ETHICAL DECISION-MAKING AMONG FAMILY THERAPISTS
AND INDIVIDUAL THERAPISTS

by

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ABSTRACT

Ethical decision-making is an important part of the daily practice of therapists. In recent years, several authors have made a strong assertion for addressing the ethics of family therapy models based on systems theory and cybernetics. The concerns expressed focus on the lack of consideration for the rights of the individual in a theoretical paradigm that focuses on systems. It is recognized in these concerns that existing ethical models utilized by professional organizations focus on individual rights, a perspective associated with Cartesian dualism and traditional psychology that focuses on the individual.

This study investigated the ethical decision-making of 30 individual and 30 family therapists to detect the types of decision-making currently being used by practicing therapists. Informants responded to three ethical dilemmas. Two of the situations were hypothetical and provided by the investigator. One of these dilemmas involved an HIV positive client who continued to have sexual relationships and the other was a family situation involving sexual abuse of the daughter. The third dilemma was a situation the informant had experienced in their own practice. Each of these interviews was assessed for decision-making style using content analysis. Kohlberg's justice reasoning that emphasizes the morality of rights and with treating all persons equally, and Gilligan's care reasoning, emphasizing relationships and the particular needs of others in specific relationship contexts, provide the conceptual foundations for this analysis.

The results of this study suggest that both family and individual therapists prefer care reasoning on all dilemma

types. The highest care scores were on the dilemma from the therapist's own practice. The second highest care scores were found on the family dilemma followed by the individual dilemma. Characteristics of informants or dilemmas did not provide clear explanations of the differences in reasoning found. This study suggests that therapists, whatever their theoretical orientation, are concerned with issues related to an ethic of care when making ethical decisions in practice. Suggestions for further research are given.

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CHAPTER I

INTRODUCTION

Statement of the Problem

In recent years, several authors have made a strong assertion for addressing the ethics of family therapy models based on systems theory and cybernetics (Green & Hansen, 1986; O'Shea & Jessee, 1982; Solovey & Duncan, 1992 Taggart, 1983; Wendorf & Wendorf, 1985). The concerns expressed by these authors focus on the lack of consideration for the rights of the individual in a theoretical paradigm that focuses on systems. It is recognized in these concerns that existing ethical models utilized by the professional organizations focus on individual rights, a perspective associated with Cartesian dualism and traditional psychology that focuses on the individual (Becvar & Becvar, 1988). Within this therapeutic context, the present study addressed the decision making process therapists utilize to resolve these dilemmas posed by the incongruence between practice theory based in cybernetics and traditional individually oriented values based in Cartesian dualism. A structured interview technique was utilized to elicit the ethical decision making currently being used by practicing family therapists and therapists who practice traditional individual therapies.

Family therapy is a way of viewing the world or punctuating experience. Within this world view are assumptions about families, individuals and the environment that distinguish it from the world view of traditional, individually oriented therapy. The therapist is concerned not about the individual and individual problems, but with relationships within the family system. The search for

understanding comes from the question of what is happening in this system of interactions and considers meaning within the context of interactions (Becvar & Becvar, 1988; Commission on Accreditation for Marriage and Family Therapy Education [COAMFTE], 1988).

When ethical decisions that have evolved out of a systems/cybernetics theoretical model are evaluated from the traditional epistemology of Cartesian dualism, they may appear to be lacking respect for the rights of the individual family members. It is in the arena of ethics that the family therapist most directly confronts the difference in expectations between the ethics and expectations established from the perspective of traditional individual therapy based in Cartesian dualism and therapeutic action developed from the perspective of cybernetics. The process of resolving this theoretical conflict places the therapist in the bind of following the traditional legal/moral definition of action and violating accepted family therapy practice or of ignoring the traditional legal/moral definitions and practicing congruent with family therapy's theoretical base.

One primary source for assisting practitioners with ethical decision making is the professional association's code of ethics. The American Association for Marriage and Family Therapy (AAMFT) is the largest professional organization for family therapists. Therefore, it would be appropriate for family therapists to utilize the 1991 AAMFT Code of Ethical Principles for Marriage and Family Therapists (AAMFT) for making ethical decisions related to family therapy. When this code is reviewed however, it becomes evident that it does not address the ethical dilemmas presented by a systems/cybernetic orientation to

therapy. The AAMFT Code of Ethical Principles provides the therapist with traditional legal/moral definitions to guide practice that evolve from a focus on individual rights.

T.C. Schneirla (Tobach, 1970) and Ludwig von Bertalanffy (1952, 1967) anticipated the problem of applying the ethics of individual therapy to work with larger systems in family therapy. Schneirla discussed levels of organization in which each level of organization is subsumed in each higher level of organization, and with this inclusion, it is modified. Due to these changes, each level produces its own laws and principles, and information. One level could not be used to predict at the next higher level because this new level contains different processes (Tobach, 1970). Von Bertalanffy (1952, 1967) also asserted that new laws appear at each level of organization and that social entities have rules of behavior that differ from individual mores. He clearly stated that traditional ethical codes that provide rules for individual behavior, would be immoral from the standpoint of responsible systems focused behavior.

Ethical decision making or moral reasoning is the method one uses to resolve conflicting values (Argyris et al., 1987; Runes, 1983). The concerns expressed by family therapists involve the resolution of the conflicting values of professional codes of ethics based on individual rights and practice models that utilize families and relationships as a focus for intervention strategies. The theoretical base for this study came from the work on moral reasoning done by Kohlberg (1981) and Gilligan (1977, 1982).

Lawrence Kohlberg (1969, 1981, 1984) was one of the first researchers to describe the process of moral reasoning. He developed what is now referred to as the justice model of moral reasoning. Moral reasoning guided by

justice focuses on the application of general principles to specific situations. Within the justice model, moral decision making is concerned with the morality of rights and treating all persons equally (Broughton, 1983; Reed, 1987). The justice perspective highlights issues of fairness, right and obligation (Flanagan & Jackson, 1987).

Carol Gilligan questioned Kohlberg's model and developed an alternate perspective to moral judgment that evolved from her concerns about the treatment of women in Kohlberg's model. Gilligan's theory focuses on what has been termed the care response. Moral requirements are viewed as arising from the particular needs of others in specific relationship contexts (Flanagan & Jackson, 1987; Gilligan, 1982). The ethic of care focuses on the relationships of the involved parties and the particulars of the situation, including the special needs of those involved (Flanagan & Jackson, 1987). When using the care perspective, one would consider the actual consequences of a decision for the involved parties, how the decision would affect the relationship, the context and specific individuals involved, the need to avoid hurt, and issues of altruism (Friedman, Robinson, & Friedman, 1987).

Many authors have criticized the traditional justice model focus of health care ethics. The perspective evolving from the justice model is guided by the assumption that decisions evolve from the ordering of ethical principles that strive to treat all individuals equally despite the context (Fry, 1989). Writings of Hare-Mustin (Hare-Mustin, 1980; Hare-Mustin, Marecek, Kaplan, & Liss-Levinson, 1979; Hines & Hare-Mustin, 1978) demonstrate the bias for justice ethics in traditional health care ethics when she questions the risks for the individual in family therapy and supports

the need to endorse independence and self-determination away from the family. These articles written by Hare-Mustin and her colleagues clearly indicate that a perspective that does not value individual rights over the rights of the whole can be seen as lacking an ethical perspective. Hare-Mustin's strong focus on individual rights would support the conclusion that her criticisms of family therapy evolve from a justice model of ethical decision making.

If, as Von Bertalanffy (1967) states, the application of traditional ethical codes to social systems "is like operating an atomic reactor with the technology of a Bushman" (p. 50), what are the alternatives? When the assumptions of family therapy, based in systems theory/cybernetics, are defined as concerns for the relationships between individuals and social systems, the moral decision making model of care seems most congruent. The care perspective views responsibilities as evolving out of relationships with others, and the concern for individual rights seen in the justice model of moral decision making is replaced by concerns for responsibility toward interdependent relationships (Gilligan, 1982). The key terms in the care model are connectedness, relationship, responsibility, interdependence, preventing harm, sacrifice, caring, and context (Lyons, 1983). These key words echo the ethical guidelines set forth by Segal (1986), von Foerster (1986a) and Bateson (1972) for systems/cybernetics paradigms. Each of these authors speaks of the responsibility of the individual to the system in a context where the welfare of the individual depends on the welfare of the system. It would appear that the utilization of the care model for ethical decision making in family therapy would provide theoretical consistency between family therapy

theory and ethical decisions. This study used interviews with family therapists and individual therapists to determine the ethical decision making perspectives that are being used by practicing therapists. The information obtained can be used to inform the development of professional codes of ethics and continuing education programs.

Definitions

For the purposes of this study, ethics was defined as the philosophical study of morality (Noddings, 1984). This included the study of judgments of approval and disapproval, rightness and wrongness, goodness or badness, virtue or vice, and most importantly for this study, the desirability or wisdom of actions, dispositions, ends objects, or states of affairs (Frankena, 1983). Within this definition, ethics is often used in three different ways that represent different issues for understanding the information presented. The three uses are: "(1) a general pattern or 'way of life,' (2) a set of rules of conduct or 'moral code,' and (3) inquiry about ways of life and rules of conduct" (Edwards, 1972, pp. 81-82). As the term ethics is used by the American Association for Marriage and Family Therapy, it refers to a set of rules of conduct or a moral code; however, since the purpose of this study was to understand the ethical processes currently being utilized by marriage and family therapists, the third understanding of the term was used in an effort to discover how family therapists and psychologists make ethical decisions.

Cartesian dualism refers to the philosophy of Descartes that establishes a separation between mind and matter. This split results in a conceptualization of humans as separate

from the environment and a world view that establishes an individual/family distinction and separates the individual from the family (Bateson, 1972; Keeney, personal communication, 1987). These phenomena are conceptualized as decontextualizing the individual from the family and the family from the larger social systems of which they are a part (Keeney, personal communication, 1987).

Systems theory refers to the body of knowledge that defines the structural rules that are valid for all systems (Simon, Stierlin, & Wynne, 1985). Discovery and description of these rules can be seen in the works of T. C. Schneirla and von Bertalanffy. Schneirla (Tobach, 1970) described levels of organization and von Bertalanffy (1952) supported this theme with his description of quantitative changes from one level of organization to another that result in qualitative differences. The general systems rule becomes an understanding that the system is a whole which contains differing levels of organization. Each level of organization then has its own rules because of the quantitative changes that occur from one level of organization to another.

A system is understood to be an ordering of elements into a unified whole (Simon et al., 1985). As general systems theory (GST) is applied to family therapy, unique understandings about the individual and the family emerge. This specialized application of GST at the level of the family is referred to as family systems theory (FST). The individual and family are seen as co-evolving with their context. This becomes the complementary interacting patterns of individual-in-context/family-in-context or individuals and families are seen as part of their interactional

ecosystem (Keeney, personal communication, 1987; Segal, 1986; von Foerster, 1984; von Galsersfeld, 1984).

As defined by Wiener (1974), cybernetics is the study of communication and control. Beer (1974) refines and updates this definition and refers to cybernetics as "the science of effective organization" (p. 2). Cybernetics of cybernetics or second-order cybernetics (von Forester, 1974) is the more appropriate conceptual framework for the social sciences because it provides the complexity to address cognition, dialogue, and social-cultural interactions (Keeney, 1983). Von Foerster (1974) defines cybernetics of cybernetics as the cybernetics of observing systems, which when transferred to family therapy becomes a way of understanding the observer's role in the system. The observer becomes part of the observed system (Keeney, 1983).

A family therapist assists a family system in evolving alternative ways to maintain itself that allow correction of problematic patterns (Keeney, 1983). For the purposes of this study, family therapists were defined as people who describe themselves as utilizing a theoretical perspective that is consistent with family systems theory and cybernetics and involved in doing therapy an average of 10 hours a week. Since the therapeutic techniques most often seen as unethical by critics of family therapy, including paradox, the "benevolent lie," reframes, and other interventions that Lindley (1987) refers to as manipulation, are most often associated with strategic therapy (DiNicola, 1988; Doherty, 1985; Hare-Mustin, 1980; Hines & Hare-Mustin, 1978; Lindley, 1987; Solovey & Duncan, 1992; Wendorf & Wendorf, 1985), the definition of family therapists included only those persons with the theoretical perspective of family systems theory/cybernetics who also identified

themselves as using the techniques of paradox, reframing, metaphoric task assignment, invariant prescription, prescribed rituals, and/or directives.

Individual therapists referred to persons who were currently involved in clinical practice an average of 10 hours a week and were not using the techniques related to strategic family therapy. The individual therapists utilized theoretical orientations that focused on individuals and did not include concepts related to systems or cybernetic theories.

Emergence of the Problem

Recognizing that family therapy did present a unique way of viewing problems, several authors attempted to address ethical issues related to family therapy. The initial writings of family therapists about ethics dealt with the practical concerns that arose when they saw more than one person in therapy at a time. These early authors discussed the types of topics that should be discussed when multiple family members were in the room, the therapist's role in keeping family secrets, and concurrent family and individual therapy for family members (Wendorf & Wendorf, 1985). Ethical issues that were specific to particular ways of doing therapy were also addressed. This included discussions of the use of paradox, the "benevolent lie," which are techniques that are primarily associated with strategic therapy, and not forcing insight (Wendorf & Wendorf, 1985). These interventions were called into criticism because it was felt that they did not respect the individual. The concerns expressed focused on what was felt to be 'manipulation' without the direct consent of the client (Lindley, 1987). These authors did not, however, consider

the differences between the theoretical assumptions of family therapy based in cybernetics/systems theory and the traditional ethical paradigms concerned with the welfare of individuals with which they were evaluating family therapy interventions (Taggart, 1983). The difficulty that arises from this oversight could be likened to using the qualities of a perfect apple to evaluate the qualities of an orange.

In an attempt to resolve the issues of the epistemological inconsistency between family therapy theory and traditional values, Taggart (1983), O'Shea and Jessee (1982), and Wendorf and Wendorf (1985) presented ethical guidelines that were more consistent with systems/cybernetic epistemology. These authors perceived the primary inconsistency in family therapy theory and the ethical systems utilized to evaluate family therapy as epistemological incongruence. Traditional Western epistemology, which forms the basis of the ethical system, focuses on the individual separate from other humans and the context in which they live (Taggart, 1982). The epistemology of family therapy focuses on the connectedness and relationships between individuals and between individuals and other systems.

O'Shea and Jessee (1982) offer a discussion of the various practical problems related to the values of therapy guided by systems/cybernetic thinking that evolve from the interaction between the two differing epistemological perspectives. At the conclusion of their discussion, they determine that the conflicts will continue to plague the systems therapist and call for more discussion and consideration of these issues by systems therapists. The authors identify ethical problems that evolve from the

differing world views but offer little direction for systems therapists in resolving this ethical confusion.

Taggart (1983) discusses the theoretical implications of systemic ethics and strongly asserts the need to align ethics with practice since these ethics do affect the therapist's action. Taggart (1983) further asserts that if the conflict of ethics is not addressed, a continued alienation between the therapy system and the ethics that guide action will exist. This split will continue the pattern that is similar to the traditional Western epistemological pattern where ethics are seen as originating outside the system under consideration. Evolutionary ethics is presented by Taggart (1983) as an ethical system that would be consistent with systems/cybernetics epistemology. Although Taggart (1983) presents a section on pragmatics of systemic values, his analysis is of one case and does not provide the reader with the information needed to begin their own process of analysis. The concept of evolutionary ethics is never clearly defined beyond more than a few vague examples.

Wendorf and Wendorf (1985) present a discussion of ethics and systems/cybernetic thinking. In this discussion, they provide the reader with specific applications of their ethical guidelines as they relate to a therapy context defined by the problem presented by the family. Wendorf and Wendorf (1985) present this as their personal ethical perspective and do not attempt to relate this perspective to the broader context of all family therapy.

More recently Becvar and Becvar (1988) addressed ethics from a systems/cybernetic perspective and presented the dilemmas faced by a systems/cybernetic approach to therapy. This discussion of ethical dilemmas was presented in a

manner that serves more to stimulate thought on the issues than to provide the therapist/student with information that would assist in the process of making ethical decisions that are consistent with the systems/cybernetic world view.

Krull (1989), in an effort to assist therapists with ethical decision making, presents her ethics of tolerance that she evolves from the concepts of recursion as the ethical paradigm that is most consistent with systems/cybernetics theory. The model for ethical decision making presented by Krull (1989) parallels the morality of response and care of Gilligan (Gilligan, 1982; Lyons, 1983). Both authors present ethics as contextual in that the relevance of the ethical decision is based on the context of the decision and/or relationship and is related to issues such as care and tolerance.

The problems with the differences between practice theory and the current ethics being utilized for evaluating these practices for therapists are validated by recent research. Green and Hansen (1986), Ratliff (1988) and Brock and Coufal (1989) found, in their independent surveys of family therapists, that these practitioners are struggling with the ethical issues that are unique to working from a systems/cybernetic perspective. The conclusions of these studies suggested more information on ethical decision making related to working from a systems/cybernetic perspective was needed. Even more recently, Wylie (1989) discussed the ambiguities of ethics in family therapy and concludes that current ethical formulas do not begin to address the complex ethical dilemmas confronting practitioners.

In the review of research on the ethical decision making of family therapists, it is evident that efforts have

not been made to assess the process of moral reasoning or ethical decision making used. Current research in this area has focused on the therapists' application of the moral principles defined within the context of traditional Western ethics (Brock & Coufal, 1989; Green & Hansen, 1986; Ratliff, 1988). Lawrence Kohlberg (1969, 1981, 1984) and Carol Gilligan (1977, 1982) offer two perspectives with which to evaluate the process of moral reasoning.

Kohlberg (1969, 1981, 1984) describes principles utilized to organize moral problem solving as primarily based in justice reasoning. Justice reasoning is based on the application of general principles to specific situations. As implied by the title, justice reasoning is concerned with treating all persons equally. This goal is achieved by objectively assessing the values with the recognition that there are fundamental human rights that must be upheld in all situations.

Gilligan (1977, 1982) presents an alternative set of principles for moral judgments that she has termed the care approach. Care reasoning bases decision making on meeting each person's needs while avoiding hurt. These principles focus on the context and relationships involved in the situation.

In addition to the theoretical problems that evolve from applying ethics developed for an individual model of therapy to a family systems perspective, a portion of the problems identified with current ethical paradigms and ethical decision making in family therapy may be the result of the research designs utilized. To date all of the research in family therapy ethics (Brock & Coufal, 1989; Green & Hansen, 1986, 1989; Morrison, Layton, & Newman, 1982) has utilized the presentation of hypothetical dilemmas

to elicit the ethical decision making processes of therapists. Kerber (1986) suggested that the impersonal character of the hypothetical dilemmas presented to subjects by researchers might elicit a justice response. These responses tend to be detached, logical and impartial or more objective in their nature because the decision maker is distanced from the details of the problem (Gilligan, 1982). Gilligan (1982) suggested that research designs utilizing a personal dilemma would more frequently elicit a care response. The writings of Kerber (1986) and Gilligan (1982) would suggest that family therapists may be using a moral decision making process in their daily practice that is not reflected in their responses to the hypothetical dilemmas that are currently being used in family therapy research on ethical decision making.

Many authors have attempted to develop models of ethical decision making. Despite the development of these models, family therapists continue to suggest that current ethical guidelines do not begin to address the complex ethical dilemmas they confront in their practices. This study provides the basis for the development of ethical decision making guidelines for family therapists by determining the methods currently being used by these therapists to make decisions when working with family systems and comparing their decision making processes with those of individually oriented therapists.

Future Outlook

Madanes (1989) takes a very strong stand on the need for an increased awareness of values in the practice of family therapy. She believes that the direction of the next decade in family therapy will be determined by this renewed

emphasis on values. This renewal is necessitated by the diversity in theoretical perspectives in the practice of family therapy and the complexity of problems currently being addressed by family therapists (Madanes, 1989). If the profession does not develop values that provide a clear direction, Madanes (1989) feels we are at risk for violating what she believes is the first consideration of the therapist, which is to do no harm.

Finally, there is an ethical crisis within the profession of family therapy. As discussed earlier, several researchers (Brock & Coufal, 1989; Hansen, 1986; Ratliff, 1988) have found that family therapists do not find current ethical guidelines offered by AAMFT useful in resolving the myriad of ethical issues they confront in their practice. Without the development of a clear ethical direction or the discovery and definition of the ethical decision making processes family therapists are using, these therapists will increasingly rely on their personal ethical systems and remain vulnerable to the criticism that family therapy lacks guidelines for ethical behavior.

Purpose of the Study

Review of the current writing in family therapy ethics demonstrates three trends. The first direction is research on therapists' application of the current ethical guidelines provided by AAMFT and finding that therapists are having difficulty defining the ethics of their practice with these guidelines. Presentation of alternate ethical paradigms is the second major emphasis in the literature. These paradigms do provide some direction for coordinating ethical theory and practice theory, but do not address the pragmatics of the complex ethical dilemmas of practice. The third area of

discussion represents a debate about the ethical guidelines provided by AAMFT. The primary focus of this discussion is related to dual relationships and the possibility of eliminating them from "real world" situations with students, colleagues, and clients.

Assumptions

Work of Kohlberg (1981) and Piaget (1965) supports the perspective that the person's assumptions function as a filter for viewing ethical issues and therefore affect not only the decision made, but what becomes a dilemma. The basic assumption of this study was that the theoretical perspectives of practicing therapists are important in that these therapists' views of the world guide their actions. This assumption was reflected in the research design by eliciting real-life ethical dilemmas of moral conflict and choice from the lives of the informants.

It was assumed that the responses obtained from the sample of family therapists utilized in this study typified those family therapists who use the identified techniques. Data was obtained from family therapists in a national sample. Therapists included in this sample were from West Virginia, Georgia, Florida, Maryland, Pennsylvania, Iowa, Illinois, Texas, Mississippi, Nevada, and Michigan.

