
Just Ethics:

Moral Courage in Clinical Practice

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Presentation for the Association of Jewish Psychologists

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Learning Objectives

At the end of this program, participants will be able to:

- 1** Describe the three levels of everyday advocacy (individual/patient, grassroots/community, and state/system).
- 2** Analyze how a psychologist's positionality (identity, power, privilege, and personal history) influences advocacy decisions, including the risk of intrusive advocacy.
- 3** Explain the psychological impact of antisemitism on patients and on Jewish mental health professionals.
- 4** Apply the levels-of-advocacy and positionality frameworks to develop clinically appropriate and ethically grounded responses to antisemitism.

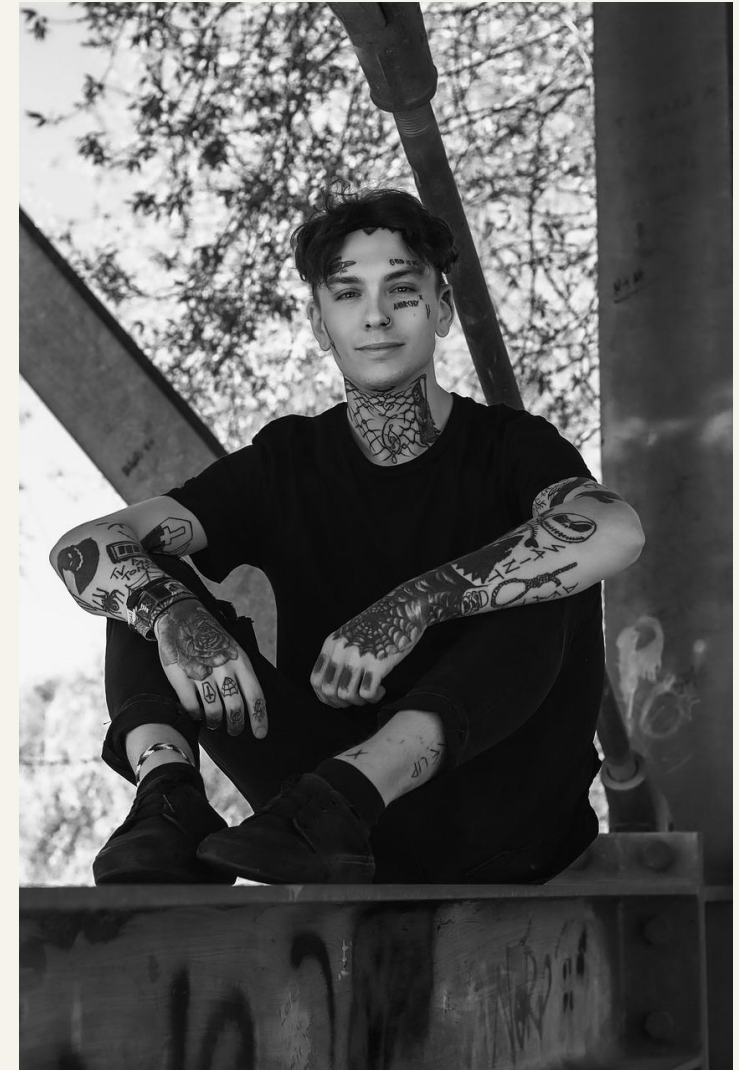
Today's schedule

Time (ET)	Segment	Minutes
12:00–12:10	Introduction	10
12:10–12:25	Case examples	15
12:25–12:40	Enlarging the definition of advocacy	15
12:40–1:00	The psychological impact of antisemitism on patients and on Jewish mental health professionals	20
1:00–1:15	The psychologist's positionality (identity, power, privilege, personal history, and countertransference) in advocacy decisions	15
1:15–1:25	Applying the levels-of-advocacy and positionality frameworks to responses to antisemitism	10
1:25–1:30	Questions and answers	5

Vignette 1: Tattoos

Dr. Sharone was surprised when first meeting her new heavily tattooed patient, as one tattoo was a swastika. Her grandfather had survived the Holocaust. She became anxious and wondered how to proceed.

How might your personal and professional values influence your response?



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Vignette 2: Social Justice

Dr. Brown has had several patients recently talk about the campus protests about the Israel/Hamas war, some favorably, some not so much. Should Dr. Brown disclose her feelings about the protests? Why or why not?

How might your personal and professional values influence your response?

What do you hope to accomplish? How do your goals work with the Ethical principles?



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Reflecting on Advocacy



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| What barriers to advocacy do you see?

| What are the opportunities that might result from advocating?

| Why don't we receive training on advocacy?

