

A Critical Exploration of Ethical Decision Making through Disability and Ethnicity-Case study



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Abstract

This essay will focus on the ethical judgements required when working with a client with disability and different ethnicity in counselling and how these may differ from able bodied clients. It includes a case study through which I demonstrate my ethical understanding and values while working with these sensitive issues. Hence, I will consider the broader aspects of these 2 areas through a client. Seeing the client with a disability and diverse ethnicity as a person with numerous personalities, roles, capacities, and environments encourages the counselling process. Therefore, with the knowledge of these issues counsellors turn out to be more sensitive to the necessities of various populations and provide more viable treatment not facilitated by a rigid, practice-based method.

Introduction

Ethical decision making is the functional process through which therapists base their activities, utilise a framework of client rights and professional obligations for decision making. It additionally includes gathering evidence and facts from research, figuring out if an issue or difficulty really exists, consultation with colleagues or peers or with supervisors to decide how best to apply proficient ethical codes, standards and values in practice. However, the perplexity brought about by limits as a continuum, ranging from withdrawal (rigidity, inflexible limits/guidelines) to enmeshment (adaptability to the point of diffusement), with a large grey area in the middle, of that is notoriously vague and dependent upon the therapist, the circumstance and the client's changing needs and conditions. This article will critically explore the decision-making process while working with a disabled client with different ethnicity. Preez 2013 [1] contends that practice-based ethical decision-making models mostly don't convert into ethical decisions, yet rather work as a device to assess or look at a circumstance. Corey, Corey and Callanan [2] raised comparable worries that these codes of practice can't be connected in a generalized or automated way, as specialists frequently get themselves confronted with a social context, complexity of personal values of individual qualities, and additionally a prescriptive professional code. Their model of decision making neglects to relate with this reality or address the level of intricacy they confront. Welfel and Lipsitz 1983 [3] found rather that ethical orientation is identified with moral reasoning.

Different components and relativistic belief are identified with counsellor empathy [4], how empathically counsellors identify with clients given the differences between the ethical reasoning of the counsellor and clients [5] which is exceptionally identified with ethical services to the clients.

Introduction to a client with disability and another ethnicity

I carried out the assessment with the client. Prior to the session, I was informed by the management that the client suffers with Alzheimer's disease (primary stage) and arteritis and previously had a refugee status in the UK. The lady is in her early sixties and originates from a Middle Eastern country but is now a British citizen. She lives alone as none of her family members are alive. She feels anxious to go out after her diagnosis of Alzheimer's. Despite a knee operation, due to her arteritis, she still has some movement difficulties. During our first session, she asked me if she could be counselled at her own home as coming to the clinic was difficult due to her health issues. Additionally, she must depend on her career to come for the sessions as she cannot remember the address of the clinic. She is referred by her GP and UK government is supporting her financially.

By equipping clients with basic knowledge of physical capacities and impediments, they may develop reasonable

individual and vocational objectives, which may likewise serve to reinforce the counselling relationship if the client feels that the counsellor can truly comprehend the challenges she is experiencing [6-9]. My client was diagnosed with arteritis when she was in her mid-forties. She has been experiencing mobility issues for the last 5 years, despite a knee operation last year and ongoing weekly physiotherapy sessions. Though the operation has helped her with daily tasks, she still has severe pain while walking. Recently she has been diagnosed with Alzheimer disease (Initial stage) where she became very confused with traffic signals, roads and addresses. One recent incident reported that she went to the local shop to buy milk and could not return to her home address. This made her very anxious and tearful. Her main goal from the counselling is to cope with this new disorder as she seems confused regarding her illnesses.