The study utilized a structured interview technique to elicit real-life narratives of moral conflict and choice from the informants. It was assumed that this approach provided opportunities for the informants to share personal approaches to moral reasoning without restrictions or concern with formal theoretical constraints and, therefore, provided data that was more consistent with the informant's perceptions of ethical dilemmas and their usual decision

making process (Argyis et al., 1987; Gilligan, 1982). When informants are allowed to present real-life moral dilemmas, it was assumed that the moral decision making process was more consistent with their usual manner of making decisions in their practice than was indicated in previous research. Gilligan (1982) has argued that the more personal the dilemma, the more responses are concerned with an understanding of relationships and responses in relationships. This is in contrast to the concern with the detached applications of the rules and the fair treatment of each person seen in responses elicited when hypothetical dilemmas are presented to informants (Lyons, 1983). Clopton and Sorell (1993) found that for parents, personal relevance of the dilemma was significantly correlated with care scores in moral decision making situations related to parenting. There was no significant relationship found between gender and care scores (Clopton & Sorell, 1993). Their data supports the argument of Hare-Mustin and Marecek (1988) and Mednick (1989) that gender differences in moral reasoning may be the result of the type of moral problem rather than stable gender attributes.

Previous work on moral choice suggested that there would be differences in the decision making of family and individual therapists. Family therapists would demonstrate a preference for care reasoning and individual therapists would demonstrate a preference for justice reasoning. This difference in reasoning would evolve from the theoretical differences in the theoretical models used for guiding therapy practice.

CHAPTER II

LITERATURE REVIEW

Review of the literature on family therapy ethics reveals an interesting split. While the leaders in family therapy argue that family therapy is developed from a theoretical framework that is distinct from individual psychotherapy, the discussions and research of family therapy ethics are founded on a tradition of individual ethics based on justice for individuals (Green & Hansen, 1986; O'Shea & Jessee, 1982; Solovey & Duncan, 1992; Taggart, 1982; Wendorf & Wendorf, 1985). This chapter presents a review of the family therapy and individual therapy ethics literature to provide the reader with perspective on the evolution of family therapy ethics in the context of health care ethics. A review of the ethical decision making literature will be presented to provide a foundation for the research methods utilized to assess the ethical decision making of family and individual therapists.

First, a review of the family therapy literature on ethics is presented to provide the reader with a perspective on the ethical criticisms of family therapy. An examination of the ethical decision making of psychologists, who are individual therapists, will also be provided to facilitate an understanding of the issues related to ethical decision making in the general literature on therapy. This will contribute to an understanding of the context from which family therapy ethics was developed and is critiqued by other therapists. The need for congruence between practice theory and ethical paradigms is presented and the deficits in current family therapy ethical paradigms are explored.

Second, a review of research methods for assessing ethical decision making is presented. This provides the theoretical framework for the assessment of the ethical decision making styles currently being utilized by family therapists. Exploration of the ethical decision making of family therapists and individual therapists is presented as an initial step in resolving the conflicts between family therapy practice theory and ethical paradigms utilized to evaluate and inform these theories.

Family Therapy Ethics

Historical Perspective

When the founders of family therapy began working with individuals-in-context, they were violating the basic belief and values of psychotherapy (Becvar & Becvar, 1988; O'Shea & Jessee, 1982; Wendorf & Wendorf, 1985). Becvar and Becvar (1988) provide an analysis of the differences in world view between the theoretical frame work of family therapy and that of individual psychology. The Becvars find the differences in world view so strong that they refer to the views of family therapy as countercultural (Becvar & Becvar, 1988) because they are so inconsistent with not only the views of traditional individual therapy, but also the world view of the American society. The traditional individual psychology world view values linear cause/effect, subject/object dualism, individualism, reductionism, value-free science and laws with a lawlike external reality (Becvar & Becvar, 1988). Within this framework the primary dualism is the individual versus the family (individual/family), stripped of context (Keeney, personal communication, 1987). This difference in world views has naturally resulted in a concurrent questioning of the values

and ethics of family therapy (Goldberg, 1993; Hare-Mustin, 1980; Hare-Mustin, Marecek, Kaplan & Less-Levinson, 1979; Hines & Hare-Mustin, 1978; O'Shea & Jessee, 1982; Taggart, 1982).

The criticisms of family therapy ethics began with concerns about the rights of individuals within the context of family therapy (Hare-Mustin, 1980; Hare-Mustin et al., 1979; Hines & Hare-Mustin, 1978). Hare-Mustin (1980) and her colleagues were concerned about the fate of the individual within a family therapy context that professed to promote and maximize the growth of "the family." Would individual confidentiality and individual growth be sacrificed for the needs of "the family?" Clearly, these concerns reflect the world view of traditional individual psychology where individualism and reductionism are valued.

Hines and Hare-Mustin (1978) initiated the discussion of the differences in ethical decision making that occur when the therapist is working with a family, as opposed to an individual. The issues explored in this article included meeting the growth needs of the entire family, as opposed to individuals' needs, requiring that the entire family be treated, confidentiality, and the impact of the therapist's values on the therapy. Hines and Hare-Mustin (1978) expressed concern that individuals were at risk of having their rights violated in family therapy. Hare-Mustin (1980) continued this challenge to family therapy in an article titled: "Family Therapy May Be Dangerous for Your Health." As the title clearly suggests, the author was again expressing concern for the rights of individuals in family therapy.

Concern for the rights of women in family therapy was expressed by Hare-Mustin (1978) when she advocated for a

feminist family therapy approach to resolve socialization practices that reinforce traditional sex roles of man the doer and woman the nurturer in the context of family therapy. The obstacles that promote the decrease in respect for the rights of women in family therapy were seen as (a) the existence of socially reinforced sex roles in the family; (b) the experience of the therapist in their family of origin and educational processes that make it difficult to perceive alternatives to the stereotyped sex roles; (c) the family's perception of the problem that is rarely defined as a problem with traditional sex roles (Hare-Mustin, 1978). Hare-Mustin (1978, 1980) and Hare-Mustin, Marecek, Kaplan and Less-Levinson (1979) viewed family therapy ethics as a subset of health care ethics based on the concern for individual rights and justice and advocated strongly for the protection of these individual rights.

Becvar, Becvar, and Bender (1982) provided further cautionary notes for the family therapist that evolved from similar concerns about the hazards of utilizing a theoretical framework that is inclusive of relationships and moves away from concern for individuals. These authors were most concerned about the risk of over-pathologizing society or using systems theories that define dysfunction in relationships in the broadest terms to include almost everyone. The primary theme was to go with caution and recognize the limits of family therapy theories and to "Let us first do no harm" (Becvar, Becvar, & Bender, 1982, p. 385).

Margolin (1982) continued the individual rights focused critique of family therapy ethics initiated by the previous authors (Hines & Hare-Mustin, 1978; Hare-Mustin, 1980; Becvar, Becvar, & Bender, 1982). She encouraged the

therapist to promote the welfare of each family member and to guard against improvement of one family member at the expense of another. Although she recognized that the focus of family therapy is the relationship between family members, she asserted that it was the therapist's responsibility to advocate for individual family members who could not accurately represent themselves. So again the importance of the individual's rights are asserted without recognizing the incongruence between the ethical principles being applied and the theoretical paradigm of family therapy.

Current Development of Systems Ethics

These initial, now classic, articles stimulated a great deal of discussion about the ethical principles of family therapy that evolved initially into a response by Wendorf and Wendorf (1985) and an edited volume on the values, ethics and legalities of family therapy (L'Abate, 1982). Two relevant articles in L'Abate (1982) addressed the values clash between family therapy and traditional individually oriented perspectives. O'Shea and Jessee (1982) initiated the discussion in L'Abate (1982) by presenting a review of the problems encountered when the family systems approach interacts with an American cultural ideology that emphasizes self-sufficiency, individual accountability and individual rights over group preferences. They discussed how ethical issues, therapist, family, and societal values, and professional codes of conduct merge in practice to present the therapist with a variety of problems. O'Shea and Jessee (1982) did not provide the therapist with guidelines or

information with which to negotiate this mine field except to advise that the profession continues discussion of the issues.

Taggart (1982), in the second chapter of L'Abate (1982), strongly argued the need to bring values under the same systems epistemology that informs family therapy. Taggart provided an excellent review of the problems encountered when an attempt is made to develop an ethical paradigm that is consistent with the theoretical framework used by family therapists. This discussion included the differences between linear and systemic values and critiqued those authors who did not consider this epistemological difference when they were critiquing family therapy ethics. Taggart presented an alternative that he termed evolutionary ethics. This article provided little guidance for the application of evolutionary ethics to family therapy practice situations.

Wendorf and Wendorf (1985) critiqued the literature on family therapy ethics and further supported the argument for a systems focused ethical paradigm. They argued for the need to use a wider lens than previous perspectives of family therapy ethics in making ethical decisions. Wendorf and Wendorf advocated for a model that considered the influences of not only the family system, but also the culture. For example, when they discussed secrets, they indicated that the therapist could decide when to keep or reveal a secret using a systemic way of thinking. They did not present principles or rules that would guide this decision making. This article, like previous articles, left therapists with a strong argument for the need for ethics that are consistent with the epistemology of family therapy, but again fell into the trap for which they criticized their predecessors, not

providing direct application of this different ethical lens to real clinical problems.

In discussions of family therapy ethics, the work of Boszormenyi-Nagy is often cited as providing ethical principles for the family therapist (Boszormenyi-Nagy, 1985; Wendorf & Wendorf, 1985). The paradigm presented by Boszormenyi-Nagy is termed relational ethics and has as its guiding principle interpersonal consequence (Boszormenyi-Nagy, 1985). Boszormenyi-Nagy discussed this principle as acting within the family with responsibility for the consequences to the next generations of the family under consideration. As Wendorf and Wendorf (1985) pointed out, relational ethics, when presented in this manner, is more an ethic for a family rather than a set of principles that can be used to guide family systems therapists in their work. So again the therapist is left to personal values and interpretation to guide ethical decision making in family therapy.

In the ongoing attempts to guide family therapists through the murky waters of systems ethics, several books have been written. The three that specifically address family therapy ethics are: Issues & Ethics in the Helping Professions (Corey, Corey & Callanan, 1984), Ethical, Legal and Professional Issues in the Practice of Marriage and Family Therapy (Huber & Baruth, 1987), and Ethical Issues in Family Therapy (Walrond-Skinner & Watson, 1987). Corey, Corey, and Callanan (1984) addressed the differing theoretical positions of individual and family therapy by aligning with Margolin (1982) and asserting that ethical family therapy is a balancing act between maintaining the individual's best interest while acting as a family advocate. The principles they used to guide this balancing

act are the traditional ones that evolve from individual therapy, i.e., guarding individual rights and promoting justice. They did not offer the family therapist principles that would be congruent with a systems theory perspective nor did they indicate that there was a need to develop a system of ethical principles that was more congruent with the epistemology used by family systems therapists.

Huber and Baruth (1987) acknowledged the ethical problems encountered when practicing systems focused therapy in a culture that is highly individualistic where each person's rights take precedence over the relationship system. They offered the therapist the option of identifying the system as the client and pursuing relationship goals unless the safety of an individual is at stake. The therapist then would advocate for the individual until the danger is resolved. Huber and Baruth concluded that the therapist ought to provide maximum benefit for the greatest number of persons. This provides a guiding principle based in utilitarian ethics. Utilitarian ethics adds another level of complexity to the therapist's decision making, for now maximum benefit must be defined. This issue represents one of the greatest debates within utilitarian thinking, what is maximum benefit and who is to define it (Beauchamp & Childress, 1989)? Although Huber and Baruth recognized the need for an ethical perspective that accommodates to a systemic paradigm, they offered little of a practical nature to the practicing family therapist.

Walrond-Skinner and Watson (1987) edited a series of articles related to family therapy ethics. This volume presented articles that supported the traditional individual focused ethical paradigms. There was little recognition of a

need to align ethical perspectives with the systems oriented theories used by family therapists.

An exception to the predominant view is Carpenter (1987) who admitted that family therapy would be less difficult in a culture that is less aggressively individualistic. He cites China as an example of a culture that assumes the individual will put the needs of the family and community above personal desires. Carpenter concluded, however, that the difficulties in the congruence between the therapist's and client's paradigms could be resolved by questioning the validity of the model that runs counter to the wishes of the client. To support his assertion that systemic thinking should be de-emphasized, he posed the question: To what extent does the systems model represent real life? This question appears to call into question the usefulness of systemic thinking in therapy.

The importance and purpose of utilizing systemic thinking as a method for approaching problem resolution is answered in the literature by several authors who have indicated that the systems/cybernetics paradigm presents a model that more accurately describes the interactions in the real world (Bateson, 1972; Bertalanffy, 1952). The question posed by Carpenter also ignored the process of paradigm shift described by Kuhn (1970) that attributed a change in paradigms to scientists confronting situations where the traditional explanations no longer work. At this point Kuhn (1970) proposed that a paradigm that better fit the puzzle or problem was adopted. This process describes the transition from individual oriented therapies that began in the 1940's to a system/cybernetic model of family therapy practiced presently (Becvar & Becvar, 1993).

Carpenter's conclusion is also incongruent with the discussion of cases he presented. Each of the case examples that was presented addressed the importance of understanding the impact of change in one individual on their social network. He clearly used systems thinking when he considered the impact of the resolution of one spouse's symptoms on the other spouse and the implications this had for the relationship, recognizing the importance of understanding the larger implications for the work of therapy.

Also in Walrond-Skinner and Watson (1987), Haldane (1987), Treacher (1987), and Lindley (1987) argued, in their individual chapters, that the fundamental concern for family therapists should be autonomy, freedoms, rights and responsibilities of the individual. They were most critical of the indirect techniques of strategic therapy. This critique was based on a concern for the apparent lack of respect for the individual's autonomy. They found it unconscionable that the individual should give up autonomy for the good of society as a whole. This argument was based on the impression that the individual is not compensated by this personal sacrifice (Lindley, 1987). Although Haldane, Treacher, and Lindley professed a belief in systems theory in their work, their assertion that the individual does not benefit when the social system is bettered denies a basic tenet of systems/cybernetic theory that asserts the system and individual are one and the same, and improvement in one results in an improvement in the other (Segal, 1986) from the perspective that all parts of the system interact to make the whole. Becvar and Becvar (1993) conceptualized this relationship between the individual and the social system from the perspective of systems theory as each person being concurrently subjects and objects and thus everyone is

involved in each other's destiny. Von Foerster (1986a) described this relationship in a very concise manner when he stated his moral imperative for systems theory. This moral imperative was: "A is better off when B is better off" (Segal, 1986, p. 4).

Haley (1977) discussed the ethics of a strategic approach that demonstrated an understanding of the need to promote consistency between the theoretical clinical methodologies and the ethical paradigm. His ethical orientation evolved from a respect for the boundaries at different system levels. Within this paradigm, Haley thought it was just as unethical to violate the boundary between the conscious and unconscious mind as it would be to violate the boundary between the context of therapy and the community by sharing what happened in a therapy session with the local newspaper. The indirect methods utilized in strategic therapy allow the client to control the flow of information from the conscious and unconscious. This perspective allows information the client needs to remain outside awareness to stay unrecognized while change occurs. Haley (1976) believed that the contract between the client and therapist was for change, and ethically change can occur without violating boundaries, including the internal ones, for these boundaries serve to protect the individual.

Walrond-Skinner and Watson (1987) offered family therapists a discussion of ethics from a variety of perspectives. As the review of these articles points out, they provided critique of the current ethical decisions being made by therapists, but provided little direction for resolving the conflicts of making ethical decisions in a manner that is congruent with a systems perspective.

Clearly, the authors represented in Walrond-Skinner and Watson used the traditional individual rights oriented ethical paradigms.

Woody (1990) attempted to build an ethical decision making model for family therapists. Her model was based on a multifaceted approach to decision making which provides a comprehensive analysis of the situation to facilitate the development of a defensible decision. The five areas identified by Woody as necessary are: (a) theories of ethics; (b) professional codes of ethics; (c) professional theoretical premises; (d) sociolegal context; (e) personal/professional identity. She chose the ethical theories of utilitarianism and contract theory to address two levels of moral thinking. These levels were intuitive and critical. She indicated that contract theory was the application of intuitive thinking that combines ingrained ethical rules related to professional duty and conduct. When a conflict occurs at this level, Woody recommended that the utilitarian theory of ethics could then be applied. This would apply the principle of the greatest good and least harm to resolving the dilemma.

The application of utilitarianism to ethical decision making presents the practitioner with the problem of identifying what is the greatest good. In their text on biomedical ethics, Beauchamp and Childress (1989) described the difficulty in determining the values that should be used to make a decision about what is greatest good. This is compounded with the difficulty in predicting future outcomes. Although Woody (1990) did not define greatest good, she did indicate that the values of the therapist's theoretical framework are involved in the ethical decision making process. She cautioned, however, that the theories

should not be used to shelter the therapist from the realities of the larger external environment. According to Woody, debates based on the validity of therapeutic approaches would not resolve the fundamental value differences between the various perspectives. Each practitioner may perceive a favored theory as a collection of empirical facts rather than preferred hypotheses, making it difficult to make a final determination of ethics from within a theoretical approach. To resolve theoretical blindness, Woody (1990) recommended that ethical decision making within the theory be subjected to the scrutiny of universal ethical principles and the organizational codes of ethics. This recommendation returns the therapist to the original dilemma: what are the values to determine the greatest good?

Krull (1989) also attempted to develop an ethical perspective for family therapy that she termed the ethics of tolerance. This ethic is based on Krull's belief that systemic thinking increases one's willingness to be open to the perspective of others and to see one's own perspective as not an absolute truth. She described three recursive levels of ethical thinking or multiversa ethics. Level 0 reflects the cultural principles. Level 1 is removed one level and enables one to make comparisons between various ethics. Meta-ethics or level 2 makes the observation that there is no absolute ethic, thus the comparisons made at level 1 can be viewed from the perspective that every system of values is equally true because there are no absolute criteria to judge one system as better than the other. This would appear to be a justification for any behavior, but it is here that Krull utilized the concept of recursion to develop a meta-meta-level or level 3. On level 3 she

reminded the reader that the idea that there is no absolute ethic must not be considered absolute either, and all principles are connected to the cultural context of level 0. Krull suggested that this recursive process constantly challenged one's ethical premises and that this process facilitated the development of a higher understanding of ethical premises. She thought that this ethical process was so much a part of systemic thinking that when one adopted this theoretical paradigm, one would be making ethical decisions from the principle of tolerance because of the recursive self-reflective nature of system thinking.

When Krull (1989) discussed the principles that would guide ethical decision making, she indicated that these would be culture specific. This places the family therapist back in the dilemma of making ethical decisions that are consistent with the perspective of family systems theory, and valuing the system in a culture that most values individual rights and responsibilities. Thus, she has apparently used the process of systems theory to develop her ethical paradigm but did not include the concepts of valuing of relationships (which is also process). Examples of the application of her model provided by Krull support this inconsistency. In these examples, Krull (1989) demonstrates tolerance for other value systems, i.e., nonfeminists by feminists, but does not demonstrate a valuing of systems that in some manner base their decisions on relationship values. Clearly, the ethic she is demonstrating is one of tolerance despite how the value system views relationships.

Recognizing the difficulty of resolving the conflicts between the welfare of individuals and the family, Zygmund and Boorhem (1989) proposed an ethical decision making model based on Kitchener's (cited in Zygmund & Boorhem, 1989)

model of ethical decision making. This model provided two levels of ethical decision making: the intuitive level and the critical-evaluative level. The critical-evaluative level is further divided into three levels: ethical rules, ethical principles, and ethical theory. When an ethical dilemma cannot be resolved at one level of ethical reasoning, the next higher level is to be used. Zygmund and Boorhem (1989) cited the AAMFT Code of Ethical Principles as an example of ethical rules that can guide the family therapist. When these rules do not resolve the conflict, the ethical principles of autonomy, nonmaleficence, beneficence, fidelity, and justice are to serve as guides. These principles are to take precedence over personal and group values. When ethical principles conflict, Zygmund and Boorhem recommended that the therapist use the ethical theories of universalizability and balancing to resolve these conflicts. As used by these authors, universalizability describes behavior as ethical only if it can be unambiguously generalized to all similar cases, and the balancing principles require that the decision produce the least amount of avoidable harm to all involved.

In their article, Zygmund and Boorhem (1989) did not provide clear direction for resolving the value conflicts between the family and individuals within the family. Their ethical decision making model utilized traditional principles and ethical theories that assert the values of individual rights. They did not make a distinction between ethical decision making to meet the needs of individuals and ethical decision making that addresses the unique issues of systemic thinking, although they asserted that this was the purpose of their article. Zygmund and Boorhem appear to add little to the need for an ethical paradigm that is more

consistent with systems epistemology. This issue was also addressed by O'Shea and Jessee (1982), Taggart (1982), Wendorf and Wendorf (1985).

To date, the attempts to assist the family therapist in making ethical decisions that are consistent with systems/cybernetic theory return to an ethic of justice and individual rights or provide critiques of what is being done without demonstrating a clear alternative. Until there is an ethical decision making process that resolves these theoretical differences, family therapy will continue to struggle with these issues. This problem is reflected in the current debate about the professional code of ethics for family therapists developed by the American Association for Marriage and Family Therapy.

Professional Ethical Codes

The code of ethics of the professional association, as Zymond and Boorhem (1989) and Woody (1990) suggest, can guide the therapist in ethical decision making. This process is not as easy as it might first appear. A code of ethics for family therapists was developed by The American Association for Marriage and Family Therapy. The most recent revision of this code was in August 1991. The code is considered binding for all the members of the Association (AAMFT, 1991). This was a revision of the 1988 Code of Ethics and included the following changes: (1) addition of sexual orientation as a category in the antidiscrimination clause; (2) revision of the dual relationships category that specifies that if a dual relationship cannot be avoided, the therapist must take appropriate precautions to maintain professional judgement to prevent exploitation; (3) clarification of those actions that are an automatic

violation of the code and make a member subject to termination of membership. These actions include (a) conviction of felonies, (b) misdemeanors related to the professional role, (c) behavior that could lead to legal convictions, (d) disciplinary action by other professional associations, (e) loss of license or certificate or discipline by a state regulatory body, (f) impairment, and (g) failure to cooperate with an investigation of an ethical complaint; (4) expansion on the ethical guidelines for supervision, including the cautions against dual relationships and sexual harassment; (5) specification of how financial matters should be handled; (6) guidelines for researchers; and (7) guidelines for advertising (Preister, 1991).