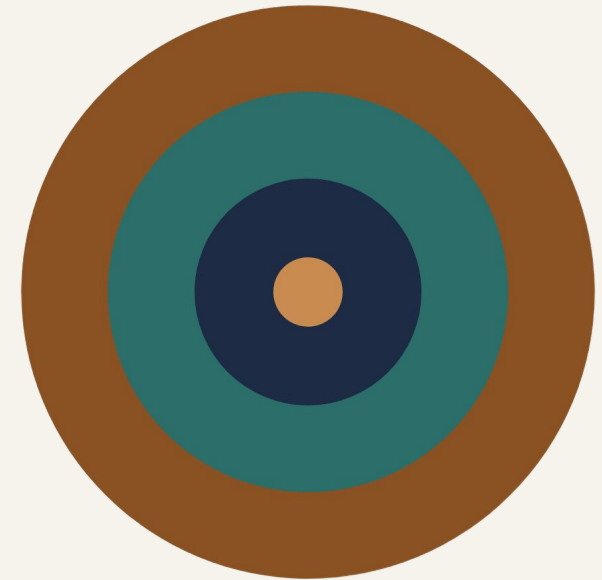
Three Levels of Advocacy



What barriers to advocacy do you see?

What are the opportunities that might result from advocating?

Why don't we receive training on advocacy?



You do not need permission to start! Start where you are!

Level 1: Individual/Patient Advocacy

Examples:

- Refusing to pathologize cultural differences
- Documenting systemic barriers: “Patient’s anxiety exacerbated by housing instability, referred to housing advocate”
- Considering social determinants of mental health issues
- Challenging a patient’s biases and bigotry in a non-offensive, therapeutic style
- Pursuing insurance options for the patient

Tool: Use your clinical voice as an ethical witness.

APA anchor: Standard 2.01 + 3.04a (APA, 2017)



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Level 2: Grassroots/community advocacy

Examples:

- Train school staff on trauma-informed responses
- Attend local groups and offer support and education to members
- Work on community task force

Tool: Meet people where they are. Your jargon-free translation of psychology is advocacy and builds trust

APA anchor: Standard 5.04 — Public Statements (APA, 2017)



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Level 3: Systems



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Examples:

- Serve on APA and other national and international committees re: access to care, rural healthcare, services for marginalized communities
- Attend advocacy days
- Advocate for systemic change by sharing psychological science
- Meet YOUR legislators at public events or fundraisers: Build relationships

Tool: “Be the person who volunteers — then change the agenda.”

APA anchor: Principle E — Respect for People’s Rights and Dignity (APA, 2017)

Vignette 3: Hunger or Pathology?

A young patient can't focus through session after session. The referral asks you to assess for attention problems. But you learn the family is food-insecure — the child often comes to you hungry. **Is this pathology, or is it a leaking roof?**

You notice a pattern in how patients of color move through your setting's referral and diagnostic process — and how a moment of racial or political conflict surfaces in the room. Staying “neutral” feels safe. **But is neutrality itself a position here?**



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Advocacy isn't “all or nothing.”

Start where you are. Influence what you touch.