During the assessment, her CORE 10 score was a bit high which leads to depression, especially when she explained her family background; coming to the UK in her adolescence as a refugee with her only brother. The more common psychological well-being diagnoses related with refugee populaces incorporate major depression, post-traumatic anxiety issue, generalized anxiety, adjustment disorder, panic attacks, and somatization [10]. Also, Kirkbride, 2008 [11] says that UK migration data recommends that the level of increased risk of psychological wellness issues may rely on how old individuals were at the point at which they migrated, as children and adolescent are at risk. The client is therefore at high risk of becoming depressed due to her own personal circumstances as a refugee fleeing war during adolescence. Although family members may usually act as a buffer against the onset of depression [12] her brother passed away a few years ago of cancer. She therefore has no living family to support her as she never married. Heikkinen et al. 1995 [13] demonstrates that numerous elderly individuals encounter depression and loneliness either because of; living alone, absence of close family ties, lessened associations with their culture of origin or a failure to effectively take an interest in the local community activities. Moreover, elderly disabled people with different ethnicity become marginalized in their relegated group [12].

Due to her physical condition, Age concern UK and social services are helping her financially as she can't bear her own expenses. She mentioned that she was a very strong and independent woman, but her illnesses made her vulnerable which is sometimes unbearable for her. Therefore, when her GP recommended counselling for her, it gave her hope that she will be able to cope with her situation well and there will be someone to talk to regarding everything. Though she has a carer to look after her, she still sometimes feels lonely and depressed. She is moderately religious and holding liberal values of life. However, sometimes she feels that it's her previous life's sin which has made her disabled and lonely in this world.

Physical disability

A physical disability can either briefly or permanently influence an individual's physical capacity as well as mobility. Albeit current models underline an ecological point of view, clients and therapists may hold ideas about disability that are impacted by religious, social and medicinal beliefs. As seen in my clients own personal belief that her previous worlds sin are a cause of her current disability. Awareness of these models and how they may affect my client with disability can facilitate the clinical process and outcomes [14-16]. These models include:

The Pre-Scientific model

Disability is considered as an epitome of evil, a punishment for a relative's or predecessor's transgression, a divine blessing, destiny or a trial of confidence and chance to beat a challenge [17,18]. Without acknowledging it, psychologists or their clients might be influenced by these profound situated chronicled constructs in a way that impacts their relationship. Some contend that a sufficient conceptualization of disability requires acknowledgment of debilitations as a target reason for characterization, to recognize disability discrimination from different sorts of segregation [19]. This model would thusly miss the mark as far as objectivity as an evaluation of beliefs depends on the patient relaying this information as they comprehend it and the therapist receiving the information in a similar vein. This exchange is inevitably tainted with the predisposition of each's own personal perspective on such matters.

However, the metaphoric utilization of disability as an image of sin, unbelief, and obliviousness additionally highlights the idea of disability as one that is seen from an ethical viewpoint though there is no scientific clarification [20]. Moreover, the philosophical significance of perfection has truly included physical flawlessness and numerous religious introductions make an immediate association between physical perfection and spiritual magnificence [21]. My client registered ideas that her previous life's sin was a cause of her current ailments and loneliness. Hence, the moral model has guided me well in my understanding of the client's needs and also made me conscious of cultural values where deprivation is linked to ignorance, fear and prejudice.

The Scientific model

The scientific models of disability reflect medical, social development and functional conventions of conceptualizing disability [14,16,22]. The emphasis is on the individual's deficiencies and elimination of the pathology or reclamation of functional capability [23]. The counselling sessions with my client rely on this model to target adjustment to disability. Holding this view may lead my client to solely focus on the hope for a cure, how to adapt and move on with daily life.

The Social model

This model emphasizes the dynamic connections of the client's individual attributes (e.g., functional status, conditions, individual and social qualities) with the natural, constructed, cultural, and social situations [16, 23-28]. This made me think of her vulnerable situation, her illnesses, lack of family or friends to support her and living on benefits etc. According to this model, my focus was to facilitate my client's positive disability identity and self-advocacy skills or consult with others (such as my placement manager, my supervisor, her social worker, carer etc.) to ensure that the client has adequate accommodations, chances for involvement, and a voice in decision making [18,26].