The role of professional codes of ethics has been addressed by several authors. Beauchamp and Childress (1989), Engelhardt (1986) and Veatch (1981, 1989) have discussed professional codes of ethics as rules of conduct of the professional group. Within this context several dilemmas evolve.

The first problematic area discussed by Engelhardt (1986) and Veatch (1981, 1989) is the paternalistic assumption by the organizations developing professional codes that they are protecting the welfare of the affected parties (consumers), although they have not included information from these persons in the development of the codes. This makes the commitment unilateral and not reciprocal. While developing codes to protect the rights of consumers, these professional organizations have eliminated the other party in the deliberations. This is most problematic for those who view ethical codes as contracts or covenants. Contracts and covenants assume an exchange

between the parties involved that articulates the moral duties as agreed upon by both participants (Veatch, 1989). This lack of mutual agreement can create conflict when those to which the benevolent actions are to be directed do not care about or desire these actions.

The second area that Beauchamp and Childress (1989) and Engelhardt (1986) discussed was the conflict between viewing professional codes of ethics as ethical guidelines rather than a description of role-specific duties or guidelines for decision making. Engelhardt (1986) and Veatch (1981, 1989) discussed the development of professional codes as a set of rules as opposed to a set of guidelines. In a situation where these codes are viewed as rules or, in extreme cases, essentially laws, violations can cause legal action to be taken.

Engelhardt (1986) develops this confusion between codes of etiquette and moral codes further. He discussed professional codes of ethics as codes of etiquette because they do not address moral issues per se, but present the professional with rules about relationships with other professionals and clients.

Similar concerns were also expressed by Veatch (1981) and Beauchamp and Childress (1989). Beauchamp and Childress (1989) attempted to clarify this point of confusion by identifying the criteria they utilize to differentiate between ethical codes and codes of conduct. The primary criteria they use, which is referred to by the other authors, is the ability for the claims made by the code to utilize universal moral principles as their base. Beauchamp and Childress (1989) suggested these principles be veracity, respect for autonomy, and justice. Veatch (1981) suggested

the use of social contract theory to arrive at a basis for making ethical decisions that would commonly be recognized as valid.

Engelhardt (1986) presented his version of the social contract for resolving dilemmas. He discussed the concept of moral communities that establish commonly agreed upon moral contracts. Engelhardt (1986) argued that within these communities, the right does not exist to force compliance for it is also important to respect the beliefs of one another.

The problems with professional codes of ethics described by Beauchamp and Childress (1989), Engelhardt (1986) and Veatch (1981, 1989) could be anticipated if one applies the concepts of logical typing described by Bateson (1972) or levels of organization as described by Schneirla (Tobach, 1970). Both Bateson and Schneirla addressed the complications that arise when levels of abstraction are confused or, as Bateson asserts, when one confuses the map with the territory. Schneirla (cited in Tobach, 1970) asserted each level of organization is subsumed by higher levels of organization and is modified by this process. This implies that rules applied at one level of analysis are not useful in describing process at another level of organization. Schneirla's position is supported from a different perspective by the theory of logical types (Bateson, 1972) which, when applied, prevents the confounding of different logical levels (Keeney, 1983). When applied to ethics, this would address the problem of professional codes of ethics (one logical level) being applied as if they were moral codes (another logical level) when in fact they represent rules of behavioral conduct.

The complexity of the interaction between professional codes of ethics and morality is further complicated when one considers that the traditional ethical models utilized to resolve professional dilemmas evolve from a tradition of theorizing that is justice based and approaches ethical decision making from the perspective of applying hierarchically arranged levels of principles that do not consider the context within which the decision making takes place (Fry, 1989). The justice model of ethical decision making has as its primary focus the rights of the individual (Gilligan, 1982). When the AAMFT (1991) Code of Ethics is reviewed, it becomes clear that the perspective presented is the traditional individual rights focused legal/moral approach. The therapist is cautioned to "respect and guard confidences of each individual client" (AAMFT, 1991, p. 2). The unit of service is described as individuals and families, and therapists have the responsibility to respect the rights of those persons seeking their assistance. The code continues to address various other issues related to the relationship between the association member and clients, supervisees, students, employees, and the association. Only when it discusses issues of confidentiality does this code indicate that ethical decision making may be more complex because the client may be more than one person. At this point, as noted above, the therapist is advised to protect the rights of each individual client. There is no recognition that ethical decision making may need to be altered because of the systems focused theoretical perspective of family therapy practice. This oversight is particularly striking since the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) indicates that the theoretical foundations of marital and

family therapy are systems and cybernetics theory (COAMFTE, 1988).

It would appear that at a theoretical level, AAMFT recognizes the importance of systems/cybernetics theory in the practice of marriage and family therapy, as is evidenced by recognition of this theory as the foundation of marital and family therapy by the CAMTE. On a more practical application level, AAMFT remains linked to the linear perspective of ethical models that are justice-based theories of moral reasoning.

Research on Ethical Decision making of Family Therapists

Current research on the ethical decision making of family therapists supports the conclusion that this split in AAMFT's perspective is problematic for the practicing family therapist (Brock & Coufal, 1989; Green & Hansen, 1986, 1989; Ratliff, 1988). The fact of this confusion is supported by ongoing dialogues among family therapists about the usefulness of AAMFT's Code of Ethics (Coyne, 1989; Doherty, 1985; Ryder & Hepworth, 1990; Tomm, 1992, 1995; Wylie, 1989).

In 1986, Green and Hansen asked seventy-five family therapists to complete a questionnaire that asked what ethical dilemmas they faced and how helpful were the AAMFT ethical guidelines with these dilemmas. Of the eight dilemmas that the therapists identified as most often faced, six were not addressed in the AAMFT Code of Ethics for 1984. These items were (a) treating a family if one member does not want to participate, (b) feeling confident of your training and/or qualifications, (c) seeing one family member without the others present, (d) informing clients of values implicit

in the mode of therapy, (e)dealing with parental requests for information differently from children's requests for information, and (f)sharing your values and biases with families. The primary conclusion of the study was that family therapists were facing ethical dilemmas that were not covered in the AAMFT guidelines and that these dilemmas were faced significantly more often than those covered in the guidelines. The recommendation that evolved from this study was that the guidelines need to be revised to better address the needs of family therapists (Green & Hansen, 1986).

If the current AAMFT (1991) Code of Ethics is reviewed, little has been done to address the concerns that family therapists identified in 1986 as problematic. The only area elaborated is the section on confidentiality. This section states that client confidences cannot be disclosed unless mandated by law or if a waiver has been obtained from all family members who are legally competent to execute such a waiver. This, however, does not address the concern identified in Green and Hansen's (1986) research related to parent's and children's requests for information.

In 1989, Green and Hansen expanded on their earlier study by increasing the sample size to 202 and assessing not only those issues family therapists find problematic, but also asking what they do when faced with these dilemmas. The instrument used to survey the population of AAMFT clinical members presented sixteen clinical vignettes, eight of which were developed from AAMFT's Ethical Principles for Family Therapists (1984) and eight of which were developed from issues expressed in the literature on ethical dilemmas in family therapy. Besides identifying whether they had experienced the situation, the informants were asked to select a response to the dilemma from a series of

alternative responses to the situation. Each vignette also had a place for alternative write-in solutions to the dilemmas.

The three dilemmas that the therapists rated as most important were reporting child abuse, family versus individual needs, and responding to a mother's request for data obtained on her minor children as part of a research project when the children have indicated that they do not want their mother to see this information. The only issue addressed by the AAMFT Code of Ethics (1991) relates to the sharing of information obtained as part of research. The code (1991) indicates that when the possibility exists that others, including family members, could obtain access to this information, the possibility, with the plan for protecting confidentiality, should be explained as part of the informed consent procedure.

Reporting of child abuse is a legal, as well as ethical, issue because it is legally mandated to be reported in all states (Huber & Baruth, 1987). The informants in this study responded to this dilemma based on their relationship with the family, as well as considering the legal requirements. Most of the respondents said they would report the abuse in spite of a promise from the father to never do it again. However, respondents also indicated that they would work with the family to report the abuse while they provided support to the family, and that they would work with the authorities to keep the father in treatment. These respondents demonstrate the tension family therapists feel between responsibilities to traditional, individually focused ethical ideals and to the family system.

This tension is further highlighted in the therapists' responses to the family versus individual needs dilemma.

Responses to this problem focused on the need to preserve the relationship with all members of the family system while not maintaining the secret shared by the wife about her affair.

In addition to the apparent need for the respondents to make decisions in a manner that would maintain families in treatment, Green and Hansen (1989) felt that the other significant finding of their study was that what were ethical dilemmas for some family therapists were considered treatment issues, for others. When the dilemmas were seen as treatment issues the informants would define the problem as a matter of technique preference rather than a choice between the right and wrong action to take. These authors concluded that this resulted from the variety of therapeutic approaches within the systems perspective. If, as Green and Hansen (1989) reported, many therapists perceive what were developed as ethical dilemmas as issues of treatment or theoretical choices, it would appear that there is a difference in the perceptions of what truly defines an ethical decision between practicing family therapists and researchers. The understanding of what practicing family therapists do define as ethical dilemmas are difficult to discern from previous research because the designs involved the researchers defining the dilemma and the informants selecting what they felt was the best response to the situation from the options provided by the researchers (Brock & Coufal, 1989; Green & Hansen, 1986, 1989; Ratliff, 1988).

Brock and Coufal (1989) surveyed 1,000 randomly selected members of AAMFT to obtain data on how closely family therapists follow AAMFT's ethical standards in their daily practice. The subjects were presented with

ethical/legal situations and then responded to how often they did this in their practice. The responses were placed on a five-point scale where the choices ranged from never to always. These authors found the greatest discrepancies between legal/ethical standards and therapists' responses in the area of legal requirements. Respondents indicated that at least 40 percent of the time they do not warn the potential victims of their clients' threats, at least one-third of the respondents sometimes do not report child abuse, and 82.9 percent rarely or never report a client's crime disclosed in therapy.

It is impossible to discern the reasoning behind these choices because the survey did not provide the respondents with an opportunity to describe their decision making process. In the areas of therapist-client relationship and controversies, which included items about AIDS and sexual relationships with clients, the therapist's responses were congruent with the accepted standards. Of the respondents, 92.5 percent said that they have never become sexually involved with a former client within one year of termination, and 72.9 percent indicated that they would never, rarely, or sometimes inform a client's partner that the client is HIV positive. Again, the design of the study makes it difficult to assign meaning to this information because the process for making these decisions was not obtained. It could be, as Green and Hansen (1989) found, that the therapists framed some of these issues as treatment issues rather than ethical dilemmas.

Ratliff (1988) surveyed 167 members of the Texas Family Therapy Association to assess their responses to the family therapy dilemmas she developed. The responses to these dilemmas were recorded on a seven-point Likert-type scale.

After reviewing her data, Ratliff (1988) concluded that family therapists are divided on how to resolve the dilemmas presented. Some of the most striking divisions occurred in areas that AAMFT has set clear standards. The dilemma that reflects therapists' response to one of the most controversial AAMFT guidelines is one that asks about reporting engaging in a social relationship with an ex-client. Forty-nine percent of the respondents said they would probably not report this situation, 10 percent said they were not sure, and 47 percent indicated they were likely to report this situation. AAMFT (1988, 1991) clearly indicates in its guidelines that dual relationships are to be avoided. This recommendation was in place at the time the study was conducted and has been strengthened in the AAMFT Code of Ethical Principles (1988, 1991) recent revisions. Almost all of the respondents to this study requested copies of the study to gain a better understanding of how their colleagues were responding to the dilemmas. The recommendations that evolved were to develop research that would provide more detailed information about the factors that are influential in making ethical decisions. This recommendation parallels that made by Stanton (1988) in The State of the Art in Family Therapy Research: Controversies and Recommendations. In his recommendations, Stanton (1988) stated: "the conceptual and operational bases for making clinical decisions are greatly in need of investigation" (p.28). As editor of this volume, Wynne (1988) noted that there was a strong consensus among the contributors that the use of exploratory, as opposed to confirmatory, research needed to be expanded to answer the yet unanswered questions in family therapy.

The recommendations of Ratliff (1988), Stanton (1988) and Wynne (1988) support the use of an exploratory methodology to further examine the ethical decision making process of family therapists. The methodology described by Brown (1988) provided such an approach for reading narratives about moral conflict and choice. Brown (1988) and her colleagues combined a semi-structured interview with content analysis for care and justice ethical decision making perspectives. The approach utilized by Brown (1988) parallels content analysis. Application of these qualitative methods to ethical decision making of family therapists would provide the perspective suggested by the writings of Ratliff (1988), Stanton (1988), and Wynne (1988).

Concern about AAMFT's position on dual relationships has generated debate in the literature that would support the professional ambivalence about these relationships expressed in Ratliff's (1988) study (Goldberg, 1993, Ryder & Hepworth, 1990; Tomm, 1992, 1995). Ryder and Hepworth (1990) responded to the 1988 AAMFT Code of Ethical Principles from their concern about the extension of the dual relationship prohibition beyond sexual misconduct to vaguely defined relationships that could be presumed to include nonromantic relationships. These authors asserted that the AAMFT legislation about dual relationships oversimplified the natural complexity of relationships. They identified the problem as an issue of exploitation and power rather than dual relationships in general. Ryder and Hepworth (1990) concluded that when relationships are legislated, in the manner attempted by AAMFT, the natural complexity of relationships is driven underground, and the development of the problems they are attempting to avoid is potentiated.

These authors expressed their greatest concern over how this could influence supervisor relationships that they perceived as having the goal of moving the supervisee/graduate student into a collegial relationship. As with any collegial relationship, this could also evolve into a more personal relationship. These authors found this prohibition against dual relationships most curious in a profession that has as its focus the understanding that paradox and contradiction are central features of human relationships.

More recently Tomm (1992, 1995) responded to the prohibition on dual relationships by AAMFT. He asserted that by prohibiting all dual relationships, the AAMFT Ethics Committee is confusing dual relationships with exploitative relationships and ignoring the benefits that can evolve from non-exploitative dual relationships. Tomm recommended that the Ethics Committee clarify the types of exploitation that occur in all relationships, primary and dual. He saw this as a method for resolving an imbalance of power in relationships that could evolve if oversimplification of relationships was not addressed in a direct manner. Tomm emphasized the importance of working on issues of power and exploitation from within the complexity of relationships rather than legislating relationships from without.

This perception of an ethic that evolves from the relationship is similar to the ethic of care described by Gilligan (1982). The subjects in her research saw moral problems as problems of care and responsibility in relationships, rather than as rights and rules from outside relationships.

Wylie (1989) presented a discussion of the complexity of the ethical dilemmas facing family therapists. He began by reviewing the multitude of ethical complexities of family

therapy, which included the power issues in therapy, the ethical issues of the interactions between individuals and family groups, the complexity of differentiating between ethical and treatment issues, the use of touch in therapy, and the interaction between social issues and family therapy. Wylie concluded, after assessing the needs of family therapists, that the daily issues confronted by the therapist in practice overflow the narrow guidelines provided by professional codes. He found the issues to be related to the ethical perspective of the therapist. This conclusion would place ethics in the relationship between the therapist and the family. As Wylie (1989) states: "The line between self and other, my needs and your needs, is perhaps in no other profession so difficult to distinguish and so critical an ethical requirement" (p. 33). Wylie addressed the same relationship complexity discussed by Tomm (1992) and like the conclusions reached by Tomm, indicates a need for an ethical perspective that can inform decision making within the context of relationship.

Ethical Perspectives of Psychology

The American Psychological Association (APA) provides the code of ethical principles for psychologists, and members of the organization are bound to these principles (APA, 1981a). Additionally, the APA has developed Specialty Guidelines for the Delivery of Services by Counseling Psychologists (1981b). Since psychology practice encompasses a broad range of services beyond counseling, the ethical principles reflect this diversity. The major areas of concern are related to research, evaluation, testing and the supervision of persons assisting with these projects (APA, 1981a).

The Specialty Guidelines (APA, 1981b) discuss issues related to the provision of quality counseling services. Responsibilities in these special directives include a description of the role of the professional counseling psychologist (psychologist with a doctoral degree from an accredited program or a program that meets APA guidelines). Additionally, the practitioner is presented with guidelines for relationships with other professionals, as well as clients. The principles that address client/therapist relationships relate to providing quality services and validating that these services are documented appropriately. The guideline that addresses the welfare of the consumer is in the general ethical principles (APA, 1981a). In this principle, the psychologist is advised to avoid dual relationships to protect professional judgment and avoid the possibility of exploitation. This section also states that "sexual intimacies with clients are unethical" (APA, 1981a, p.3). In the annual reports of the APA Ethics Committee for the years of 1990 and 1991, this guideline represented the largest percentage of cases opened.

Data supporting the general difficulty practicing psychologists have with dual relationships was obtained by Pope and Vetter (1992) in a national survey of 679 psychologists. These psychologists identified 703 situations that were ethically challenging or troubling, and of these situations, dual relationships accounted for 116 (17%) of the problems identified. This was the second most commonly cited item. The area rated first in the number of incidents related to issues of confidentiality ($n=128$; 18%). It is interesting to note that in their research, Pope and Vetter (1992) included sexual issues as a separate category. This accounted for 28 incidents or 4% of the total

identified problems. Most authors consider sexual issues as dual relationship concerns, and if these numbers are combined with the dual relationship numbers, then dual relationships would be the most commonly identified problem in this sample. Since dual relationships appear to be the most problematic for therapists, it is not surprising that several authors have written and done research in this area (Borys & Pope, 1989; Holroyd & Brodsky, 1977; Miller & Lee, 1989; Pope, 1991; Stake & Oliver, 1991).

Research on the attitudes of psychologists toward sexual contact and touching between therapist and client was conducted by Holroyd and Brodsky (1977) and Stake and Oliver (1991). In 1977, Holroyd and Brodsky found in a national survey of 703 Ph.D. psychologists that 70% of male therapists and 88% of the female therapists thought erotic contact would never benefit opposite-sex clients. Twenty-seven percent of the therapists in this sample engaged in nonerotic touching with opposite-sex clients. After reviewing the responses of their subjects, Holroyd and Brodsky (1977) concluded that male therapists are most often involved in erotic contact, female clients are most often the objects, and therapists that disregard this boundary once are likely to repeat. These observations were related to Butler's (1975) observations that therapists who have sexual relationships with clients are meeting their own needs. The needs identified included being needy, lonely, frightened of intimacy, or needing to maintain a dominant position in the relationship. Based on this data, Holroyd and Brodsky (1977) concluded that the concerns of feminist psychologists that erotic contact with patients is based on therapist needs for power or sexual gratification and does not meet therapeutic goals were justified.

In 1991, Stake and Oliver surveyed psychologists to obtain a clearer picture of what is considered acceptable and unacceptable behaviors with clients. The results of their study indicated that if kissing is considered sexual misconduct with clients, then 7.3% of this sample had engaged in misconduct. If erotic contact is not defined in this manner, then only 2.2% of the sample had engaged in sexual misconduct. They concluded that it was appropriate to include kissing as sexual misconduct since the majority of respondents in this and previous studies identified it as misconduct rather than nurturance. Stake and Oliver (1991) concluded that the incidence of sexual misconduct from their study makes this an area for continued professional concern.

Pope (1991) reviewed the literature and the attention that licensing boards and other agencies devote to dual relationships. He also discussed sexual and nonsexual dual relationships and the common beliefs and strategies that promoted both types of relationships. He concluded, after the literature review, that dual relationships regardless of type, cannot be beneficial. Pope (1991) cited selective inattention as a way in which dual relationships and other forms of unethical behavior are made tolerable. He felt this occurs because the therapist involved blocks out awareness of the duality of the relationship or justifies the relationship by suggesting that it would be beneficial for the patient. Pope also indicated that the ease with which colleagues of a therapist screen out and become selectively inattentive to the situation contributed to the perpetuation of dual relationships. This professional inattention is supported by the prevalence of dual relationships and a tradition of dual relationships, especially in the area of bartering for services. Pope concludes that the potential

for harm to clients in dual relationships remains high enough that neglect of this issue by the profession is very difficult to justify.

Miller and Lee (1989) examined the ethics involved in establishing friendships after termination of therapy. These authors concluded that post-therapy friendships or the possibilities of such a relationship contaminate the therapeutic relationship and should not occur. They base their argument on the possibility of countertransference issues and inequality of power in the therapy relationship. The position presented by Miller and Lee (1989) is in direct contrast to the arguments of Tomm (1992), presented earlier, about the problems that arise when the complexity of interpersonal relationships is ignored and exploitation is confused with dual relationship. Again the issues of paternalism and the role of professional ethics discussed in Engelhardt (1986) and Veatch (1981, 1989) are also brought into discussion, for Miller and Lee conclude that clear guidelines for the therapist should be developed to set limits on this behavior. They also recommended that applicants to doctoral psychology programs be carefully screened and that personal therapy for therapists be required. Clearly, Miller and Lee assumed the traditional position that the client should be protected from the therapist and reinforced the negative connotation that the mental health client is too weak, "crazy" or otherwise dysfunctional in all situations to make rational decisions about their relationships with the therapist.

Borys and Pope (1989) surveyed 1600 male and female clinicians from the American Psychological Association, the American Psychiatric Association and the National Association of Social Workers for a total sample of 4,800

about dual relationships. It is interesting that they did not survey marriage and family therapists because "this group does not have a well-organized national association with a membership list" (Borys & Pope, 1989, p. 284). This statement is in error because AAMFT was established in the 1940's and was publishing a directory of service providers in the 1980's (AAMFT, 1980). The participants were randomly assigned to one of two groups, ethics and practices. The ethics form provided a scale and respondents indicated their beliefs regarding the degree to which they considered the behavior as ethical. The practices form provided a frequency scale and respondents indicated the proportion of clients with whom they had engaged in the listed behaviors.