Psychological Impact of Antisemitism on Patients' Mental Health

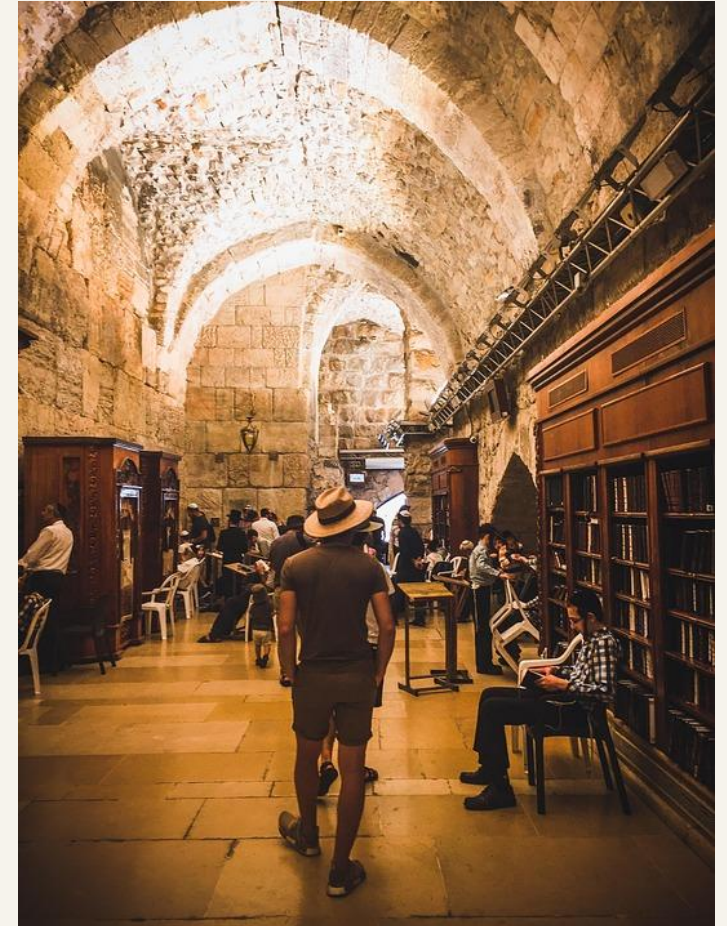


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- Antisemitism: systemic beliefs, attitudes, or actions directed toward Jewish people and communities (American Psychological Association, 2024; The Nexus Project, 2024).
- US is experiencing a historic rise in antisemitism, with Jews being one of the most targeted groups in the US relative to their population size (U.S. Department of Justice Community Relations Service, 2024).
- Specifically, after African Americans, Jews were victimized more often than any other group, including Asians, Native Americans, Latinos, women, Muslims, gay men, lesbians, and people with disabilities (Federal Bureau of Investigation, 2024).

Psychological Impact of Antisemitism on Patients' Mental Health

- Surprisingly few studies examining the impact of antisemitism on Jews' mental health in the United States (Walker et al., 2025)
- Found only one prior quantitative study of experiences or perceptions of antisemitism and mental health in American Jews (Hibel et al., 2025)
- Exposure to antisemitic speech was associated with negative psychosocial consequences, including anxiety and distress (Leets, 2002)
- Numerous studies across several different identity groups have emphasized perceived discrimination as a unique psychosocial stressor with the potential to erode mental health (Clark et al., 1999; Pole et al., 2005)



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Psychological Impact of Antisemitism on Patients' Mental Health

- In general, numerous studies across several different identity groups have shown discrimination such as antisemitism aggravates the experience of daily stressors (Flores et al., 2008)
- Discrimination is translated into higher levels of next-day depressive symptomatology (Torres & Ong, 2010), leading to increased chances of a mood, anxiety, or substance use disorder (Cobb et al., 2021)
- In addition, it can lead to lower levels of happiness, and worse health status (Padela & Heisler, 2010)
- Building personal and social resilience is particularly important for individuals experiencing stress and trauma.
- Thus, clinicians can stress connection to Jewish cultural and religious practice as a way to increase resilience to antisemitism.



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Antisemitic Experiences Among Jewish Mental Health Professionals

Although antisemitism has been rising in the United States in recent years, including within the mental health field, experiences of antisemitism among mental health professionals have only recently been examined.

In a 2026 study of 218 Jewish mental health professionals: (Brosbe et al., 2026)

74%

reported experiencing antisemitism

39%

reported experiencing antisemitic harassment

39%

reported negative statements regarding Jews from clients

Participants reported many consequences of antisemitism, including anxiety in the work setting, professional exclusion, and harmed relationships with colleagues.

Antisemitic Experiences Among Jewish Mental Health Professionals

- These experiences were most often encountered from colleagues through social media or professional listservs
- Thus, experiences of antisemitism appear prevalent among mental health professionals and associated with various personal and professional consequences
- This highlights the need to address antisemitism in professional psychology and provide support for Jewish mental health professionals



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Ethical Considerations for Addressing Patients' Prejudicial Comments in Psychotherapy



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- Be curious. Ask patients to talk about their beliefs.
- Tell me what you mean. Help me understand.
- What does it feel like to be your patient?
- Explore their motivation for making such comments. Focus on emotions tied to the prejudicial comment and/or experiences that may have contributed to the development of the prejudicial belief.
- Are they open to other perspectives?

Ethical Considerations for Addressing Patients' Prejudicial Comments in Psychotherapy

Would an intervention be likely to succeed?

- Would addressing the issue with the patient likely be successful in helping to change their attitude or behavior?
- What factors would make it likely that the intervention would work, or not work?
- How could you discuss the issue in a manner that reduces the likelihood that the treatment relationship would be harmed?



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What happens if you unintentionally embarrass, humiliate, or antagonize your patient?