Several critics contend that extraordinary forms of the model unrealistically deny or downplay the role of disability itself as a source of hindrance [29-32]. Others, nonetheless, argue that this criticism is lost, because the British Social Model does not preclude the significance from claiming debilitations yet rather seeks to restrict the notion of "disability" to social oppression and exclusion [33]. The social and medical model both lay on a false polarity between biological impairments and social restrictions. There are two renditions of this objection. One maintains that disability is a very complex phenomenon, in which biological inability and social prohibition are profoundly intertwined and hard to prod separated [29,34]. The other form of this objection rejects the treatment of impedance as a (entirely) biological phenomenon. "Disability," the contention goes, is no less a social construction than the hindrances confronted by individuals so classified. Claims that there is a stable biomedical reason for arranging a variety as a disability are raised doubt about by moving groupings; by the "medicalization" of few conditions (shyness) and "demedicalization" of others (homosexuality) [35-38]. What is considered a disability may rely on which varieties have all the earmarks of being disadvantageous in salient or familiar environments, or on which varieties are liable to social bias. For such reasons, it is hard to establish the objectivity of the disability classification by offer to an unmistakable and undisputed biomedical standard. Amundson [38] goes so far as to deny that there is any biological reason for an idea of functional normality -a claim determinedly dismissed by Boorse [39]. In summary, I was focusing on my client's psychological oppression. As a result, she has developed a "false consciousness," whereby she come to believe that she is less skilled than others [40]. Therefore, I tried to encourage my client to not only look towards a future society devoid of environmental, attitudinal and structural barriers, but one that can "rejoice difference and values people irrespective of gender, sexual preference, race, age and impairment" [41].

Ethnicity

Since the last two decades counselling in a multicultural setting has been based on expansion with more training projects now including issues of race, culture and ethnicity. According

to Owusu-Bempah and Howitt [42], traditional psychological research inclines to disregard the practices of psychologists and dismisses the likelihood that psychologists could be racists. However, a noteworthy helpful approach in counselling psychology is psychodynamics, which depends on the work of Freud and Jung among others [43]. Richards [44] portrays Freud and Jung as 'alleged racists' as they call a few societies "primitive" and others 'acculturated'. As counselling psychology is partially informed by Freud and Jung's considerations [45], it is crucial to examine what the roles of race, culture, and ethnicity are in practice. Prejudice existing in therapy may originate from fundamental human emotions, for example, aggression, envy and fear [46]. Because of the power dynamics in the therapy room, discussing social contrasts may appear troublesome and feel like an attack [47]. Consequently, ethnicity issues might be maintained at a strategic distance to avoid this happening. This need to avoid addressing to contrast comes from the therapist's guilt and shame at some level [48]. Guilt and shame stems from prejudices' socially built nature and because of this, ethnicity definitely enters the therapy room, estranging the client and making the therapist anxious [49].

Alongside the BPS rules, Ibrahim [50] and Essandoh (1996) required an outlook change in counselling psychology in the way culturally diverse treatment is seen. Advocating seeing all therapy as a multicultural attempt where all societies are really grasped instead of infrequent references to ethnic minorities. Adding to and echoing this idea, Gilbert and Orlans (2011) say anti-oppressive practice is a therapist's ethical obligation and they ask practitioners to know about societal issues. Counselling and psychotherapy within a multi-cultural context raise a few uncertain issues that are particular to the process of counselling and therapy, for example, the language(s) talked, pitches, tone, expressions, shared meanings, verbal and non-verbal misunderstandings, differential expectations, the uses and misuses of metaphors, and conflicting belief systems of the client and counsellor. With this client, I always tried to make sure she understood my words well to reduce the effects of a potential language barrier. Sometimes I used to repeat my sentences using different words to make sure there was no misunderstanding. In addition, Barnett and Johnson [51] stated that there are times when ethnicity or religious or spiritual concerns might be applicable to the reasons why clients look for treatment from a psychotherapist. For example, when ethnicity or religion is an area of distress or conflict or conversely, a source of support and strength. Gonsiojorek et al. [52] highlighted that most therapists perceive the fuse of ethnicity, religion and spirituality into counselling as posing 'inherent messiness', particularly where competence in religion or spirituality is concerned. Hence, with my client I was always careful that my cultural or religious beliefs did not interfere in the counselling process as my client is from different ethnicity.