When the ethical belief responses were reviewed, it was found that all dual relationship behaviors, all behaviors involving sexualized relationships, and all behaviors involving extra fee financial relationships had lower ratings, or were seen as less ethical than behaviors involving incidental involvements, social involvements and special fee arrangements. Female therapists and psychodynamically oriented respondents rated dual professional roles as less ethical than did other categories of respondents. Respondents who live and work in the same small town rated these relationships as significantly more ethical than did respondents in other practice areas.

Behavioral frequency ratings demonstrated that psychodynamically oriented clinicians had the lowest frequency of involvement in dual relationships. Borys and Pope (1989) attributed this difference to psychodynamic training that stressed an informed awareness of a role that should be clear, nonexploitative, and therapeutically oriented, as well as preparing the therapist to recognize

their own needs, motives, and desires and separate these out from the relationship with the client. Male respondents reported engaging in social financial involvements and dual professional roles with clients more than did female therapists. The data also suggested that male therapists tended to engage in nonsexual dual relationships more with female clients than with male clients.

Borys and Pope (1989) recommended that educational programs address the issues of dual relationships more directly with students and faculty. This would involve setting clear standards for professional behavior, discussing the consequences of this behavior, acting appropriately against students and faculty who violated the standards that prohibit exploitative relationships, and provision of a safe environment for those who report violations of the standards. These authors concluded that the best summarization of their research is the principle "Do not exploit" (Borys & Pope, 1989, p. 292).

It is interesting that Borys and Pope (1989) concluded that the problem was related to exploitive relationships and did not include all dual relationships. This parallels the argument of Tomm (1992) when he asserted that it was important to recognize the complexity of relationships and that family therapists should focus on exploitive relationships, dual or otherwise.

In an attempt to understand clinical ethical decision making, Smith, McGuire, Abbott and Blau (1991) surveyed mental health professionals to assess the reasons they used to resolve professional ethical conflicts. Their findings indicated that although the clinicians evaluate what should be done according to professional ethical guidelines, they may not always be willing to implement the ideal as

presented in the professional ethics guidelines. These authors found that the psychologists' response to a situation more likely evolved from personal values and practical considerations than professional ethical guidelines. Smith et al. felt that their study confirmed the observation that professional codes of ethics are not always adequate and suggested that future research be directed at identifying specific ethical principles and reasoning processes that underlie areas of professional decision making and behavior that are not directly addressed by the professional codes of ethics. These areas might include privacy issues with minors and families, limits of personal competence and informed consent (Smith et al., 1991).

Research in the ethical decision making of psychologists presents issues similar to those identified by family therapists and supports the need to utilize alternative methods for understanding this process. This finding supports the recommendations made by Stanton (1988) for family therapy research. Stanton (1988) suggested that the processes for making decisions in family therapy are greatly in need of investigation and indicated that exploratory research would be a useful method to increase this understanding.

It is interesting that several authors have recognized the special ethical dilemmas of psychologists working with families (Alessi, 1989; Hansen, Green, & Kutner, 1989; Jensen, Josephson, & Frey, 1989). Jensen, Josephson, and Frey (1989) addressed the problems that occur when there are competing "best interests" among family members. The solution these authors proposed involved informing the family at the beginning of therapy that the process could impact individual needs in the system. It was felt that this

informed consent provides an opportunity to discuss the hazards of the therapeutic process with the client, provides the client with an opportunity to participate in the decision making about the therapy, and assists in the development of a therapeutic alliance. These authors did not recognize the need for a different, systems focused approach to these ethical dilemmas posed by working with families.

Alessi (1989) and Hansen, Green and Kutner (1989) acknowledged that the ethical guidelines established by the American Psychological Association (APA) are more appropriate for those psychologists practicing individual therapy and that family therapy practice may require an ethical model developed from a systems perspective. Neither of these articles proposed a model of ethical principles that evolved from systems theory. Hansen, Green and Kutner (1989) proposed that the psychologists have a clear understanding of the potential problems before they started working with families and develop appropriate policies to prevent difficulties they foresaw within the context of the system. They also recommended that the psychologist obtain appropriate training and supervision when working with families, see the whole family as much as possible, establish clear guidelines with the family before the beginning of treatment about confidentiality between family members and other systems in the community (i.e., schools), and that the referring agencies have a clear understanding of issues of confidentiality. Alessi (1989) proposed that the key to clarifying the ethical problems of working with families is to have clear goals. He felt that these goals help to clarify rights, issues about what problems should be addressed, choice of therapeutic techniques, and the progress of treatment that in turn produce ethical therapy.

Neither Alessi (1989) nor Hansen, Green and Kutner (1989) provided ethical guidelines derived from a systems perspective. They did however present psychologists with a basis for questioning the basic assumptions of APA ethical principles when applied to family systems. This supplements the same process presented by family therapists who are questioning the appropriateness of ethical principles that do not evolve from a systems perspective being applied to systems oriented therapy.

It would appear that individually oriented psychologists have the most difficulties in making ethical decisions related to dual relationships (APA, 1990, 1991; Borys & Pope, 1989; Miller & Lee, 1989; Pope, 1991; Stake & Oliver, 1991). The resolutions that are currently being offered are reflected back to the ethical principles established by APA based in traditional justice ethics (Casas & Thompson, 1991). As was discussed in the section on family therapy ethics, the justice based ethical paradigm appears to diminish the complexity of interpersonal relationships and thus continues to provide little guidance for practicing therapists with the complex decision making in relationships. Psychologists who practice individual therapy are faced with the same relationship dilemmas family therapists confront when working with the family as client.

This might indicate, as Casas and Thompson (1991) suggested, that individually oriented psychologists would find more relevant guidance with their ethical decision making if they moved away from the individual rights focused justice model and adopted an ethical perspective that combines the aspects of a justice perspective with a relationship focused perspective. Casas and Thompson (1991) referred to the work of Noddings (1984) and Gilligan (1982)

for the model of relationship focused ethical paradigms. As is suggested by the research of Stake and Oliver (1991), the ethical behavior displayed by psychologists who practice individual therapy may be based in an ethical paradigm that demonstrates a care perspective. This would suggest that the theoretical orientations of individual focused therapy models that emphasize the rights of individuals do not contribute to ethical decision making of the psychologist as much as the interpersonal relationship the therapist has with the client.

Ethical Decision Making

Ethics or morality provide guidelines for resolving conflicts in human interests to optimize the benefits of persons living in social networks (Rest, 1986). Rest (1986) proposed that a moral system is working well when persons appreciate that their interests are being considered, when they see that the distribution of burdens and benefits is shared equally, and when they choose to remain a part of the system because they perceive that the mutual benefits of living together are being optimized.

Ethical decision making or moral reasoning is the method one uses to resolve conflicting values (Runes, 1983). Empirical studies to describe ethical decision making have primarily focused on justice-based theories of moral reasoning from cognitive psychology or a contextually based mode of moral reasoning based on the principle of care to interpret their findings.

Justice Perspective

The justice model of ethical decision making is represented in the work of Kohlberg (1969, 1981, 1984). The

philosophical foundation for the justice tradition is best represented by the philosophical traditions of John Locke and Immanuel Kant. The driving concern in these theoretical frameworks is the preservation of individual moral and personal autonomy. A justice perspective is strongly individualistic, morally preparing people to care for themselves while protecting them from the demands of others and the state (Kittay & Meyers, 1987).

Kohlberg (1969, 1981, 1984; Reed, 1987) proposed five stages of moral development based in a cognitive developmental perspective. These stages are placed in three levels of moral reasoning. The levels of moral reasoning are conventional, post-conventional, and conventional. Each of these levels is divided into two stages, producing six stages. This perspective focuses on reasoning about moral behavior and not the behavior itself. Kohlberg assumed this position out of a belief that the meaning of the situation to the individual was a much better indicator than behavior of developmental processes. This position was motivated by awareness that the same behavior could be seen at different developmental levels and yet the reasoning behind the behavior could be very different. The focus of Kohlberg's stages is the individual's social perspective (Lerner, 1986; Reed, 1987). This development progresses toward the inclusion of larger social systems in the perspective, while the individual's ability to abstract is also increasing.

Within the justice model of ethical decision making a moral problem is defined by the need for reciprocity between separate individuals, and decision making evolves into mediating conflicting claims in relationships or attempting to resolve issues in a manner that treats each participant fairly according to the rules. Decisions are based in a

system of logic that values impartial decisions based in rules perceived to promote justice (Gilligan, Lyons & Hanmer, 1991). The autonomous independent self of the justice perspective is in direct contrast to the interdependent self perceived in the care perspective.

The study on which Kohlberg based the development of his theory included controls for social class, age, and sociometric factors. Females were not included in this sample. The omission of women was briefly addressed as a way of decreasing the number of variables that needed to be considered (Colby, Kohlberg, Gibbs, & Lieberman, 1983).

Evaluation of Kohlberg's conclusions and research design should be tempered with understanding of the social context in which he was working. The primary world view or epistemology was the justice orientation that valued abstract, logical thought disconnected from contextual considerations (Eichler, 1988; Keller, 1985). Since epistemologies determine the boundaries of what one knows, thinks or decides (Keeney, 1983), Kohlberg was rightly influenced by the predominate world view of his time. Because these world views determine ways of knowing it becomes quite difficult to remove oneself from this perspective and consider alternate explanations for observations or for theory development (Keeney, 1983). Understanding the influence of epistemologies provides the foundation for a reconsideration of the current assumptions of ethical-decision making and can be discussed in greater depth after a discussion of the care perspective (Flanagan & Jackson, 1987).

Care Perspective

The care perspective is represented by the work of Gilligan (1982; Kittay & Meyers, 1987). This perspective was developed by Gilligan to address the concerns of women in the development of ethical decision making theories that she felt were not represented in the justice perspective. Gilligan's criticisms of the justice perspective evolved from her understanding that women appeared to consistently display deficient moral development when Kohlberg's criteria for moral development were applied to their ethical decisions. She perceived this outcome as a paradox, for the traits that have traditionally defined women as good, caring and sensitive to others needs, were now making them appear inadequate in mature moral development (Gilligan, 1982). Gilligan and her co-workers have adjusted their perspective to acknowledge Kohlberg's justice model as appropriate for addressing that aspect of moral conclusions related to the ethics of justice and rights and the ethic of care as appropriate for issues related to care and responsibility (Benhabib, 1987).

The theoretical framework for the care perspective has evolved from the work of Gilligan (1982) and Noddings (1984). The primary themes presented in the work of Gilligan and Noddings are of interconnected relationships, nurturance, caring, emotional responsiveness, and understanding of situations in context (Kittay & Meyers, 1987; Walker, 1989). Murdoch is often cited as the person who set the precedent for this perspective with her work to establish a moral epistemology of love or unselfish, concentrated attention (Murdoch, 1992; Walker, 1989). Murdoch rejects the objective decision-maker of Kant (1959) that is central to Kohlberg's (1981) model of moral

development and advocates a moral philosophy that places love in the center of the ethical life (Lyons, 1988; Murdoch, 1992).

The primary themes that predominate Gilligan's theory of moral reasoning are related to interpersonal responsibility and increased understanding of relationships (Gilligan, 1982). This increased understanding of interpersonal relationships is combined with increased sophistication in caring for oneself without neglecting others. The concepts of responsibility and care are primary in Gilligan's understanding of the moral domain (Gilligan, 1982).

Theoretical Perspectives on Ethical Decision Making

The tradition of seeking a moral perspective that considers more than a deductive approach, as utilized by Kohlberg (1981), to moral decision making is not a new phenomenon. Plato, Aristotle and Hume emphasized the importance of love and virtue over justice in moral deliberation (Kittay & Meyers, 1987; Murdoch, 1992). Aristotle and Plato considered contextual and circumstantial features to be crucial in ethical decision making (Benhabib, 1987; Murdoch, 1992). Hume emphasized the importance of emotion and personal concern as the base upon which ethical decisions are made. Hume indicated that reason alone could not motivate moral action. The understanding and consideration of relationships were central to his ethical perspective. Haan (1978) cited the work of Rawls and Habermas, who focus on dialogue as a method of resolving moral conflict, to support her use of an interpersonal approach to ethical decision making.

Contemporary ethicists, Alistair McIntyre and Bernard Williams, continue the emphasis on the personal point of view that contrasts with the more formal traditions (Benhabib, 1987). Support for a contextual relationship focused ethical paradigm can be found in historical and contemporary ethical theory. This parallels the work currently being done by and her colleagues (Gilligan, 1977, 1982; Gilligan & Attanucci, 1988; Gilligan, Lyons, & Hanmer, 1990). Instead of basing moral decisions on the assumption that the rules valid for the generalized other are also valid for the individual in context, Gilligan perceives dilemmas in a contextual voice that is aware of the perspective of the concrete other (Benhabib, 1987).

Current Perspectives on Justice and Care Orientations

The debate about moral decision making between the perspectives of justice and care continues. Kohlberg recognizes a care position directed to relations of special obligation such as family and friends (Benhabib, 1987; Friedman, 1987). Friedman (1987) points out that although Kohlberg acknowledges an ethic of care, he continues to assert the primacy of the justice perspective based on the belief that an understanding of these special relationships should only supplement the generalized obligations of the justice perspective. Kohlberg (1983) supports the approach with the recognition that when differences are seen between men and women in ethical decision making, this can be accounted for by differences in education and experience in social institutions. Men and women with the same educational backgrounds and experience in social institutions demonstrate the same ethical decision making considerations.

Friedman (1987) asserted that the arguments used by Kohlberg (1983) to support his position at best only serve to support the traditional western perspective that the world of interpersonal relationships, traditionally relegated to women, is of lesser moral importance than the male dominated world outside the home. The justice perspective focuses on the social contracts between abstract persons that do not require a personal relationship. In her critique of the justice model Friedman went beyond the traditional arguments that Kohlberg's framework is biased against women and addressed metaethical and methodological considerations.

Friedman's (1987) most pressing disagreement evolved from Kohlberg's (1983) claim that the primacy of justice is supported because he succeeded in elaborating stages which parallel Piagetian cognitive tradition. Friedman took issue with Kohlberg's assertion from the perspective that there is no evidence that a moral system should be presented in Piagetian terms to be valid, and certainly this issue cannot be resolved by assuming that this is the appropriate framework for a theory of ethical decision making.

Finally, Friedman (1987) argued that, although Gilligan did not emphasize it, the care model of ethical decision making provided a framework for understanding the broader contextual framework of the ethical dilemma. She cited Kohlberg's Heinz dilemma as an example. Friedman asserted that the true problem in the Heinz dilemma was the larger social issues involved in the delivery of health care. Although Kohlberg's choices focused on the relationship between Heinz and the pharmacist, the underlying issue was the inadequacy of health care resources for the poor, a problem that could only be seen when a contextualized

version of the dilemma was presented. When the broader contextual perspective of the care model was used to resolve the dilemma, a foundation was provided for understanding reasoning in complex, richly detailed situations.

Gilligan's wisdom of placing the data she had in a gender paradigm has been questioned by others (Broughton, 1983; Flanagan & Jackson, 1987; Nails, 1983). This questioning has been based both in the review of research on ethical decision making and theoretical review.

Gender of Informant

Hare-Mustin and Marecek (1988) and Nails (1983) cautioned that Gilligan's (1982) ethic of care could have inadvertently been influenced by an exaggeration of the importance of gender as producing the differences seen between males and females in her samples. The differences described by Gilligan could be attributed to a variety of other variables. The contribution of other variables to this difference has been demonstrated by the research done by Clopton (1989), Walker (1989), and others (Pratt, Golding, Hunter & Sampson, 1988; Peter & Gallop, 1994).

Nails (1983) referred to Gilligan's (1982) ethic of care as social-scientific sexism that could increase the risk of paradoxically supporting the sexism Gilligan is purported to criticize. This author asserted that the manner in which Gilligan presented her material could be used to show the inferiority of women unless it can be proved that males go through a similar development, the ethic of care is proven to be superior, or all of the assumptions about ethical decision making are proven to be invalid.

Hare-Mustin and Marecek (1988) indicated that in husband-wife conflicts the wives usually emphasize caring

and the husbands emphasize rules and logic. In parent-child conflicts the same women emphasize rules and the children advocate for sympathy and understanding. This observation supports their assertion that the differences between men and women seen in Gilligan's research could be related to social structure and the individual's position in this structure. While in a dominant position most persons tend to support rules, discipline, control and rationality, similar to the justice approach described by Kohlberg. The rules were developed to support the maintenance of the status quo and are therefore supported by the dominant social group. When someone is in a subordinate position, they often appeal to mercy, sympathy, and understanding, as in the ethic of care (Hare-Mustin & Marecek, 1988). Similar behavior has also been documented in other groups that are in fewer powerful positions in their social networks. Harding (1987) and Stack (1986) describe this experience for Black males, who experience financial disfranchisement. These men develop a perspective that emphasizes interpersonal connection that resembles the ethic of care presented by Gilligan (1984).

Clopton and Sorell (1993) found no indication that gender differences in the use of care and justice perspectives in moral reasoning were significant for their sample of husbands and wives. They indicated that this similarity resulted from restricting the domain of decision to areas of parenting. Clopton and Sorell argued that past differences seen in the moral reasoning of men and women may result more from the types of dilemmas they encounter than stable intrapsychic characteristics.

Additionally, Nails (1983) criticized both Kohlberg (1982) and Gilligan (1982) for developing causal links in their theories without providing support from other

resources or from outside the immediate situation. This criticism included the development by both Kohlberg and Gilligan of stages of moral development. Nails asserted that the assumption that stages can exist in this area is based in a highly controversial and nebulous realm of criteria for ethical development. It was Nail's belief that the generalizations about the sexes made by Gilligan from questionable data could establish boundaries that would limit expectations for both males and females. It was also important to Nails that generalizations about groups not be confused with the response of any particular individual. Nails concludes her critique with a plea to perceive moral development as a complex process that might best be viewed as an interaction among multiple variables.

Flanagan and Jackson (1987) reviewed claims made by Kohlberg (1984) and Gilligan (1982) in an attempt to gain perspective on the moral psychology debate. Flanagan and Jackson (1987) proposed a moral psychology that is virtue-theoretical in the Aristotelian tradition. They desired to move away from the cognitive-developmental tradition of Piaget (1962) which they saw as Kohlberg's position. The basis for this perspective is threefold. First, Flanagan and Jackson argued that there is no clear taxonomy of the elements of both the justice and care orientations. The lack of careful analysis of the differences between good and "bad" kinds of care provided the second area of concern addressed in this article. Finally, the authors presented the variety of perspectives that can be used as foundations for moral outlooks and reflected on the inaccuracy of self-report as a tool for discerning an individual's psychology. The position proposed by Flanagan and Jackson advocated for a diversity of moral positions and supported the conclusions

proposed by Nails (1983). All of these authors found little to support the claim that the care or justice perspectives should be considered central.

Dilemma Characteristics and Response

Support for Gilligan's (1986) assertions that gender influences moral orientation were found by Langdale (1986). In her study, Langdale presented 144 subjects, ages 24-60+, four dilemmas. All of the subjects were presented the Heinz dilemma, seventy-six of the respondents were given one of two versions of an abortion dilemma generated Langdale, and thirty of the participants generated a real-life dilemma. Results of this study demonstrated consistency in orientation, justice or care across dilemmas. Males demonstrated a consistent preference for justice reasoning across dilemmas and care was predominately used by females.

Recent research on the effects of gender on decision making have suggested that characteristics other than gender may have influence on this process (Clopton, 1989; Friedman, Robinson, & Friedman, 1987; Pratt, Golding, Hunter, & Sampson, 1988; Walker, de Vries & Trevethan, 1987; Walker, 1989). Each of these studies suggested that men and women use a mix of care and justice in moral reasoning and that dilemma characteristics influence the decision making style.

Freidman, Robinson, and Friedman (1987) found, in their study of 101 psychology students, no significant gender differences in responses to questions about four traditional hypothetical dilemmas (Heinz, Doctor, Prisoner, & Newspaper). Students were presented with a list of Gilligan (G) items and Kohlberg (K) items that had been developed from the respective theoretical frameworks. Both sets of items were presented after each dilemma and the students

were asked to check all the items that applied to the dilemma. None of the individual dilemmas produced significant differences in either the K or G scales.

Walker, de Vries, and Trevethan (1987) assessed reasoning on hypothetical dilemmas and a real-life dilemma using 80 family triads (mother, father, and child). Gender did not significantly contribute to the differences in reasoning on either dilemma. Consistently age did demonstrate significant differences for decision making when children and adults were assessed. When the content of the real-life dilemma for adults was assessed differences were found in the content of the dilemmas generated by men and women. Men generated more impersonal dilemmas and women produced more personal themes. Analysis of response type and hypothetical dilemma type indicated that personal relationship focused dilemmas produced more care as opposed to rights responses regardless of subject's gender.

In their test for gender differences in moral orientations, Pratt, Golding, Hunter, and Sampson (1988) contributed more to the growing evidence that factors other than gender influence moral choice. Twenty-four (12 men, 12 women) subjects were presented with two of Kohlberg's hypothetical dilemmas and a Gilligan personal dilemma task. No gender differences were found in responses to hypothetical dilemmas when they were measured by Kohlberg's element categories. Assessment of the real-life dilemmas found that men were significantly more likely to demonstrate justice responses than were women. When the content of the real-life dilemmas was assessed women provided more personal relationship problems. Gender differences for the real-life dilemmas were not significant for relational dilemmas. This

finding would suggest that dilemma content may indeed have an influence on moral reasoning.

Walker (1989) conducted a longitudinal study of moral reasoning using 233 subjects, 5 to 63 years old. Two identical interviews were conducted with a two-year interval. Each of the subjects responded to hypothetical and a real-life dilemmas which were scored utilizing both Gilligan and Kohlberg criteria. Gender did not demonstrate a significant interaction. After assessing the content of the real-life dilemmas, Walker concluded that the nature of the dilemma is a better predictor of moral orientation than gender.