Ethical Considerations for Addressing Patients' Prejudicial Comments in Psychotherapy



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- ✓ The goal of addressing prejudicial comments is to provide an environment to explore the patient's beliefs.
- ✓ This is most difficult when the psychologist is a member of the targeted group.
- ✓ The conversation should be collaborative rather than confrontational.
- ✓ Avoid instilling guilt and shame in the patient.
- ✓ Conversations about values, prejudice, and discrimination are painful and usually avoided.
- ✓ In addition, consultation can provide a broader perspective and reduce dysphoric affect.

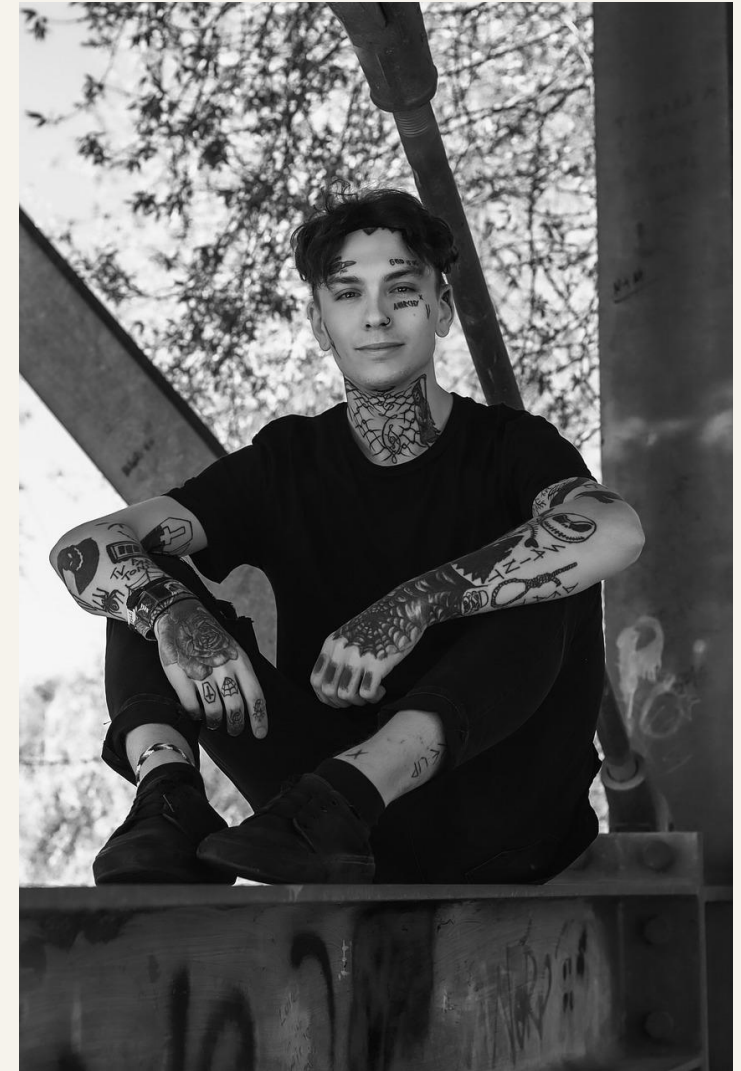
Revisiting Dr. Sharone

Dr. Sharone's new patient has a swastika tattoo. Her grandfather survived the Holocaust.

How could Dr. Sharone use curiosity to understand what the tattoo means to her patient?

Would raising it now be likely to succeed, or would it harm the treatment relationship?

How might her family history shape her response, and how could consultation help?



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Before We Advocate, We Reflect

What we bring into the room shapes how we respond to what our patients bring.

Positionality: Psychologist Variables

Cultural Background	Power Differential
Countertransference	Privileges
Gender	Relationship to Authority
Vulnerabilities (needs, desires)	Setting (private, hospital, community)
Professional History	

Lived Experience: Patient Variables

Cultural Background	Length of time in treatment
Transference	Expectations of Psychotherapy
Gender	Level of Safety
Complexity	Patient position in system
Socioeconomic Status	Relationship to Authority

When Countertransference Serves the Therapist, Not the Patient

Countertransference is inevitable, but it becomes an ethical issue when it shifts from a source of information to a source of the therapist's gratification.

Feelings (e.g., protectiveness, curiosity, frustration) that **inform the therapist about the patient's relational patterns** and help advance the patient's goals.

Feelings that **meet the therapist's own needs** (e.g., need to be the "savior," need for admiration, need to avoid one's own discomfort).

How Unresolved Feelings Become a Risk to the Patient

Unresolved, unprocessed strong feelings from the therapist's own history are the most dangerous form of countertransference because they operate outside of awareness and are enacted, not thought about.

The therapist unconsciously acts out their own relational template from the past, pulling the patient into a re-creation of an old drama (e.g., the therapist becomes the critical parent, the patient becomes the helpless child).