Furthermore, this has led to me strongly advocating the inclusion of political and socio-economic constructs as part of a wider explanation of multicultural counselling. In the Culture infused counselling model [53], stresses reflective practice, challenging career-practitioners to reflect potential cultural impacts in three areas:

- a. self-awareness regarding personal cultural identity or ethnicity,
- b. Awareness about the culture or ethnicity of my client, and
- c. Awareness of how culture or ethnicity impacts the working alliance between me and my client.

My experience working with this client and ethical support with from my placement:

Research proposes therapists and other mental health professionals frequently lack adequate knowledge of disability issues and have inadequate practice in working with clients who have disabilities [54,55]. With inadequate understanding of disability experience, a therapist may feel anxious, confused, fearful, repulsed and vulnerable when working with a disabled client. In my first session with this client I was feeling nervous regarding her Alzheimer disease. Observing her mobility issues and being asked to provide counselling at her personal address only added to my anxiety. On one hand, I wanted to offer valuable support and on the other hand I wanted to make sure I was not doing anything unethical. Therefore, I crossed checked with my placement manager what should be the best way to proceed in supporting her. He subsequently informed me that according to their policy a female counsellor can provide home based counselling to a female client if the counsellor is comfortable to do so. He also mentioned that if I am considering providing such a service then there are a few things I should keep in mind regarding the ethical boundaries and associated risk factors. These extra considerations include:

- a. Change the service contract
- b. That there will be a proper room for counselling without any guest or disturbances
- c. Not to accept any tea or coffee as I am not a guest
- d. Complete the risk assessment form of the organization after the first visit and submit to the office
- e. Keep in mind that if any time I am feeling uncomfortable or insecure, leave the place immediately.
- f. For safety purpose, always before entering and after leaving client's place, text the coordinator to inform about your home visit which will help her to take necessary action if require.

Moreover, the Equality Act [56] stated that as an alternative, a psychologist may conduct sessions in a mutually suitable accessible setting or refer the client to a suitable psychologist with similar or greater qualifications whose workplace is more easily accessible. Therefore, I decided to provide home based counselling. However, there are some boundaries from BPS code of ethics and conduct [57] that I considered regarding any ethical decision making. For example:

- a. Boundaries for client safety
- b. Boundaries for counsellor safety
- c. Boundaries for organizational reputation

These also involve some legal responsibilities. For example:

- a. Organizational policies
- b. Data protection act
- c. Confidentiality & unauthorized disclosure
- d. The contract for therapy outcomes of not responding to legal issues

My placement manager specifically emailed me with an attached link of Equality Act [56] where it implements laws that protect disabled individuals from being treated unfairly and applies to many circumstances. He also mentioned that according to the organization's policy I am allowed to text my client to remind her about our appointment because of her illness and she doesn't need to pay any gift aid to the charity as she is unemployed.

Conclusion

To meet least norms of practice, consequently, counsellors will be required to be proficient in disability and ethnicity issues [58,59]. In fact, Humes, Szymanski, and Hohenshil [60] recommended that counsellors have not encouraged the self-development and growth of their clients with disabilities. In addition, the emphasis on ethnicity shifts to understanding the intersectionality of a client's different personalities, and the significance of the crisis the client faces in terms of what core values or perspective, and identities are influenced (Conwill, [61]; Eklund [62]; Ibrahim [50]). It is unlikely to anticipate or expect that a counsellor will know the social practices of all cultural groups and ethnicity. In practice, affirmation of possible differences, and looking for clarification before acting, are keys to overcoming this issue. Therefore, whenever I felt confused about anything during the counselling process I clarified with my placement manager and supervisor [63-76].

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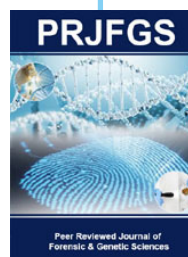
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