A need to consider an integrated moral theory and to conceptualize the ethic of care more broadly than a gender specific perspective is also supported by research (Clopton, 1989). Clopton (1989) explored the ethical decision making of informants on real and hypothetical ethical dilemmas. The results of this study suggest that the characteristics of the dilemma rather than the gender of the respondent are more important in determining the type of reasoning used.

Clopton (1989) developed a study to test the differences in ethical decision making between men and women in hypothetical and real-life dilemmas. The respondents were forty married couples. Half the couples were the biological parents of handicapped children and half were the biological parents of non-handicapped children. Each respondent was asked to respond to four dilemmas: (a) a structured, hypothetical dilemma designed to have equal relevance and emotional appeal to both parent groups; (b) a structured, hypothetical dilemma that had equal emotional appeal but unequal relevance to the parent groups; (c) the parents of handicapped children were asked to describe a real-life

dilemma they experienced in their parenting and parents of nonhandicapped children were asked to imagine they were parents of a mentally retarded, physically handicapped child and describe a dilemma they encountered parenting this child; (d) parents of the nonhandicapped children were asked to discuss a dilemma they encountered raising their own children.

The results of Clopton's (1989) study indicated that there were more care responses on the dilemmas that were rated higher in emotional appeal, personal involvement, difficulty, and importance. The author indicated that the most surprising result of the study was the lack of gender differences in any of the scores on the dilemmas. The results of Clopton's work add to the data that suggests characteristics of the dilemma rather than gender of the respondent influence the type of moral reasoning utilized.

This literature (Clopton, 1989; Friedman, Robinson, & Friedman, 1987; Pratt, Golding, Hunter, & Sampson, 1988; Walker, de Vries & Trevethan, 1987; Walker, 1989) would suggest that it is time to remove theories about moral reasoning from the social political battle ground and begin a search for a theory of ethical decision making that integrates the perspectives of care and justice. As is suggested by Flanagan and Jackson (1987), it is important to consider a rich diversity in ethical decision making and to utilize research methods that provide opportunities to consider a complex moral system. Research methodologies that provide the subjects with the opportunity to self-select a moral dilemma and describe their reasoning in these situations were shown to provide an initial framework to address the need for a model that allows the integration of the justice and care perspectives (Clopton, 1989).

Moral Reasoning and Professional Orientation

As discussed previously, the traditional focus of health care ethics parallel the justice model of decision making (Fry, 1989). The goal of the justice perspective is to treat all individuals equally, regardless of the context. Decisions are based on the logical, impartial application of ethical principles to achieve justice for all. When the ethical principles for the professional associations of family therapists and individual therapists, are reviewed they reflect this focus on individual rights and justice. The focus of these codes is concern about assuring the rights of individual clients (AAMFT, 1991; Corey, Corey, & Callanan, 1984).

The COAMFTE(1988) indicates the course that provides information about the theoretical foundations of marital and family therapy must enable the students to conceptualize about human problems from a systems paradigm. To accomplish this goal the commission indicates that the students should be taught systems and cybernetics theory. When the assumptions of both justice and care perspectives of ethical decision making are reviewed, the assumptions of the care perspective provide the best fit with systems/cybernetic theory.

The ethic of care has as its primary concern the complexities of attachment within relationships and has as its goal to achieve a balance in these relationships to meet the needs of all concerned. The primary metaphor is one of a web or connections (Lyons, 1990). The justice perspective has as its primary concern individual rights and fairness with a focus on adherence to standards or principles that evolve from an objective, rational perspective.

Systems/cybernetic theory, the theoretical framework for family therapists, values the understanding of the relationships that connect individual parts into a whole and the understanding of the patterns that connect these parts (Keeney, 1983). This focus of systems/cybernetic theory aligns it with the ethical concerns of the care perspective. It could therefore be predicted that family therapists would make ethical decisions using a care perspective.

The code of ethics developed by the American Psychological Association (APA) addresses a variety of issues that reflect the diversity of practice sites for psychologists. These practice sites vary from positions that focus on research, to industrial psychology, to individual, private therapy practices. Ethical concerns of psychologists, as described in the research of Pope and Vetter (1992), reflect this diversity. The issues most frequently identified by the 679 respondents to Pope and Vetter's questionnaire identified issues related to confidentiality as the most frequently encountered problem, followed by dual relationship issues and concerns related to reimbursement for services.

To assist those psychologists in counseling roles the APA provides speciality guidelines for their practice (Corey, Corey, & Callanan, 1984). These guidelines reflect the theoretical assumptions of the models of helping. Corey, Corey and Callanan (1984) place all therapeutic models into four categories: the moral model, the compensatory model, the medical model, and the enlightenment model. The differences in these categories are based on the distinction about where the responsibility for discovering solutions to problems resides. The moral model sees the individual as responsible for the problems in their life, as well as for

discovering the solutions. The compensatory model does not make the individual responsible for their problems but does make them responsible for the solutions. Individuals are perceived as responsible for neither their problems nor the solutions to these problems and are thought to need treatment from the outside expert in the medical model. In the enlightenment model, individuals are responsible for their problems but require the direction of others because they are unwilling or unable to develop solutions. Each of these models focuses attention on the individual rights and responsibility.

With this focus on individual rights and responsibility, it would appear that the ethical decision making model that provides the best fit with the theoretical framework of psychology would be the justice model. When the psychologists identified the issues they most often confront, the areas that were identified related to concerns about relationships with clients. Issues such as reporting of child abuse, the development of friendships with clients, and seeing clients who are friends with a personal friend of the therapist are a small sample of the general types of ethical dilemmas identified in the research done by Pope and Vetter (1992). When the psychologists were asked what would help them with these dilemmas, they requested principles that clearly and realistically address the situations (Pope & Vetter, 1992). There is no indication that the respondents found the justice model inadequate for making the decisions related to the identified situations.

Contribution to the Literature

Family therapy is currently involved in the process of developing an ethical perspective that is consistent with the framework from which interventions evolve (Green 1986; O'Shea & Jessee, 1982; Solovey & Duncan, 1982; Wendorf & Wendorf, 1985). This process has gone in two directions. The work initiated by Hare-Mustin and her colleagues (Hare-Mustin et al., 1979; Hare-Mustin & Hines & Hare-Mustin, 1978) placed into question the process of ethical decision making that might require the sacrifice of the rights of individuals for the good of the family system. This criticism initiated a movement among family therapists who attempted to develop an ethical perspective that was theoretically consistent with family therapy. This process was initiated because of a belief that the rules being used by Hare-Mustin and her colleagues to evaluate the ethical decisions made by family therapists were not consistent with the systems/cybernetics theoretical framework of family therapy (Green & Hansen, 1986; O'Shea & Jessee, 1982; Solovey & Duncan, 1992; Taggart, 1982; Wendorf & Wendorf, 1985).

T. C. Schneirla (Tobach, 1970) and Ludwig von Bertalanffy (1952, 1967) provided a theoretical perspective supporting the hypothesis that ethical decisions made from a systems/cybernetics epistemology need to be evaluated using a set of rules that are different from those applied to the traditional individual therapies. Both Schneirla and von Bertalanffy asserted, based on their research of systems, that the laws and principles that apply at one level of system organization do not necessarily hold true at another

level of organization. Each level contains different processes. Therefore, social entities would have different rules than individual systems (Von Bertalanffy, 1952, 1967).

The primary concerns in systems theory are related to interactional patterns at various system levels. The focus of family therapy, guided by systems theory, then becomes assisting the system in evolving alternate patterns of interaction that facilitate functioning (Keeney, 1983). This perspective appears problematic when evaluated utilizing traditional ethical criteria that evolve from the individually focused traditional justice perspective (Fry, 1989).

The majority of the work on ethical decision making in family therapy has been in the area of proposing alternative ethical theoretical perspectives the authors felt were more consistent with systems/cybernetics theory (Wendorf & Wendorf, 1985). Little attention has been given to understanding the process utilized by family therapists in making ethical decisions within a systems/cybernetics theoretical framework.

Green and Hansen (1986), Ratliff (1988) and Brock and Coufal (1989) attempted to assess the ethical decision making of family therapists. This research focused on the therapist's application of moral principles to hypothetical dilemmas. If moral decision making is a complex process that involves the characteristics of the dilemma, as was suggested by Clopton and Sorell (1993) and Flanagan and Jackson (1967), then methods to assess the decision making done by therapists should accommodate this complexity. It appears that if a true picture of the process used by family therapists in making moral choices is to be discerned, a

research methodology that elicits real-life moral dilemmas would be most useful.

Current research and theory suggest that there are at least two perspectives from which ethical decisions are made, justice and care. The type of moral reasoning used may be context dependent which is suggested by the differences seen in those decisions made in real-life as opposed to hypothetical dilemmas (Clopton, 1989; Friedman, Robinson, & Friedman, 1987; Pratt, Golding, Hunter, & Sampson, 1988; Walker, de Vries & Trevethan, 1987; Walker, 1989). The work of Kohlberg (1981) and Piaget (1965) also suggests that the individual's moral decisions are influenced by personal perceptions that provide a filter for viewing these issues. The need to understand that personal perspective can influence moral decision making is supported theoretically by cybernetics of cybernetics that proposed the viewer cannot be separated from the observed (Keeney, 1983). Understanding that context and type of dilemma used influence the decision making process would support research questions that explore how family therapists make ethical decisions for real-life situations.

Empirical studies to describe moral reasoning have focused on two models. The justice model as described by Kohlberg (1969, 1981, 1984) and the ethic of care as presented by Gilligan (1982). Ethical decision making that evolves from the justice model focuses on issues of fairness, individual rights and maintaining standards or principles. The care perspective is concerned with the complexities of attachment in relationships and finding a balance that meets everyone's needs (Clopton, 1989). It would appear, based on the theoretical perspective, that the ethic of care would be more congruent with a systems/

cybernetic theoretical framework and that therapists that are making decisions in this context would use this perspective. However, this issue has not been examined in a manner that would reduce the bias toward making decisions from the justice perspective. All of the research on the ethical decision making of family therapists has depended on hypothetical dilemmas and not assessed their decision making in real-life situations.

The purpose of this study was to facilitate the development of an ethical decision making perspective for family therapists that is theoretically consistent with systems/cybernetic theory. To provide a base for this development, this study was designed to elicit the type of decision making therapists are using with real-life dilemmas. The content of the dilemmas and the decision making utilized to resolve them was analyzed to determine the perspective used to make the decision. This data can provide a data base from which to develop theoretically congruent ethical guidelines for family therapists utilizing a design demonstrated to enhance understanding of the individual's ethical decision making process.

The guiding questions for this study were as follows.

1. How are practicing family and individual therapists making decisions about the ethical issues they face in their practice?

Previous research on the ethical decision making of family therapists has utilized hypothetical dilemmas to elicit information about family therapists' ethical decision making (Brock & Coufaul, 1989; Green & Hansen, 1986, 1989; Ratliff, 1988). This research did not demonstrate how family therapists are making ethical decisions in their practice, but the therapists did indicate that the models of ethical

decision making currently presented by the AAMFT are not useful in making these decisions. Gilligan (1982) and Kerber (1986) have suggested that informants reason differently on hypothetical and real-life dilemmas. In their work on ethical decision making, these authors have hypothesized that the abstraction of hypothetical dilemmas separates the moral problem from social contingencies and predisposes a preference for justice reasoning on the hypothetical dilemmas and for care reasoning on the real-life dilemmas (Gilligan, 1982; Kerber, 1986). This suggests that family therapists and individual therapists will demonstrate a preference for care reasoning on the real-life dilemmas that will be elicited by this research. This preference would be increased by the theoretical orientation of family therapy that emphasizes relationship (COAMFTE, 1988), as does the care perspective.

As previously discussed, past research on ethical decision making of individual therapists has also utilized the hypothetical dilemma design to elicit information or has asked psychologists to identify areas that were ethically troubling (Borys & Pope, 1989; Holroyd & Brodsky, 1977; Pope & Vetter, 1992; Stake & Oliver, 1991). Based on the information about ethical decision making cited above, it could be predicted that individual therapists who practice individual therapy would prefer care reasoning, as opposed to justice reasoning, in real-life dilemmas (Gilligan, 1982). This effect would be diminished compared to the one seen for family therapists because of the emphasis on individual rights and responsibilities found in the theoretical focus of psychology (Casas & Thompson, 1991).

The following statistical hypotheses were tested:

H1: Both family therapists and individual therapists

will score higher in care on the real-life dilemma than the hypothetical dilemmas.

H2: The care scores of family therapists will be significantly higher than the care scores of the individual therapists for care on the real-life dilemma.

2. Does the theoretical orientation of family therapists or individual therapists, affect the frequency of justice and care responses in real life dilemmas?

Although past research has suggested that real-life dilemmas produce a greater proportion of care responses than hypothetical dilemmas (Gilligan, 1982), the potential effects of the basic theoretical assumptions of therapeutic orientations cannot be ignored. The theory that supports family therapy emphasizes relationship and attachment (COAMFTE, 1988), and the theory that supports individual therapy focuses on individual rights and responsibilities (Casas & Thompson, 1991). The individual rights' focus is more congruent with the justice model of ethical decision making. The care model, with its focus on relationship, is more congruent with the theoretical framework of family therapy than is the justice model with its focus on context-free rules and individual rights.

As discussed previously, the work of Gilligan (1982) suggests that informants reason differently on hypothetical and real-life dilemmas. In Gilligan's research, justice reasoning has been the predominant response to hypothetical dilemmas. It was therefore predicted that both family and individual therapists would demonstrate similar scores on the hypothetical individual dilemma. It was further predicted that family therapists would have a higher

percentage of care responses than the individual therapists to the family hypothetical dilemma. Although the family dilemma is a hypothetical dilemma, it would elicit a theoretically congruent response from both therapist types which, for family therapists would be more congruent with care reasoning.

The statistical hypotheses tested were:

H3: Scores for family therapists and individual therapists will not differ on the individual therapy hypothetical dilemma.

H4: Family therapists will score significantly higher in care than individual therapists on the family hypothetical dilemma.

CHAPTER III

RESEARCH DESIGN

As discussed in Chapter I, previous research on the ethical decision making of family therapists has utilized hypothetical dilemmas to determine the types of decisions the therapists are making. Kerber (1986) suggested that the impersonal character of the hypothetical dilemmas presented to subjects by researchers might elicit a justice response. These responses tend to be detached, logical and impartial or more objective in their nature because the decision maker is distanced from the details for the problem (Gilligan, 1982). Gilligan (1982) suggested that research designs that utilize a personal dilemma more frequently elicit a care response. The writings of Kerber (1986) and Gilligan (1982) would suggest that family therapists may be using a moral decision making process in their daily practice that is not reflected in their responses to the hypothetical dilemmas that are currently being used in family therapy research on ethical decision making.

The proposals of Gilligan and Kerber have been addressed by several projects that reviewed responses to real-life and hypothetical dilemmas. Research by Pratt, Golding, Hunter, and Sampson (1988), Walker, de Vries and Trevethan (1987), Walker (1989) and Peter and Gallop (1994) has demonstrated that the nature, or type of dilemma impacts the type of moral orientation. These authors found that real-life dilemmas could be further categorized as personal or impersonal and that personal dilemmas generate a care

orientation and impersonal dilemmas generate a justice orientation. A personal dilemma is one involving a person, or group of people, with whom a participant has a significant, generally continuing relationship. An impersonal dilemma involves a person or group of people with whom a participant does not have a significant relationship (Walker et al., 1987).

When this understanding is placed in the context of the current debate in family therapy about the development of ethical guidelines to assist with decision making in complex circumstances, the need for research that provides better understanding of these processes becomes apparent. The research model developed by Gilligan that utilizes open-ended clinical interviewing techniques and content analysis can provide information that will facilitate the development of ethical guidelines that integrate theory and practice in family therapy and provide information on how this process may be different for individually oriented therapists.

This chapter will begin with a presentation of content analysis. Content analysis is a method of observation and measurement that can be applied to any form of communication. It is used to determine emphasis or frequency of communication phenomena (Babbie, 1992; Kerlinger, 1986; Stempel, 1990).

The second portion of this chapter will describe the methods utilized in this study. Information related to selection of informants, procedures for the interviews, development of the interview schedule, coding of data, and strategies for data analysis will be included.

Content Analysis

Content analysis is a technique that facilitates the systematic analysis of the content of communication (Stempel & Westley, 1990). It is appropriate to apply content analysis to any form of communication (Babbie, 1992). Leininger (1985) identified content analysis as an appropriate method for analyzing value data. She identified value analysis as focused on the abstraction of "preferences, choices, any thing or idea that is viewed as desirable, and implicit or explicit forces that tend to guide human thoughts and actions" (Leininger, 1985, p. 61). Since the purpose of this study was to understand the ethical decision making of family and individual therapists, this study would be defined as value analysis and the use of content analysis would be appropriate.

Gilligan and her colleagues have established a precedent for utilizing content analysis as a method for the analysis of data on ethical decision making. This method is outlined in A Guide to Reading Narratives of conflict and Choice for Self and Moral Voice (Brown et al., 1988). Brown et al. (1988) constructed categories that meet the objectives and conceptual framework of this study. The method described by Brown and her colleagues guides the reader to code latent and manifest content in a process that places content in proper context. This method for reading narratives was refined by Clopton (1989) to more clearly define care and justice and to streamline the evaluation process in a manner that facilitates the use of data in statistical analysis. This study used the method that was

first described by Brown et al. (1988), as it was refined by Clopton (1989). The test for category appropriateness described by Babbie (1992) and Stempel and Westley (1990) was met because the defined categories have been demonstrated as useful in similar research (Clopton, 1989; Friedman, Robinson, & Friedman, 1987).

Reliability and validity of the information obtained from content analysis are evaluated through intercoder reliability and verification with a panel of experts (Brink, 1989; Kerlinger, 1986; Weber, 1990). Intercoder reliability is established when coders, unaware of the study purpose, analyze the same text and produce comparable results. These results are then confirmed by the panel of experts (Brink, 1989; Weber, 1990).

Informants

The ability of the sample selection to enhance the validity of the information obtained is an important consideration. When the sample is theoretically representative of the role being studied, the validity of the information obtained is enhanced (Brink, 1989; Leininger, 1985). The informants for this study were selected utilizing criteria that ensured that they represented the approach to ethical decision making of family therapists and individual therapists in a manner that fulfilled the theoretical demands of the research questions.

Both the individual and family therapists were selected based on purposive sampling methods. Purposive sampling assures that all informants are deliberately selected

according to the theoretical needs of the research (Glaser & Strauss, 1967; Morse, 1986, 1988). The researcher can choose to interview those informants whose experience is considered typical or those who have particular expertise. Glaser and Strauss (1967) and Morse (1986, 1988) suggest that evaluation of samples be based on appropriateness and adequacy of the sample to provide the information necessary to meet the theoretical demands of the study. This study utilized experts representing strategic family therapy and individual therapy and professional standards established by the recognized professional organizations to determine the appropriateness of informants for the theoretical purposes of this study.

Names of potential informants were obtained by contacting regional faculty of the Family Therapy Institute of Washington, D.C., talking with individual therapists representing professional organizations, and referrals from potential informants and interviewers. Initial contact with each informant occurred by telephone. Sixty-two informants were contacted by the three interviewers, 31 individual therapists and 31 family therapists. During this interaction an initial assessment was conducted to determine the ability of the therapist to meet the theoretical demands of the study. If the informant met the criteria a subsequent interview was scheduled (refer to Appendix A for Phone Contact Data sheet). All of the potential informants contacted agreed to an interview. Two potential informants, one family therapist and one individual therapist, were

dropped from the interview list because of difficulties in scheduling the two-hour interview.

Informants were family therapists who defined themselves as utilizing the methods identified with family systems theory and strategic therapy and individual therapists who identified themselves as utilizing methods that are not identified with family systems/cybernetic or strategic focused family therapy. Final assessment of the therapist's theoretical compatibility with the study was done with a demographic data form (refer to Appendix A, for Demographic Data for Therapists form) that required the potential informants to identify their primary professional and theoretical identification and the therapeutic techniques they utilized.

The methods that define strategic family therapists include paradox, the "benevolent lie," reframes, and other strategic therapy interventions (Haley, 1976; Lindley, 1987). The faculty and staff of the Family Therapy Institute of Washington, D.C., a nationally recognized training institute for strategic family therapy, assisted in identifying potential family therapist informants. This provided an expert panel to certify the expertise of the informants since they are recognized as the primary trainers for this family therapy model. Additionally, the family therapist informants were involved in providing direct client services at least ten hours per week on the average.

Individual therapists were currently involved in clinical practice an average of 10 hours a week and did not apply techniques related to strategic or family therapy

within the theoretical framework of these systemic models. Therapists who identified themselves as individual therapists and identified that they used a theory that is individual in perspective were placed in this group. The individual therapist group excluded persons who identified themselves as utilizing theory and techniques identified with strategic family therapy.

Thirty individual therapists and thirty family therapists were interviewed. This resulted in 60 interviews. Demographic data was obtained on the therapists from both groups to assess for differences other than theoretical perspective (refer to Appendix A, for Demographic Data for Therapists form). Items considered here were gender, age, educational preparation, years of experience, professional certifications, primary professional identification, theoretical identification, therapeutic techniques used, licensure, time spent doing therapy, and involvement with ethics education. Each informant was told that the purpose of the study was to increase understanding of professional ethical decision making which could then facilitate the development of professional standards that would better serve the practitioner. This information encouraged participation by demonstrating how the informant could personally benefit from the data. Each participant was offered a summary of the research results at the conclusion of the study.

Analysis of Demographics

The sample consisted of 30 family therapists and 30 individual therapists. The family therapy group included 16 men and 14 women, whereas the individual therapy sample included 14 men and 16 women. A chi-square analysis indicated there was no difference between the groups in gender representation, $\chi^2 (1; N = 60) = p > .60$.