The patient, in a vulnerable state, often complies with the therapist's unconscious pull, reinforcing their own maladaptive patterns.

The Advocacy Tightrope: Risks of Silence and Intrusion

When faced with injustice in a patient's life, the therapist's positionality dictates a spectrum of responses. The two ends of that spectrum, silence and intrusion, both carry significant ethical risks.

The Risk of Saying Nothing

The therapist adapts to the status quo, avoids conflict, and prioritizes "neutrality" or professional safety over the patient's need for advocacy. **Complicity with the injuring system.**

The Risk of Intrusive Advocacy

The therapist imposes their own agenda, values, or outrage onto the patient's situation, regardless of the patient's readiness, culture, or goals. Epistemic injustice (speaking over the patient's own voice) and re-traumatization through a loss of control. **The advocacy meets the therapist's need for justice, not the patient's need for empowerment.**

Integration: A Final Vignette

Advocacy, positionality, and countertransference in one case.

Final Clinical Vignette

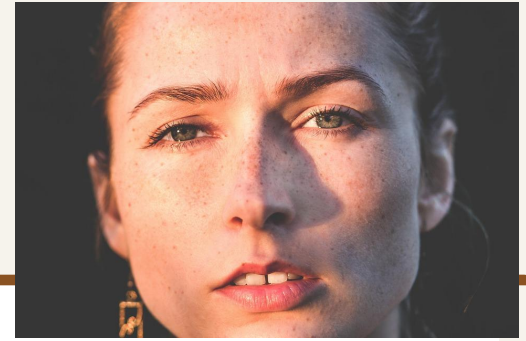
Sarah, a 34-year-old Jewish woman, presents with anxiety, hypervigilance, and sleep disturbance. Since regional conflict began, she has faced antisemitic incidents at work: colleagues dismissing Jewish "privilege" and a supervisor calling her "too emotionally invested." After a nationally publicized synagogue event, she now fears for her safety and has begun hiding her Jewish identity at work. Her therapist, who is also Jewish and has experienced similar workplace discrimination, feels a strong pull to validate Sarah's experience and encourage her to challenge the supervisor's conduct as part of broader advocacy for workplace equity.

Yet Sarah explicitly states she needs to "keep my head down" to feel safe.



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Some thoughts on the final vignette



1. Recognizing Antisemitism as a Legitimate Systemic Stressor

- Sarah's anxiety, hypervigilance, and sleep disturbance are rational responses to documented discrimination
- Her workplace experiences are real injustices warranting clinical attention and documentation

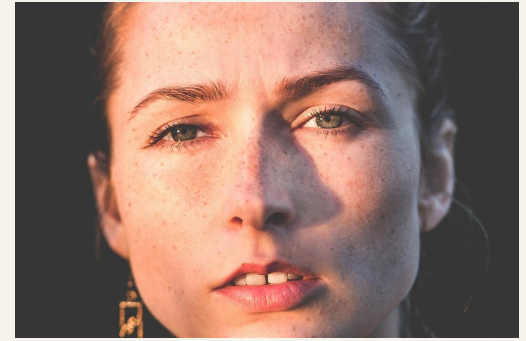
2. The Therapist's Countertransference and Positionality

- The therapist's shared Jewish identity and similar experiences create powerful parallel process
- The "strong pull" to encourage challenge may reflect the therapist's own unresolved issues
- Risk: countertransference shifting from information to the therapist's gratification

3. Risk of Intrusive Advocacy

- Encouraging Sarah to challenge her supervisor imposes the therapist's justice agenda over her autonomy
- Risks overriding her voice and perspective, and re-traumatization through loss of control

Some thoughts on the final vignette (cont.)



4. Appropriate Level 1 Advocacy

- Be curious without prescribing action
- Document systemic barriers in clinical notes
- Build resilience through connection to Jewish identity and community
- Bear witness to the injustice and validate without imposing action

5. The Core Dilemma: Validation Without Intrusion

- Sarah needs validation that discrimination is real and wrong
- She also needs her therapist to respect her judgment about what's safe
- **Consultation is indicated for this dynamic**

Key Takeaways

- 1** Advocacy isn't all or nothing. It happens at the individual, community, and systems levels, so start where you are.
- 2** Antisemitism is a real and rising stressor for patients and for Jewish mental health professionals.
- 3** Know your positionality. Countertransference becomes an ethical risk when it shifts from information to gratification.
- 4** Avoid both silence and intrusion: validate, bear witness, respect the patient's judgment, and seek consultation.

Questions and Answers

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