians avoid certain topics due to their own discomfort or their lack of awareness, clients are harmed by what goes unsaid. This was evident in the case of Sarah and Ignacio. Due to Sarah's discomfort with addressing cultural differences, she neglected to attend to a vital part of Ignacio's identity. By not addressing the complexity of clients' multiple identities, clinicians

may reinforce a client's assumption that therapy (like the larger society) is not a safe space to discuss racial or other cultural experiences. This inadvertent silencing would certainly make the development of a working alliance more difficult. Additionally, as Sue (2003) has stated, the incorrect assumptions we can draw based on our worldviews and assumptions of what constitutes "normal" behavior as opposed to abnormality may bias us toward an incorrect diagnosis and labeling of a client of color. This label may then inform treatment and other professional opinions, which may inadvertently harm the client's well-being. Conversely, the case of Dr. Louis and Rachelle illustrates that when clinicians attend to clients' cultural identities, they validate and affirm their experiences as cultural beings. Dr. Louis acted in a manner that involved not only taking care to do no harm, but also creating a positive and supportive interaction with Rachelle, his client. AQ20

Beneficence can be seen to extend beyond the conventional individual treatment model to examine the person in relation to their community, as well as the social and political systems in which the practitioner and client both exist. As an ethical principle, beneficence obviously demands that the clinician works toward the ultimate benefit for the client. In the utilitarian sense (the greatest good), a clinician motivated by beneficence might devote time and energy to working toward policy change in order to increase criminal penalties for domestic violence. This advocacy work might not impact a current client who is leaving an abusive situation, but can serve the overall good of the community. This example may seem to overlap with the notion of justice, but Kitchener's (1984) original justice question, posed over 30 years ago, is particularly relevant to psychology today: "To what extent do we have an ethical obligation to insure equal access to mental health services?" (p. 50). Communities of color experience inequities in access to mental health care services and are given treatments that are inadequate. Thus, it follows that justice is not being upheld generally in clinical practice. Did the response of Ms. Williams and the staff of the Arch Street Center uphold the spirit of beneficence? In short, no. Alternatively, if they had taken Maria's concerns seriously and changed their policy to adapt to and meet the needs of the people they serve, they would then be upholding the ethical principle of beneficence. As an overarching principle, it is imperative that ethical services with persons of color remove barriers to access and are delivered in a way that is culturally competent and aware of the individual and community needs. As another example, in the case of Dr. Avery and Mia, Dr. Avery's desire to do good did not serve the ultimate benefit of the client, Mia. Instead, as suggested, Dr. Avery should work to advocate and connect Mia to services and the support of her community, thereby creating a sustained, positive contribution to Mia's well-being.

Finally, the principle of fidelity asks that clinicians are truthful and loyal to their clients. Here it is recommended that clinicians be truthful about the nature and limitations of practice and about their competency, and in this way work to create a strong alliance between themselves and their clients. Loyalty asks clinicians to go beyond what may be a standard obligation of services, extending loyalty to the clinician's investment in the community in which they work. Faithfulness to the community represents a principle of mutuality or solidarity with communities of color. While the clinician may not be from the community and may be able to be

differentiated by a myriad of identity dynamics, they may strive toward being a strong ally and seek to understand the community they serve, including knowledge of the history, leaders, cultural institutions, and social services that exist in a community. Sue (2003) suggests that culturally competent therapists "do not live in isolation from a diverse world. They are involved with culturally diverse groups outside of their work role – community events, celebrations, neighbors, and so forth. They realize that becoming culturally competent comes best through lived experience" (p. 6). This approach may challenge some clinicians' views of appropriate boundaries. Boundaries are themselves a cultural enterprise. We must be flexible and creative when working within communities of color. Dr. Louis, in the case example above, acted in a manner that served to strengthen his fidelity to the therapeutic relationship with his client. By attending her poetry reading, he relinquished the power and authority of the therapeutic office and moved into a shared space that required vulnerability on his part, as well as from Rachelle.

AQ21

Conclusion

Cultural competence is an ethical imperative. Effective service to racial and ethnic communities requires clinicians to have cultural knowledge, to be aware of their own biases, privileges, assumptions, and positionality, to apply their skill set appropriately to meet clients' needs, and to utilize advocacy skills to challenge policies, practices, and barriers to their clients' well-being. Cultural competence requires a holistic appraisal of the person and their environment, as well as the ability to design a range of interventions to address clients' needs. Furthering competence, cultural humility is the manifestation of ethical practice that is culturally informed. Cultural humility is not only aspirational – by its very nature, it outlines the attributes befitting of culturally competent practice. With cultural competence and cultural humility as the foundation, mental health professionals should be equipped to provide ethical and efficacious services.

Note

1. Greenleaf and Bryant (2012) briefly mention a similar situation about bus transportation, rush hour, and agen cy policy. We utilized our own experiences with client transportation difficulties, expanded the Greenleaf and Bryant example, and added details for our purposes.

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