Analysis of therapist characteristics indicated the sampling methods were successful in identifying two groups with similar professional qualifications, but theoretically distinct orientations toward therapy (see Table 3.5). The mean age for therapists was 41.48 ($N = 60$, $SD = 7.61$) years. There was no significant difference between individual and family therapists on age, $F (1,59) = .58$, $p > .45$. The mean for years of doing therapy was 12.88 ($N = 60$, $SD = 6.79$). There was no significant difference between the two groups on this variable, $F (1,59) = 1.85$, $p > .17$. The mean number of hours per week spent doing therapy was 17.47 ($N = 60$, $SD = 6.23$), with no significant difference between the family and individual therapists, $F (1,59) = 2.15$, $p > .14$. Equivalent numbers of family and individual therapists were licensed, $n = 25$ and $n = 26$, respectively. The informants did not differ significantly in the degree to which they were licensed, $\chi^2(1, N = 60) = .0000 = p = 1$. Both the family and individual therapists reported a high degree of professional certification, with frequencies of 30 and 27, respectively. There was no statistical difference between the groups regarding certification, $\chi^2 (1, N = 60) = 3.16$, $p > .07$.

Significantly more of the family therapists ($n = 27$) than the individual therapists ($n = 17$) indicated that they supervised other therapists, $\chi^2 (1, N = 60) = 8.52, p = .0035$. Post hoc difference in two proportion analysis indicated there was a significant difference in the two groups for those reporting that they did not supervise (difference = .03) with more individual therapists reporting that they did not supervise. There was not a significant difference between those saying they did supervision. A 2×3 , supervision by dilemma type repeated measures analysis of variance of care scores of the therapists on the personal, individual and family dilemmas did not demonstrate a significant effect for supervision status, $F = (1, 58) = .66, p = .418$ (refer to Table 3.1, p.105, for source table). There was a significant within-subject effect for dilemma type, $F = (116, 2) = 6.60, p = .002$. This would indicate that there is greater difference in each therapist's scores than there is between the supervision versus nonsupervision therapists (refer to Table 3.1, for source table).

Family therapists reported a higher frequency of the master's degree ($n = 16$) as their highest professional degree than did the individual therapists ($n = 11$), whereas the individual therapists reported more frequently than family therapists that the doctorate was their highest degree ($n = 19$; family therapists $n = 14$) was their highest professional degree. This difference was not statistically significant, $\chi^2 (1, N = 60) = 1.68, p = .194$. Difference of two proportions post hoc analysis indicated that the difference between the therapist groups with a master's

degree was significant at the .05 level ($p = .05$), while the difference for the Ph.D. degree between the two groups was not significant ($p = .06$).

As shown in Table 3.2, most of the family therapists identified family therapy ($n = 14$) or social work ($n = 10$) as their primary professional discipline. Four family therapists identified psychology, one identified medicine and one identified other as their primary disciplines. Individual therapists identified psychology ($n = 15$) as their primary professional organization. Additionally, seven individual therapists identified social work, three identified nursing, two identified medicine, and three identified other (counseling) as their primary professional identifications. As would be expected there was a significant difference between the family and individual therapists with respect to their primary professional identification, $\chi^2 (5, N = 60) = 25.23, p < .0001$. Difference of two proportions tests were conducted to assess for the location of significant differences in professional identification (Hoel, 1960). Post-hoc analysis indicated that significant differences occurred with family therapy, nursing, psychology, medicine, and other. More family therapists indicated identification with family therapy, whereas more individual therapists indicated identification with nursing, psychology, medicine, and other.

Reflecting the selection criteria, the theoretical frameworks most frequently used by family therapists were strategic and structural therapy ($n = 28$ and 25 , respectively). Among individual therapists, individual

behavioral and brief therapy ($n = 18$ and 15 , respectively) were most frequently selected as the theoretical frameworks (see Table 3.3, p. 107).

Therapist use of theoretical frameworks was examined in separate chi-square analyses for each theory because each informant could select multiple theories. Examination of the theoretical frameworks found that individual and family therapists do differ in their identification with several models (see Table 3.3). The family therapists indicated that they were more likely than the individual therapists to use MRI, strategic, structural, solution focused, systems and brief therapy models.

Overall, family and individual therapists were significantly different in the therapy techniques they used. On six of the eight techniques the two groups were distinguished from one another (see Table 3.4, p. 108). There was a significant difference between the groups in the use of directives, prescribed rituals, positive connotation, ambiguous task assignment, paradox, and metaphoric task assignment. For each of these techniques, family therapists indicated that they used them more frequently than did the individual therapists.

The two techniques on which family therapists and individual therapists did not demonstrate significant difference were invariant prescription and reframe. Most of both the individual ($n = 27$) and family ($n = 24$) therapists indicated that they did not use invariant prescription, whereas reframe was indicated by all but two of the informants as a technique that they used.

Prior professional experience with ethics committees and ethics education was the same for both the individual and family therapists. The majority of both the individual ($n = 23$) and family ($n = 21$) therapists indicated that they had been exposed to ethics education, $\chi^2 (1, N = 60) = .341, p > .559$. Difference in two proportions post hoc analysis indicated that there was no significant difference at the .05 level between the groups for those who indicated they had ethics education while the groups that did not have ethics education were significantly different. More family therapists than individual therapists had not had ethics education.

Few of the informants from either group had experience with ethics committees. Of the family therapists, only two indicated that they had experience with ethics committees, whereas among the individual therapists only seven had this experience, $\chi^2 (1, N = 60) = 3.26, p > .07$. Post hoc difference in two proportions tests show that there was no significant difference between the two groups on this measure.

Evaluation of all characteristics associated with the informant groups demonstrated that the family and individual therapists differed as expected. The individual and family therapy groups met the theoretical demands of the study (refer to Table 3.5, pages 109-110 for a summary of the characteristics of therapists and therapy practice).

Procedures

The need for the interviewer to have skills in developing rapport while obtaining the desired information is especially important when the area of inquiry is of intimate or secretive knowledge (Leininger, 1985). Since the goals of this study were to increase understanding of the moral decision making of the therapists, the development of rapport by the interviewer was crucial. The interviewers were selected by the investigator, in part, because of an ability to develop rapport with the informant population and were persons who could easily be perceived by the informants as trustworthy. The interviewer's ability was evaluated by experience with similar research, professional experience with potential informant groups, and review of the first interview taped by the interviewer.

Two Ph.D. prepared faculty from West Virginia University Health Sciences Center Department of Behavioral Medicine and Psychiatry and one Ph.D. prepared faculty from Florida State University School of Social Work were trained to administer the interviews. Two of the interviewers were doctorally prepared family therapists with backgrounds in social work and content analysis research methods. One interviewer was a doctorally prepared psychologist who had extensive experience in administering semi-structured and open-ended clinical interviews.

The interviewers were required to review the interviewer's guide developed for this study before conducting any interviews. After the interviewers had reviewed the guide, the investigator discussed the

information to assure mutual understanding of the purposes and processes of the interviews. The investigator maintained contact with the interviewers throughout the interviewing process to discuss concerns and problems as they arose. These discussions occurred at regularly scheduled meetings along with periodic review of the taped interviews to assess for interviewing consistency. The interviewer's guide can be found in Appendix B. This guide was developed from the suggestions made by Spradley (1979), Clopton (1991), and Gilligan and her colleagues (Brown et al., 1988).

Each informant was interviewed at a mutually agreed-upon location by the trained interviewers. Informant's confidentiality was maintained at all times. Each informant was given a number code by the interviewer. The informants were told of this process and of the fact that there was no master list kept that could be used to identify them by their code number. All interviews were taped for later transcription. All therapists completed a survey of the demographic data before the interview began and signed a consent to participate in the research (see Appendix A, p.161). The consent gave the informants an opportunity to request a summary of the research findings. The consent for participation was filed separate from the coded interview to maintain the confidentiality of the informants.

Both the family therapists and the individual therapists were asked similar questions based on structured interviewing principles. The initial question requested that the informants talk about a clinical decision they actually faced that required a difficult choice. Follow-up

questions asked by the interviewer facilitated the informant's description of the decision making process related to this situation. These questions were adapted from the "Real-Life Moral Conflict and Choice Interview" developed by Gilligan and her colleagues (Brown et al., 1988; Gilligan, 1982), as it was revised by Clopton (1991).

Besides describing a real-life dilemma, the informants were asked to respond to two hypothetical dilemmas that were read to them. The hypothetical dilemmas were designed to assess the effects of type of client system (individual or family) on the informant's decision making, whatever the therapist's theoretical or professional orientation. The first dilemma described a situation that occurs when a therapist works with an individual client. The gender of neither the client nor the therapist was identified to avoid potential biasing effects related to the gender of the protagonists. The second dilemma addressed a situation that evolves from working with a family and was related to the relationships within the family. The gender of the therapist was not identified to avoid gender biases. The gender of the clients was identified because of the nature of the roles in a family system, i.e., husband-wife. To provide equal emotional appeal for both hypothetical dilemmas, the dilemma was a client situation and did not involve the relationship between the client and the therapist as might occur when decisions are being made about dual relationships.

The hypothetical dilemmas typified the issues not involving dual relationship concerns identified in previous research as most difficult for both family therapists and

psychologists (Green & Hansen, 1986, 1989; Pope & Vetter, 1992; Ratliff, 1988). They were adapted from a workbook on ethical decision making developed by N. Ratliff (1988) (see Appendix A).

The first dilemma focused on an individual therapy situation related to issues of confidentiality. The client was involved in behaviors that placed others at risk and did not demonstrate a willingness to discontinue the activities. This dilemma was selected because issues of confidentiality have been identified as either one of the most frequently encountered or most troubling by the therapists in previous family therapy and psychology research (Green & Hansen, 1989, Pope & Vetter, 1992; Ratliff, 1988).

Hypothetical dilemma number two presented a family situation involving child abuse. The family referred themselves for treatment and revealed a recent history of sexual abuse between the father and the daughter. Again this situation was selected because family therapists have identified issues related to child abuse as problematic. The subjects in a study conducted by Green and Hansen (1989) rank ordered it number one for ethical significance, and Ratliff (1988) found that the family therapists in her sample rated this issue as number one in need of attention by professional organizations.

As with the real-life dilemma, following presentation of each hypothetical dilemma the informants were asked the same questions to facilitate description of the decision making process related to the situation presented (see Appendix A, pp.170-174). The follow-up questions about the

hypothetical dilemmas were open-ended and as similar as possible to those asked about the real-life dilemma to maintain consistency.

After describing the real-life dilemma, and following responses to each hypothetical dilemma, the informants were asked to rate the dilemma on a scale from 1, very low, to 5, very high, according to the importance, difficulty, and degree of interpersonal relationship perceived in the dilemma (see Appendix A, p.161 for dilemma rating form). The informants were provided with the rating forms to complete if the interview was conducted in person. If the interview was conducted over the telephone, the questions were read to the informant by the interviewer.

Interviewer 1 conducted 42 of the interviews, 15 with individual therapists and 27 with family therapists. Interviewer 2 conducted 15 of the interviews, 14 with individual therapists and one with a family therapist. Interviewer 3 conducted three interviews with family therapists. To obtain a sample of family therapists who met the theoretical criteria for informants, Interviewer 1 conducted 24 interviews by long distance phone calls. The remaining interviews were done in face-to-face interactions with the informants. After review of sample tapes from each interviewer and all transcripts, it was determined that all of the interviews were of good audio quality, followed the appropriate format and were used in the data set.

Among family therapists 20 were interviewed over the phone whereas 10 were interviewed in person. Twenty-six of the individual therapists were interviewed in person and

four were interviewed on the phone. Chi-square analysis of the interview location indicated that there was a significant difference between the two groups in location, $\chi^2 (1; N = 60) = 17.77 = p < .001$. More family therapists were interviewed over the phone than in person and more individual therapists were interviewed in person than over the phone. One-way analysis of variance for the effects of location of the interview on the type of ethical decision making used demonstrated that there was no significant effect for location on care scores for each of the three dilemmas, $F (1,58) = .79, p = .37$. This disparity between in-person and phone interviews found when comparing individual and family therapists was due to the difficulty in obtaining a local sample of family therapists that met the sampling criteria of the study.

The primary investigator did not conduct any of the interviews and, after reviewing the first two interviews of each interviewer, did not listen to the tapes. This procedure allowed the investigator to remain blind to the professional orientation and gender of the therapist for most of the tapes. This procedure placed the investigator in a position to code the interviews blind to the informant's gender and professional identity.

Verbatim transcriptions of the interviews were typed into the computer software program, Qualpro (Blackman, 1992) by one of four typists. References that would identify the informant's professional identity, geographic location, agency identification, personal identity, and client's identity were concealed before the interviews were coded.

Transcription of each interview averaged four hours of typing time.

Qualpro is a text database manager that expedites the location, coding, and labeling of text. The codes are attached to the text without altering the document, and codes and code frequencies can be compiled. This program differs from other data management programs such as Ethnograph, Tap, Textbase, and Alpha because it provides the opportunity to compute intercoder reliability. Beyond reporting reliabilities between coders, Qualpro provides a Table of Agreements and a Confusion Matrix that assist with the identification of exactly where sources of confusion between coders exist. This program also provides quantitative frequency counts of the categories and qualitative narrative data from the text. This information was utilized in the development of intercoder reliability.

The transcripts were coded utilizing the manual found in Appendix C. This manual was developed by Gilligan and her associates (Brown et al., 1988) and revised by Clopton (1991). This guide directs the coders on how to classify responses in the interviews according to care or justice. The coders were blind as to the professional identity and gender of the informant. The coders were provided with printed transcripts of the interviews to code. It required approximately two hours to code one interview. After the coders marked the interview transcripts, this information was added to the interviews in the Qualpro program. The Table of Agreements and Confusion Matrix for the Qualpro

printouts was utilized to identify specific areas that needed refinement in the coding process.

The primary investigator and a graduate student in women's studies divided the interviews for coding. The primary investigator was the primary coder for 20 of the interviews and the graduate student was primary coder for 40 of the interviews. Because of her familiarity with the theoretical foundation for this project that evolved from her work in women's studies, the graduate student quickly demonstrated the level of understanding of the concepts of care and justice necessary to code the interviews.

The transcripts were coded by the primary investigator or coder in groups of three or four. The codes for each interview were marked in the margins of the text and then entered into the Qualpro program. A printout of the codes with the lines of text that received that code was then obtained from the computer program. After the coding of each group of interviews, a meeting was held to discuss the coding process and clarify areas of discrepancy. The codes that were developed after the discrepancies were resolved were used for data analysis. Each informant's responses resulted in one set of codes that were utilized in data analysis. The coding process took approximately two hours per interview.

After the coders reviewed the coding manual, intercoder reliability was assessed utilizing a sampling of text that had been previously coded by the researcher. The training process for coders continued until an intercoder reliability of at least .80 was achieved. The .80 reliability level is

based on the recommendations made by Krippendorff (1980) for inferences based on category coding. Topf's (1986) review of the literature on intercoder reliability indicated that she found a consensus among behavioral scientists that a percentage agreement of 70% was necessary, 80% was adequate, and 90% is good. Topf's standard for adequate differs from intercoder reliabilities achieved by researchers utilizing the category definitions established for care and justice by Gilligan and her colleagues (Clopton, 1991). Clopton (1991) indicated that the intercoder reliability for the categories of care and justice has been .74 to .72. Clopton (1991) achieved .75 and .73 for her study utilizing the care scores for the dilemmas for correlation. Clopton's intercoder reliability was consistent with the data from previous studies utilizing this coding process (Donenberg & Hoffman, 1988; Gilligan & Attanucci, 1988; Lyons, 1983; Walker, 1989). Krippendorff (1980) and Weber (1990) indicate that lower percentage agreements result from ambiguous definitions or coders' inability to understand the meaning of the category. Topf (1986) and Washington and Moss (1988) recommend a process that allows ample time for debriefing of the coders to refine the tool and increase understanding of the theoretical constructs.

Topf (1986) and Washington and Moss (1988) argue that measures of interrater reliability should give researchers a methodology that assesses agreement about the occurrence and nonoccurrence of the measurable event. Topf presents three methods for estimating interrater reliability. The methods she discusses are percentage agreement (T%), kappa (κ) and

phi (Φ). The use of percentage agreement increases the risk for inflated estimates because it does not correct for chance agreement. Kappa and phi control for chance agreement using correlation-like measures of agreement. These measures devalue high or low frequency agreement and favor moderate frequencies. Additionally, significance levels are available for the lower levels of agreement for both kappa and phi. These two measures will equal one another within .20 of a point. The correlation-like measures reflect formal reliability theory.

Baer (1977) argued that having the estimate of interrater agreement to be part of formal reliability theory is not appropriate. This argument is based on the understanding that formal reliability theory is concerned with item homogeneity on psychometric tests and homogeneity across raters is different. The process of increasing interrater agreement does not usually involve dropping or adding raters as is done with items on the psychometric test. The same raters are retained and refinement and revision of the category is used to improve the quality of agreement. Because of this debate, Topf recommends that the researcher provide documentation of the methods used in obtaining the reliability measures reported and suggests that multiple estimates of reliability could be reported to provide accurate measures of validity.

With the assistance of the table of coder agreements from Qualpro to identify areas of greatest confusion between coders, the investigator worked with the coders to achieve at least a .80 level of agreement suggested by Krippendorff

as acceptable for content analysis. Three sets of interviews were coded. The first trial produced agreement of 44% total agreement, 30% occurrence agreement, and 70% nonoccurrence agreement. The second trial produced 84% total agreement, 57% occurrence agreement, and 78% nonoccurrence agreement. This resulted in a kappa of .60. The final trial produced 90% total agreement, 66% occurrence agreement, and 79% nonoccurrence agreement. This resulted in a kappa of .62. Since other authors did not indicate that they used kappa it is assumed that they were reporting total agreement, therefore the .90 total agreement achieved by this study is above the .80 level of agreement suggested by Krippendorff and the .72 to .75 achieved by previous researchers using the care and justice categories as defined by Gilligan.

During the training sessions it became evident that agreement on what not to code was easy to achieve. The difficulty became defining the unit of care and justice to code. Initially there was some disagreement related to the distinctions between care and justice. This issue was greatest when the distinctions were attempted without attending to context cues or the discussion around the coded entity. Once agreement was achieved between the coders about the appropriate context cues to consider, the agreement about care and justice responses became much more consistent.

This issue is best exemplified by review of lines 102 to 118 in the interview of Informant 3 (see Table 3.6, p. 111). Line 102 is coded care by both coders. Lines 103 to

111 are uncoded by both coders. Coders agreed that lines 112-115 should be coded justice, however, Coder A also coded lines 116-118 as justice while Coder B left them uncoded. Thus, the coders agreed on the type of decision making taking place in a particular sequence of text but were not in agreement on how much of the text should be included in the sequence.

Data Analysis

Content analysis, in more recent years has been utilized to preserve the meaning of qualitative data that focuses on inductive analysis of the phenomenon studied (Lenninger, 1985; Sells, 1993). The inductive process of content analysis requires that hypotheses or questions be systematically derived from a theory related to context before hypotheses or causal propositions in quantitative research are presented (Smith, Sells, & Newfield, in press). Marshall and Rossman (1989) refer to these questions as guiding hypotheses and caution the researcher to use these only as tools to generate questions and to search for patterns. Content analysis was utilized to identify care and justice type moral reasoning in the informant interviews.

Coders read the transcripts for clear moral statements, and each statement was coded as either care or justice. Each informant was given a separate score for the individual, family, and personal dilemmas. These scores were based on the percentage of the responses that represented care responses. The number of care responses was divided by the total number of coded responses for each dilemma and for the

complete interview. After the interviews were coded, the care scores were assigned to the overall response of each informant, as well as, the personal dilemma, the family therapy dilemma and the individual therapy dilemmas separately. These scores were then used in planned comparisons to test the differences between the individual and family therapists.

Table 3.1
Source Table for Supervision by Dilemma ANOVA

Source	D.F.	SS	MS	F	<u>P</u>
<u>Between Groups</u>					
Within+Residual	58	42492.86	732.64		
Supervision	1	486.54	486.54	.66	.418
<u>Within Groups</u>					
Within+Residual	116	376.22			
Dilemma Type	2	4964.15	2482.08	6.60	.002
Supervision x					
Dilemma Type	2	1733.57	866.79	2.30	.104

N = 60

Note. Supervision refers to whether or not the therapist was a supervisor.

Table 3.2
Primary Professional Identification of Therapists

Professional Identifications							
	Family Therapy	Social Work	Nursing	Psychology	Medicine	Other	Totals (n)
Family (n)	14	10	0	4	1	1	30
	46.66%	33.33%		13.33%	3.33%	3.33%	
Indiv- (n)	0	7	3	15	2	3	30
idual		23.33%	10%	50%	6.66%	10%	
Totals (n)	14	17	3	19	3	4	60
Percent	23.30	28.3	5.0	31.7	5.0	5.0	100

Table 3.3
Theoretical Orientations of Therapist Types

Theory Types	Family Therapists	Individual Therapists	χ^2	D.F.
Strategic	28	2	45.07***	1
Structural	25	5	26.67***	1
Brief Therapy	29	18	11.88**	1
Individual Psychodynamic	9	10	.077	1
Family Psychodynamic	9	7	.340	1
Individual Behavioral	14	18	1.07	1
Family Behavioral	15	7	4.59	1
MRI	20	2	23.25***	1
Experiential	8	2	4.32	1
Solution Focused	22	12	6.79*	1
Systems	22	7	15.02***	1
Other (counseling)	12	12	00.00	1

* $p < .01$

** $p < .001$

*** $p < .0001$

N = 60

Table 3.4
Therapists Using Various Techniques

Technique	Family Therapists	Individual Therapists	χ^2	D. F.
Paradox	26	10	17.78***	1
Reframing	30	28	2.07	1
Metaphoric Task Assignment	23	5	21.69***	1
Invariant Prescription	6	3	1.18	1
Prescribed Rituals	26	7	24.31***	1
Positive connotation	30	8	34.74***	1
Ambiguous Task Assignment	21	4	19.82***	1
Directives	30	19	13.47**	1

* $p < .01$

** $p < .001$

*** $p .0001$

Table 3.5
Characteristics of Therapy Practice

General Description	Family Therapists (n = 30) M ± SD	Individual Therapists (n = 30) M ± SD
Age (Years)	42.33 ± 8	40.73 ± 7
Years of Therapy Experience	14.06 ± 8	11.70 ± 5
Hours per week of Therapy	18.63 ± 6	16.30 ± 6
Percent of time doing individual therapy	29.44 ± 22	61.23 ± 30
Percent of time doing family therapy	50.67 ± 25	7.30 ± 11
Percent of time doing conjoint therapy	8.61 ± 18	.80 ± 2
Percent of time doing group therapy	2.33 ± 5	22.83 ± 29
Percent of time doing other therapy	1.60 ± 4	3.83 ± 13

Table 3.5
(Cont.)

General Description	Family n	Individual n
<u>Gender of Informant</u>		
Female	14	16
Male	16	14
<u>Highest Professional Degree</u>		
Masters	16	11
Doctorate	14	19
<u>Professional Certification</u>		
Yes	30	27
No	00	03
<u>Supervise Other Therapists</u>		
Yes	27	17
No	03	13
<u>Primary Professional Identification</u>		
	14	00
Family Therapy	10	07
Social Work	00	03
Nursing	04	15
Psychology	01	02
Medicine	01	03
Other (counseling)		
<u>Licensed</u>		
Yes	26	26
No	04	04
<u>Served on Ethics Committee</u>		
Yes	02	07
No	28	23
<u>Experienced Ethics Education</u>		
Yes	21	23
No	09	07

Table 3.6
Coding Samples Table of Agreements
Informant 003

Code No.	Line No.	Coder A	Coder B	Match
95	102	Care	Care	Agree
96	103	Uncoded	Uncoded	Agree
97	104	Uncoded	Uncoded	Agree
98	105	Uncoded	Uncoded	Agree
99	106	Uncoded	Uncoded	Agree
100	107	Uncoded	Uncoded	Agree
101	108	Uncoded	Uncoded	Agree
102	110	Uncoded	Uncoded	Agree
103	111	Uncoded	Uncoded	Agree
104	112	Justice	Justice	Agree
105	113	Justice	Justice	Agree
106	114	Justice	Justice	Agree
107	115	Justice	Justice	Agree
108	116	Justice	Uncoded	Disagree
109	117	Justice	Uncoded	Disagree
110	118	Justice	Uncoded	Disagree

CHAPTER IV

RESULTS

Hypotheses Testing

The following statistical hypotheses were tested:

1. Both family therapists and individual therapists will score higher in care on the real-life dilemma than on the hypothetical dilemmas.

2. The scores of family therapists will be significantly higher than the scores of the individual therapists for care on the personal (real-life) dilemma.

3. Scores for family therapists and individual therapists will not differ on the individual therapy hypothetical dilemma.

4. Family therapists will score significantly higher in care than individual therapists on the family hypothetical dilemma.

To test the hypotheses, each subject's care scores were entered in a 2 x 2 x 3 (Type of therapist [family or individual] by gender by dilemma [individual dilemma, family dilemma, personal dilemma]) repeated measures analysis of variance with dilemma the repeated measure (see Table 4.1, p. 118, for mean dilemma scores; see Table 4.2, p.120 for source table). The individual therapy dilemma was hypothetical and involved an HIV positive client who refused to discontinue sexual relationships. In the family therapy hypothetical dilemma, the family presented requesting the therapist not report the father had sexual relationships with one of the daughters. The personal dilemma was a situation from the informant's own practice that they identified as having involved difficult decision-making. The results of this analysis demonstrated no significant

interaction between therapist type and dilemma type, $F(2, 112) = 1.18$, $p = .310$, indicating that the individual therapists and family therapists did not differ in their care scores within each dilemma. There was also no significant interaction between gender and dilemma type, $F(2, 112) = .74$, $p = .479$. There was however, a within-subject effect for dilemma, $F(2, 112) = 8.67$, $p < .001$. These results indicated that there was a significant difference across the care scores of each dilemma regardless of therapist type or gender. The mean scores for the individual, family and personal dilemmas were 59.28 ($SD = 21.95$), 62.95 ($SD = 22.10$), 73.65 ($SD = 22.96$), respectively. These scores indicated that the therapists were making care-based decisions more than 50% of the time on all of the dilemmas, with the personal dilemma demonstrating the greatest percentage of care-based decisions.

To test the specific hypotheses, planned comparisons were performed to evaluate differences between: (H1) family and individual therapists' care scores on the personal (real-life) versus the hypothetical dilemmas; (H2) care scores of the individual versus the family therapists on the personal (real-life) dilemma; (H3) care scores of the individual versus family therapists on the individual hypothetical dilemma; and (H4) care scores of the individual versus the family therapists on the family hypothetical dilemma (see Figure 4.1).

In the analysis of Hypothesis 1, care scores of the family and individual therapists were pooled because the hypothesis indicated that together, the therapist types would score higher on the personal dilemma than on the hypothetical dilemmas and the repeated measures showed no

interaction effect of therapist type with dilemma. A significant difference was found between the mean care scores for the personal dilemma and the two hypothetical dilemmas, $F = (2, 179) = 6.70$, $p = .0016$, T probability of the contrast of personal versus family and individual dilemmas $< .0001$. The results of post-hoc Tukey-HSD tests were consistent with the findings of the planned comparisons indicating that there was a significant difference between the mean personal dilemma scores and both the individual and family dilemma scores. The difference between the individual and family dilemma scores was not significant. Hypothesis 1 was supported.

Hypotheses 2, 3, and 4 were tested with 2×1 (Therapist type by Type of Dilemma) planned comparisons because the hypotheses addressed therapist type differences within the same dilemma (see Figure 4.1, page 117 for Planned Comparison Weights). There was not a significant effect for type of therapist when the individual therapy, family therapy, and personal real-life dilemmas were assessed separately, $F_{s(1,59)} = .81$, $p = .37$,; $.91$, $p = .35$,; $.57$, $p = .45$, respectively. Thus, Hypotheses 2 and 4 that predicted significant differences between the individual and family therapists on the personal and family dilemmas were not supported. However, Hypothesis 3 which predicted that scores for family and individual therapists would not differ on the individual dilemma was supported.

Supplementary Analysis of the Dilemma Characteristics

Previous research has suggested that the characteristics of the dilemma more than informant characteristics may influence the type of moral reasoning

utilized (Clopton, 1989; Kerber, 1986). Therefore, supplementary analyses of the dilemma characteristics for which respondent ratings were obtained were calculated.

The means of the ratings of the three dilemmas on degree of perceived interpersonal relationship in the problem, respondent's personal involvement with the problem, perceived importance of the problem, and perceived difficulty of the problem, by therapist type and gender were all inter-correlated (see Table 4.3, p. 121). Correlations for the ratings with gender and therapist type were low and not significant.

According to the results in Table 4.3, respondent ratings of difficulty and importance were significantly correlated within each dilemma type (i.e., difficulty ratings for the hypothetical personal dilemma were significantly correlated with importance ratings for the same dilemma). Personal involvement and importance ratings were also correlated significantly within each dilemma type. Personal involvement and difficulty ratings were significantly correlated within the individual and personal dilemmas. Personal involvement and degree of interpersonal relationship ratings were significantly correlated within the individual dilemma. Personal involvement ratings for the individual dilemma and interpersonal relationship ratings for the family dilemma were also correlated.

Difficulty ratings were significantly correlated with one another across all of the dilemmas. Ratings of interpersonal relationship were also significantly correlated between the personal, individual and family dilemmas.

Ratings means were compared among dilemma types in a series of one-way ANOVAs followed by post-hoc tests with

familywise error rate set at $p < .05$ to assess for significant differences in ratings between the dilemmas. The ratings of importance of the dilemma and degree of difficulty were the only two ratings that demonstrated significant differences between the dilemmas, $F(2, 177) = 23.58$, $p < .0001$, & 6.46 , $p < .01$, respectively. The post-hoc tests indicated that the greatest difference on the ratings of importance was between the personal dilemma and the family and individual dilemmas as shown in Tables 4.4 - 4.7. The mean importance rating for the personal dilemma was significantly lower than the mean importance ratings for both the family and individual dilemmas. Degree of difficulty ratings were found by the Tukey HSD test to be significantly different between the individual dilemma and the family and personal dilemma. The individual dilemma mean rating was significantly higher than the mean ratings for both the personal and family dilemmas.

Regression analysis of ratings by care scores within each dilemma was conducted to further assess the correlations of dilemma ratings. Overall care scores for each dilemma type the dependent variable for each of the three dilemma types. The ratings of difficulty, interpersonal relationship, importance, and personal involvement for the dilemma were entered. The overall F was not significant. The only significant R^2 was degree of interpersonal relationship for the personal dilemma ($R^2 = .117$; $B = 7.53$; $\beta = .35$; Sig. $T = .01$). The results of this analysis for the personal dilemma can be found in Table 4.8, p.127. Given the overall nonsignificant F and the lack of significant predictors of care scores, it would appear that care scores are not predicted by difficulty, interpersonal

relationship, importance, and personal involvement assessments by the informants.

Table 4.1.
Mean for Moral Orientation
Scores for Dilemmas 1-3

	Individual Dilemma	Family Dilemma	Personal Dilemma
Family Therapists (N=30)	<u>M</u> 56.73 <u>SD</u> 22.90	<u>M</u> 65.67 <u>SD</u> 22.59	<u>M</u> 75.90 <u>SD</u> 23.70
Individual Therapists (N=30)	<u>M</u> 61.83 <u>SD</u> 21.02	<u>M</u> 60.23 <u>SD</u> 21.64	<u>M</u> 71.40 <u>SD</u> 22.37

	Individual Dilemma		Family Dilemma		Personal Dilemma	
Hypothesis 1	-1		-1		+2	
	IT	FT	IT	FT	IT	FT
Hypothesis 2	0	0	0	0	-1	+1
Hypothesis 3	+1	-1	0	0	0	0
Hypothesis 4	0	0	-1	+1	0	0

FT= Family Therapists
IT= Individual Therapists

Figure 4.1. Planned Comparison Weights

Table 4.2
Source Table for 2 x 2 x 3 Repeated Measure ANOVA
Dilemma is Repeated Measure
(N = 60)

Source	D.F.	SS	MS	F	p
<u>Between Groups</u>					
Within + Residual	56	41705.72	744.75		
Type	1	163.56	163.56	.22	.641
Gender	1	904.80	904.80	1.21	.275
Type x Gender	1	252.07	252.07	.34	.563
<u>Within Groups</u>					
Within + Residual	112	43366.58	387.20		
Dilemma	2	6711.19	3355.59	8.67	.000
<u>Between x Within Groups</u>					
Type x Dilemma	2	916.72	458.36	1.18	.310
Gender x Dilemma	2	573.74	286.87	.74	.479
Type x Gender x Dilemma	2	415.05	207.53	.54	.587

Key: Dilemma = Dilemma Type (Family, Personal, Individual)
Type = Therapist Type (Family or Individual)
Gender = Gender of Therapist (Male or Female)

Table 4.3

Correlations of Ratings for Family and Individual Dilemmas

(N=60)

	IPR Ind	IPR Fam	PI Ind	PI Fam	IMP Ind	IMP Fam	DIF Ind	DIF Fam
IPR Ind								
IPR Fam	.70***							
PI Ind	.47***	.43**						
PI Fam	.20	.24	.75***					
IMP Ind	.13	.10	.33*	.19				
IMP Fam	.13	.10	.30	.30*	.57***			
DIF Ind	.31*	.20	.38*	.25	.35*	.17		
DIF Fam	-.02	.07	.02	.08	.21	.31*	.39*	
Gen- der	-.24	-.11	.00	.18	.06	-.03	.08	-.17
Type	-.13	-.08	-.28	-.24	-.12	-.20	.02	-.09
FAM Care	-.07	-.10	.03	.01	.23	.11	.15	-.02
Ind Care	.06	.11	.04	.09	.08	-.02	.14	.12
Per Care	.03	.04	.07	-.05	.08	.06	.05	-.07

KEY

Per = Personnel Dilemma
 Fam = Family Dilemma
 Ind = Individual Dilemma

* $p < .01$
 ** $p < .001$
 *** $p < .0001$

IPR = Degree of Interpersonal Relationship
 PI = Degree of Personal Involvement
 IMP = Importance of the Dilemma
 DIF = Difficulty of the Dilemma
 Care = Dilemma Scores

Table 4.3 (cont)

	IPR Per	PI Per	IMP Per	DIF Per	Gender	Type	Fam Care	Ind Care	Per Care
IPR Per									
PI Per	.35*								
IMP Per	.34*	.33*							
DIF Per	.21	.52***	.51***						
Gender	.06	.08	-.02	-.05					
Type	.81	-.26	-.02	.05	-.13				
Fam Care	-.004	.14	.08	.03	-.02	-.12			
Ind Care	.15	.04	.24	.20	-.22	.12	.26		
Per Care	.32*	.13	.03	.10	-.06	-.10	.10	.33*	

KEY

Per = Personnel Dilemma
 Fam = Family Dilemma
 Ind = Individual Dilemma

* $p < .01$
 ** $p < .001$
 *** $p < .0001$

IPR = Degree of Interpersonal Relationship
 PI = Degree of Personal Involvement
 IMP = Importance of the Dilemma
 DIF = Difficulty of the Dilemma
 Care = Dilemma Scores

Table 4.4

Source Table for Ratings of Personal Involvement
for All Dilemmas
(N=60)

Source	D.F.	SS	MS	F	p
Dilemma	2	5.03	2.52	1.92	.1495
Error	177	231.92	1.31		
Total	179	236.95			

Tukey HSD

<u>Dilemma</u>	<u>Mean</u>
Individual	3.67
Family	3.73
Personal	4.05

Note: No two groups are significantly different at the .05 level.

Table 4.5
Source Table for Rating of Degree of Interpersonal
Relationship Comparing All Dilemmas
(N=60)

Source	D.F.	SS	MS	F	p
Dilemma	1	1.23	.62	.5054	.6041
Error	177	215.97	1.22		
Total	179	217.20			

Tukey HSD

<u>Dilemma</u>	<u>Mean</u>
Individual	4.02
Personal	4.00
Family	4.18

Note: No two groups are significantly different at the .05 level.

Table 4.6
Source Table for Importance of Dilemma Ratings
Comparing All Dilemmas
(N=60)

Source	D.F.	SS	MS	F	p
Dilemma	2	24.23	12.12	23.58	.0001
Error	177	90.97	.51		
Total	179	115.20			

Tukey HSD

<u>Dilemma</u>	<u>Mean</u>	<u>Sig. Differences</u>
Personal	3.88	Individual & Family
Family	4.62	
Individual	4.70	

Table 4.7
Source Table for Degree of Difficulty
Comparing All Dilemmas
(N=60)

Source	D.F.	SS	MS	F	p
Dilemma	2	14.81	7.41	6.46	.002
Error	177	202.83	1.15		
Total	179	217.64			

Tukey HSD

<u>Dilemma</u>	<u>Mean</u>	<u>Sig. Differences</u>
Individual	4.25	Personal & Family
Personal	3.65	
Family	3.63	

Table 4.8

Summary of Simultaneous Regression Analysis for Variables
Predicting Care Scores with Care Score for Personal Dilemma
as Dependent Variable

Variables	<u>B</u>	<u>SE B</u>	β
Interpersonal			
Relationship	7.530	3.042	.347*
Involvement	.021	3.189	.001
Importance	-3.403	3.749	-.139
Difficulty	2.350	3.739	.103

Note: $R^2 = .118$; $F(4, 55) = 1.84$, $\text{Sig.} = .14$

* $p < .01$

CHAPTER V

DISCUSSION

This project has brought content analysis to the study of ethical decision making of therapists in an effort to inform the development of guidelines for ethical decision making congruent with the theoretical foundation of family therapy. Family and individual therapists were asked to discuss their ethical decision making processes around three dilemmas. The dilemmas were: an individual therapy dilemma that involved an HIV positive client; a family therapy dilemma related to sexual abuse, and a dilemma from the therapist's own practice.

Limitations

The findings of this study were limited by several factors.

1. The sample was limited by its size and its representativeness. It only represents those family therapists who identify themselves as utilizing the therapeutic techniques of paradox, reframing, metaphoric task assignment, invariant prescription, prescribed rituals, positive connotation, ambiguous task assignment and directives and individual therapists who identify themselves as individually oriented therapists.

2. The findings are limited in generalizability to those therapists who do family therapy and utilize the specified therapeutic techniques and to those individual therapists that identify themselves as individual therapists and do not utilize theoretical frameworks consistent with systems/cybernetic theory.

3. The structured interview technique may yield biased results since all informants were volunteers who consented to an interview.

Delimitations

Specific delimitations included in the study were:

1. Each informant was interviewed with the same interview schedule.

2. The research design that elicits real-life narratives of moral conflict and choice from the informants may limit the bias toward ethical decision making from the justice model (Clopton & Sorell, 1993; Walker et al., 1987).

3. Each interview was conducted a trained interviewer.

4. Each interview rater was trained according to the format presented by Argyis et al. (1987) and revised by Clopton (1989). Each interview rater was evaluated on sample interviews and an interrater reliability of 90% was established.

5. Ethical decision making may be affected by the informant's gender. Gilligan (1982) asserted that women are rated lower than men on Kohlberg's scales of moral reasoning because of early developmental experiences. Based on her research with women, Gilligan developed an alternate model for women's moral reasoning. Review of research based on Kohlberg's model of moral reasoning (Walker, 1989; Rest, 1983) has not discovered a clear-cut gender bias in this research. Meyers and Kittay (1987) argue that the differences between male and female responses on moral dilemmas can be attributed more to significance of the dilemma to the individual than to the gender of the decision maker. Clopton and Sorell (1993) found no support for the argument that differences in the use of care and justice

moral reasoning are related to gender in their sample of parents.

Major Findings

The major premise of this study was that there would be a significant difference between individual and family therapists in their process of ethical decision making which evolved from their theoretical orientations. Individual therapists were predicted to favor a justice model because of the emphasis on the rights of the individual in the theoretical models used to direct their practice. Family therapists were predicted to favor a care orientation to ethical decision making derived from family therapy's theoretical focus on understanding relationships within a particular family system. Analysis of the data clearly did not support these predictions.

Both the individual and family therapists demonstrated a preference for a care approach to ethical decision making in both the real-life and hypothetical dilemmas. There was no significant difference between the two therapist types in their preferred decision making style. This preference for care decisions was evident even in situations where the therapist recognized clear legal guidelines that mandated certain behaviors as in the family therapy sexual abuse situation.

Consistently, in all of the dilemmas the therapists would place emphasis on meeting the client's/family's needs and maintaining the relationship with the client. This would indicate practicing therapists have, in their practice, adopted a model of decision making that focuses on values identified with an ethic of care. This was most strongly demonstrated with the care scores for the personal dilemma

selected from the therapists' own practice. The mean care score for this dilemma was 73.65, indicating that the informants utilized care reasoning more than 73 percent of the time on this dilemma. Therapists, regardless of theoretical orientation, appear to share a common ethical foundation which values relationship. It appears that these therapists practice the interpersonal focused care model of ethical decision making that Casas and Thompson (1991) and Stake and Oliver (1991) recommended as providing a more appropriate model for resolving the complex interpersonal relationship issues confronted by individual therapists. This study would suggest that a therapist's ethical perspective supersedes their theoretical orientation when making ethical decisions.

Informant Characteristics

Differences in the use of care and justice reasoning could not be explained by any of the factors related to informant characteristics. The traditional explanation of reasoning differences in decision making, gender of informant, was not found in this study to be related to the increased frequency of care responses. Gender was not related to the increased frequency of care responses. This finding was congruent with the findings of Friedman, Robinson, and Friedman (1987), Walker (1989), and Clopton and Sorell (1993).

The research of Dreyfus and Dreyfus (Benner, 1984) suggested that proficiency at a task influences the decision making process. Those persons with limited experience may rely more on context-free rules for making decisions. Utilizing context free rules for ethical decision making parallels the justice approach for making ethical decisions.

Measures for experience used in this study were supervision and years of therapist experience. It was assumed that those who supervise other therapists had more clinical experience and expertise than those that were not. Again, the difference in decision making seen in this study was not explained by therapist characteristics. Level of expertise did not significantly affect the number of care and justice responses for the therapists in this study. It would appear that dilemma characteristics more than those factors related to informants' gender, experience, theoretical perspectives or training explain the differences found in ethical decision making.

Assessment of the ratings of dilemma characteristics did not provide information that explains the significant differences in the care scores on the personal dilemma and the individual and family dilemmas. The only dilemma characteristic rating that paralleled the pattern found in the care scores of the dilemmas was importance where the family and individual dilemma ratings were significantly different from the ratings for the personal dilemma. This difference did not, however, directly parallel the differences found between the care scores of the dilemmas. When the care scores for each dilemma were assessed, the personal dilemma had the highest rating. When the means for the importance rating were reviewed, the mean ratings for the family and individual dilemmas were higher than the mean rating for the personal dilemma. Thus, although the informants made the most care responses to the personal dilemma, they rated the individual and family dilemmas as more important than the personal dilemma.

Personal Dilemma

The therapists' scores on the personal dilemma supported the first hypothesis suggesting that both groups of therapists would have higher care scores on this dilemma than on the two hypothetical dilemmas. Clearly, informants had greater concern for relationship issues in making a decision about a real-life situation that they selected than in making decisions about hypothetical dilemmas.

Peter and Gallop (1994), Pratt, Golding, Hunter and Sampson (1988), Walker et al. (1987), and Walker (1989) have found that when relationships are perceived as more personal, care reasoning is used more frequently. The only dilemma characteristic that was rated higher for the personal dilemma than the individual or family dilemmas was personal involvement. The present study provides support for the nature of the relationship having an impact on moral reasoning. Personal involvement, however, did not contribute significantly to any of the dilemma care scores in the regression analysis. This would suggest that the relationship between personal involvement and care scores in the present study, although present, is not strong.

Personal involvement as a characteristic that increases the use of care decision making was not supported by the findings of Clopton (1989). Clopton concluded that her findings made "the general proposal that higher levels of personal involvement in a dilemma will cause an increase in the level of care responses even more difficult to defend" (p. 92). The findings of this study, which suggest that personal involvement may contribute to the type of decision making used, support the need to further investigate dilemma characteristics as factors that influence moral choice.

The personal dilemma was rated second for degree of difficulty. This rating does not assist in understanding the high percentage of care responses provided by the informants because its rank as number two for difficulty does not correspond with its rank as number one for percentage of care responses.

In the present study, the preference for care decisions was not strongly statistically associated with the dilemma characteristics assessed after each interview. Continued lack of agreement on the impact of dilemma characteristics on moral reasoning suggests there may be other factors not investigated in this study that may influence informant responses. This supports the recommendation of Clopton (1989) for continued investigation of dilemma characteristics that contribute to decision making preferences.

Individual Dilemma

The lowest scores for care were found on the individual hypothetical dilemma. The individual dilemma addressed an HIV-positive client who indicated that he or she continued to have sexual relationships despite an adequate understanding of the disease process. Lack of difference between the two therapist groups on their decision making approach to this dilemma supported the third hypothesis of the study. This would suggest that theoretical and professional characteristic differences between the therapist groups did not influence their reasoning on this individual therapy based hypothetical dilemma.

When reviewing the dilemma characteristics, this dilemma received the highest scores for importance and degree of difficulty and the lowest scores for personal

involvement. These ratings of dilemma characteristics suggest that of the hypothetical dilemmas, this one was perceived as the most difficult and important, however, this dilemma received the lowest personal involvement score of all of the dilemmas. The low score on the personal involvement does, however, parallel the findings of Pratt et al. (1988), and Walker et al. (1987) that suggest personal involvement or relevance may contribute to an increase in care responses. Clopton and Sorell (1993), however, reported mixed support for the interaction between care scores and personal involvement or relevance. It must be remembered that the relationship between care scores and dilemma characteristics for this study did not produce statistically significant results and, therefore, cannot be considered to provide strong support for the link between dilemma characteristics and care scores. The lack of consistent patterns linking ratings of dilemma characteristics and the care score of dilemma continues to suggest that additional factors not evaluated in this project contributed to the informant's method of ethical decision making.

The low care score for this dilemma could possibly be related to the lack of familiarity therapists had with this issue. Lack of therapist experience with this issue is supported by the characteristics of difficulty and importance being rated the highest for this dilemma. If therapists have had no experience with the situation, they may find it more difficult to resolve the issues and may perceive that it would be an important issue. A lack of familiarity could encourage therapists to appeal more to authority or legal remedies in decision making which would be reflected in a lower care score.

Family Dilemma

This dilemma involving sexual abuse in the family received the second highest care score. Dilemma characteristic scores rated this situation as number one for degree of interpersonal involvement and the lowest for difficulty. It received the number two rating for degree of personal involvement. Again, the dilemma characteristic scores provide little information about the care scores for this dilemma since they are not consistent with the dilemma's care score. The degree of personal involvement rating parallels the second position care score ranking. Again, however, this characteristic did not enter the regression analysis as a significant predictor of care scores. Since the relationship between degree of personal involvement and care score was not statistically significant, this provides additional support for Clopton's (1989) conclusion that defending this characteristic as a contributor to increased care responses is difficult.

The low difficulty rating could possibly be related to the clear legal guidelines provided for resolving issues related to child abuse. Legally, therapists are required to report abuse to the appropriate agencies of social control. Although there are clear legal guidelines to provide initial direction for therapist decision making, the care score of 62.95 indicates that at some point the informants are integrating decisions that move away from a pure legalistic response and incorporate a response to relationship issues. Tomm (1992, 1995) and Ryder and Hepworth (1990) have argued that the current professional guidelines do not reflect interpersonal complexities and recommend that the professional organization adopt methods of addressing ethical situations in a manner that reflects these concerns.

If the low difficulty rating is linked to the presence of legal guidelines and the care score reflects the informant's need to maintain a relationship with the family while responding to the legal demands of the situation, the results of this study provide some support for the current discussion about AAMFT's guidelines on dual relationships. The present study suggests that therapists are responding to a complex moral/legal situation in a way not currently being considered by the professional organization since the current professional guidelines favor a justice perspective.

Dilemma difficulty ratings could also be influenced by the frequency with which the therapists encounter the problem. If many therapists have encountered this issue in their practice, they may have developed strategies for resolving the issues prior to the presentation of the dilemma in this study, in turn decreasing the perceived difficulty of the dilemma.

Reliability

Caution should be exercised when applying the results of the present study that did not support the hypothesized relationship that family and individual therapists would differ in their decision making style. This finding contradicts the current theories that suggest family therapists make ethical decisions differently than individual therapists because of their theoretical foundation (Becvar & Becvar, 1988; Goldberg, 1993; Hare-Mustin, 1980; Hare-Mustin et al., 1979; Hines & Hare-Mustin, 1978). This was the initial application of this design to the exploration of therapists' ethical decision making using a very select population.

Additionally, the complexity of the coding system is important to consider when reviewing the interview ratings. Ideally, coding systems should clearly define what is to be coded and provide conceptual clarity about the coded labels (Gravin, Kennedy, & Cissna, 1988). Clopton (1989) reported interrater reliability of .75 and .73 for the coding of her interviews. Lyons (1983) reported correlations of .70, .71, and .82, while Walker (1989) reported .88 when using a coding process similar to the one utilized for this study. This study achieved interrater reliability of 90% total agreement after an intensive training period for the coders. This was well within acceptable levels of reliability and congruent with that achieved by similar studies that strengthens findings of this study.

Clopton (1989) also discussed concerns in establishing interrater reliability for her study. She addresses the difficulty of utilizing Gilligan's (1987) conceptualization of care and justice that originates from lack of conceptual clarity. As reported in Clopton, Gilligan suggests that a redefinition of validity and reliability may be necessitated by this design. However, as was found in this study, the difficulties of coding may be addressed, in part, by utilizing highly qualified coders combined with the increased use of context cues when identifying codeable entities. Rather than redefining validity and reliability, this study suggests that addressing issues of conceptual clarity for care and justice coding may be more productive. Support for this approach and for the findings of this study is provided by the .90 total agreement achieved in this study. Certainly this is a challenging aspect of this content analysis design that warrants continued analysis and refinement.

Implications of the Study

The most outstanding result of this study is that family and individual therapists do not differ significantly in the frequency with which they utilize care as a model for making ethical decisions in both real-life and hypothetical situations. Additionally, both types of therapists select a care response greater than 50% of the time when making ethical decisions. This indicates that despite theoretical orientation, therapists are making ethical decisions based on relationship concerns and responses to client's needs, as opposed to a reliance on justice and individual rights. Fry (1989) has suggested that traditional ethics, utilized by professional associations, support equal treatment of all individuals that is congruent with the justice perspective. When this outcome is viewed with an understanding that the ethical codes of professional organizations emphasize justice ethics, it clarifies the concerns expressed by therapists that the professional ethical codes do not address their needs.

Critics of the current ethical perspectives in family therapy (Becvar, Becvar & Bender, 1982; Goldberg, 1993, Hare-Mustin, 1980; Hare-Mustin, Marecek, Kaplan & Less-Levinson, 1979; Hines & Hare-Mustin, 1978; O'Shea & Jessee, 1982; Taggart, 1982) have consistently argued that family therapy is uniquely different from individually focused therapies because of its theoretical foundations in systems theory. Evolving from this perception of difference is concern about ethical decision making utilized by family therapists (Becvar, Becvar & Bender, 1982; Goldberg, 1993, Hare-Mustin, 1980; Hare-Mustin, Marecek, Kaplan & Less-Levinson, 1979; Hines & Hare-Mustin, 1978; O'Shea & Jessee, 1982; Taggart, 1982). As a result of this difference, it

has been suggested that either family therapy needs to develop a unique set of ethical principles to guide this different practice or because of this difference, family therapists violate ethical guidelines that support individual rights. Clearly, the results of the present study do not provide support for emphasizing the difference in ethical decision making between individual and family therapists. Neither family nor individual therapists demonstrated a preference for justice decision making and appear to be more alike than different in their approach to ethical decision making. Their bias is for care-based decisions. This is reflected most strongly in their decisions related to a personal real-life dilemma choosing a care response 73.65% of the time. The results of this study would suggest that it is time for professional organizations to reevaluate their traditional approaches to ethical decision making and incorporate care-based reasoning into their guidelines.

The complexity of developing a professional code of ethics that respects a care perspective presents a unique challenge to therapy professions that have traditionally functioned from justice-based models. The process of applying the nontraditional ethics of care to health care situations is currently being explored by feminist ethicists. Holmes and Purdy (1992) provide examples of this pioneering work in their edited work that includes the articles from two special issues of Hypatia: A Journal of Feminist Philosophy on feminist medical ethics. More recently Rave and Larsen (1995) have also attempted to address the issues related to developing alternative ethical systems for therapists using a feminist perspective. The model of ethical decision making described in this book

attempts to combine the rational-evaluative process with the feeling-intuitive process. The feeling-intuitive process includes contextual information and particular therapist and client characteristics in the decision making.

Professional therapy associations should begin dialogues with their constituents that explore ethics of care and the implications that this orientation has for future decision making. Moving to a care-based ethic would provide family therapists with an ethical model that is more congruent with system/cybernetics theory as discussed earlier. Evidence provided by this study that demonstrates family therapists already favor the ethic of care when faced with ethical decisions should facilitate revision of professional ethical codes. This addresses the concerns expressed by several authors (Goldberg, 1993; Ryder & Hepworth, 1990; Tomm, 1992, 1995; Wylie, 1989) related to the need to address the natural complexity of relationships in decisions. Clearly, the ethics of care recognize the importance of context and relationship and place the ethical decision in the context of the relationship.

Recommendations for Further Research

The present study established that both individual and family therapists interviewed prefer using care-based decisions in their practice of therapy when addressing both real-life and hypothetical dilemmas but more so on real-life. Further research is clearly needed to expand the exploration of this finding to a broader sample of therapists.

Although characteristics of the dilemma appeared to affect the type of decision making utilized, this study did not produce clear information on the relevant

characteristics. The present study continues to add support to the growing body of knowledge that dilemma characteristics contribute to moral reasoning styles (Clopton, 1989; Pratt et al., 1988; Peter & Gallop, 1994; Walker et al., 1987; Walker, 1989). Findings are not consistent in identifying those characteristics that contribute to differences seen in moral reasoning. Continuing efforts to define the dilemma characteristics that affect moral choice are strongly indicated by consistent findings that suggest dilemma type more than any other factor influences moral choice. Factors that could contribute to lack of consistency in identifying dilemma characteristics that influence choice should be examined. Definition of the characteristics and consistency in measuring these variables are possible areas for further development. Those characteristics that have been consistently evaluated are personal involvement and degree of interpersonal relationship. Additional characteristics that have been measured and provided mixed results are degree of difficulty and importance. In this study, evaluation of the care scores on the hypothetical dilemmas demonstrated that the lowest scores were given to the individual dilemma which was rated highest in difficulty and importance. This could indicate that dilemmas perceived as important and that challenge decision making capacities elicit more justice responses. Certainly, this suggests that further investigation of these characteristics is warranted.

The effects of gender on moral choice were again explored. This study added to the growing evidence that gender is not an important variable in determining care and justice responses. Continued investigation of demographic

factors that may have influence on moral choice could include further refinement of professional experience and educational preparation as variables since they have been identified by Benner (1994) as influencing professional decision making. These variables may have influenced the decision making in a manner not identified by this study.

Finally, professional associations could begin to develop alternative guides of ethical decision making. These models could be tested with professional ethics committees in their real-life deliberations and with focus groups utilizing hypothetical dilemmas.

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APPENDIX A
INSTRUMENTS

Phone Contact Data

Name: _____

Address: _____

Phone: _____

1. Family therapist____; Psychologist____ Individual therapy__ Other____ (please specify)_____.

2. Do you use any of the following techniques in your therapy (Check all that apply)? paradox__, reframing__, metaphoric task assignment__, invariant prescription__, prescribed rituals__, positive connotation__, ambiguous task assignment__, directives__.

3. **Date, time, and place of scheduled interview:** _____
_____ Informant's home, office or telephone interview? Describe: _____

4. **Date interview completed:** _____

5. **Do they want summary of study results?** _____

File separately without identifying subject number.

CONSENT FORM

Title

Ethical Decision-making Among Family and Individual Therapists

Introduction

I, _____, have been asked to participate in this research study which has been explained to me by Susan Newfield, R.N., M.S.N., C.S., who is a faculty member of West Virginia University and a Ph.D. candidate at Texas Tech University, or her authorized representative. This study is being conducted in partial fulfillment of the requirements for the Ph.D. in Marriage and Family Therapy degree.

Purpose of the Study

The purpose of this study is to learn more about the decision-making of family and individual therapists when they are faced with difficult choices in their professional practice.

Description of the Procedures

I understand that I will be asked to describe the decisions I would make/made in three situations. Two of the situations will be hypothetical and provided by Ms. Newfield or her representative. The third situation will be a situation that I describe as having been a difficult choice in my own therapy practice. The presentation of each of these situations will be followed by questions from a trained interviewer that will provide more information about my decision-making related to the choice I identify. This interview will be audio-tape recorded. In addition to the interview, I will be asked to complete two forms. The first form provides basic information about my professional preparation and additional professional development experiences. The second form will ask me to rate the three situations on a five point scale.

The study requires that I meet with the trained interviewer for no more than two hours. This meeting will occur at a time and place that is mutually determined by myself and the interviewer and may occur during a telephone conversation. There will be approximately 60 therapists interviewed for this project.

Risks and Discomforts

There are no known or expected risks from participation in this study, except for the risks that occur with personal self-disclosure, however, I understand that the information I give will remain as confidential as legally possible and be used only for the research proposed by Ms. Newfield.

Benefits

I understand that this study is not expected to be of direct benefit to me, but the knowledge gained may contribute a more complete understanding of the processes used by therapists to make decisions when faced with difficult choices. This information could assist educational programs and professional organizations to better meet the needs of practicing therapists. I also understand that I can request a summary of this study from Ms. Newfield to enhance my knowledge of the study topic.

Contact Persons

For more information about this research, I can contact Susan Newfield Monday through Friday during the day at 304-293-2331 or at 304-599-8755 after 6:00 p.m. and on weekends. Ms. Newfield's mailing address is: 3027 HS North, Robert C. Byrd Health Sciences Center, West Virginia University, PO Box 9610, Morgantown, WV 26506-9610. I may contact the dissertation supervisor, Gwendolyn T. Sorell, Ph.D., by phone at 806-742-3000 or by mail to: Texas Tech University, Department of Human Development & Family Studies, PO Box 41162, Lubbock, Texas 79409-1162. If I have questions about my rights as a research participant, I may contact the West Virginia University Institutional Review Board at 304-293-7073 or the Texas Tech University Vice Provost for Research at 806-742-3884, Room 203 Holden Hall, Texas Tech University, Lubbock, Texas 79409-1035.

Confidentiality

I understand that any information about me obtained as a result of my participation in this research will be kept as confidential as legally possible. I will not be identified in any reports made of this study, and all information about me will be coded so that my name will not be on it. All data, including the code number/subject name list, will be kept secure in a locked file cabinet accessible only to the investigator. Tapes from the audio taped interviews will be coded so that no identifying information is on the cassette. They will be kept in a secure locked file cabinet and will only be used to complete the goals of this project. Only code numbers will be used when the tapes are transcribed, no names or personally identifying information will appear on the transcriptions, and tapes will be erased after the transcriptions are made. In any publications that result from this research, neither my name or any information from which I might be identified will be published.

Voluntary Participation

Participation in this study is voluntary. I understand that I am free to withdraw my consent to participate in this study at any time. Refusal to participate or withdrawal will involve no penalty or loss of benefits nor will it affect my current or future relationship with West Virginia University or Texas Tech University. I have been given the opportunity to ask questions about the research, and I have received answers concerning areas I did not understand and by signing this form, willingly give my consent to participate in this study. Upon signing this form, I will receive a copy.

Signature of Participant:_____ Date:_____

Signature of Project Director
or Authorized Representative:_____ Date:_____

Demographic Data for Therapists

Subject Number _____

1. Age _____ 2. Sex _____

2. Family therapist _____ Individual therapist _____

3. Highest Professional Degree

Bachelor's _____ Master's _____ Doctorate _____

4. Professional certifications: i.e., AAMFT Clinical Member, clinical psychology, ACSW, Nurse Clinical Specialist, etc. _____

5. Primary professional identification: i.e., psychology, medicine, social work, nursing, etc.

6. Theoretical identification: (mark all that apply)
strategic _____; structural _____; brief
therapy _____; individual psychodynamic _____;
individual behavioral _____; family behavioral _____;
family psychodynamic _____; MRI/communication _____;
experiential/Whitaker _____; solution-focused _____;
systems/cybernetic _____; other (please
specify) _____.

7. Do you use any of the following techniques in your therapy (check all that apply)? paradox____, reframing____, metaphoric task assignment____, invariant prescription____, prescribed rituals____, positive connotation____, ambiguous task assignment____, directives_____.

8. How often do you use these techniques in your therapy?

Paradox:

Always	Often	Less than once a week	Seldom	Never
5	4	3	2	1

Reframing:

Always	Often	Less than once a week	Seldom	Never
5	4	3	2	1

Metaphoric task assignment:

Always	Often	Less than once a week	Seldom	Never
5	4	3	2	1

Invariant prescription:

Always	Often	Less than once a week	Seldom	Never
5	4	3	2	1

Prescribed rituals:

Always	Often	Less than once a week	Seldom	Never
5	4	3	2	1

Positive connotation:

Always	Often	Less than once a week	Seldom	Never
5	4	3	2	1

Ambiguous task assignment:

Always	Often	Less than once a week	Seldom	Never
5	4	3	2	1

Directives:

Always	Often	Less than once a week	Seldom	Never
5	4	3	2	1

9. If you are a family therapist where did you get your preparation for this? (Check all that apply) family therapy graduate program____ (masters, PhD), other post bachelors graduate program____, workshops____, special training at an institute____, (how long was this program?____), reading books and journals____, other (please specify)_____.

10. If you are an individual therapist, where did you get your preparation for this? post bachelors graduate program____, workshops____, special training at an institute____, (how long was this program?____), reading books and journals____, other (please specify)_____.

11. Are you licensed? Yes____, No____. If yes please describe_____.

12. Professional organization memberships (Please list)_____
_____.

13. Number of years you have been doing therapy?_____.

14. What percentage of your time is spent doing the following types of therapy? individual_____; conjoint_____; family/marital_____; group_____; other (please specify)_____.

15. Number of hours per week you do direct therapy._____

16. Do you supervise others doing therapy? Yes__, No__. If yes, please describe_____

17. Have you ever been involved in a professional ethics committee?

Yes_____, No_____.

18. Have you ever been involved in an educational program on professional ethics? Yes__, No__. If yes, please describe, briefly._____

_____.

Interview Schedule

NOTE: These questions should follow references to judgements about the situation. Have the informant also elaborate on feelings in a manner that assists in understanding how they relate to the choices involved in the situation. Also ask for elaboration on moral language. Have the informant talk about the shoulds and oughts etc, i.e. What makes this something one should do or that you thought you should do? Your goal is to have the informant paint as complete a picture as possible about the decision they made in the situation.

I am trying to understand how therapists make difficult choices in their professional practice. I would like you to tell me about a difficult choice you have had to make, a decision that involved a situation where you weren't sure what to do.

1. What was the situation? (Be sure to get a full elaboration of the situation. Remind informants not to use names or provide other information that could be used to identify the client).
2. What was the conflict for you in that situation? What made it a conflict?
3. In thinking about what to do, what did you consider? What made these important considerations? Was there anything else you considered?
4. What did you decide to do? What happened as a result of this decision?
5. Do you think this was the right thing to do? Why/why not?

6. What was at stake for you in this situation? What was at stake for others? In general what was at stake?
7. How did you feel about the decision? How did you feel about it for the other(s)?
8. Is there another way to see the situation, other than the way you described it?
9. When you think back over the situation, do you think you learned anything from it? What did you learn?
10. Do you consider the situation a moral problem? Why/why not?
11. What does morality mean to you? What makes something a moral problem for you?
12. Do you think that this decision fit the ethical guidelines provided by your professional association (AAMFT or APA)? Describe how it did or did not fit.
13. What made it (difficult or easy) to apply the ethical guidelines from your professional association to this situation?
14. Do you have any recommendations for your professional association about the ethical guidelines they provide for their members?
15. What might you tell a new therapist about the ethical guidelines provided by your professional association and the practice of therapy?

Hypothetical Dilemma Interview Schedule

I'm going to read you a therapy situation, and I'd like to know your answers to some questions about the situation. There aren't any right or wrong answers to the questions I will ask. I just want to know your opinion.

After many sessions a client informs you that they have tested positive for AIDS. When you discuss this with them, they demonstrate an understanding of the disease process and mode of transmission. Although the client has been aware of this condition for several months, they have continued to engage in sexual relationships. The client indicates an unwillingness to discontinue sexual activity or to discuss this information with past and present sexual partners.

What would you do?

Why did you decide to do that?

What was the conflict for you in this situation?

In thinking about what to do, what did you consider?

Was anything else considered?

How did you decide what to do?

What made you decide to do that?

What were your responsibilities or duties in the situation?

Did you make the right decision? Why or Why not?

What was at stake for you in the decision?

What was at stake for others?

How do you feel about it?

Is there another way to see the problem other than the way you described it?

When you think back over the situation, do you think you

learned anything from it?

What did you learn?

Now I will read another situation and I'd like to know your answers to some questions about this story, too.

A family referred themselves to your office to address communication issues. The family consisted of five persons at home; mother, father, two daughters and a son. After several sessions, it was disclosed that sexual abuse had occurred to the oldest daughter by the father. The father had stopped the abuse several months ago, and the family indicated that their primary reason for seeking therapy was to address issues related to the abuse. The family had kept this a secret and confided in you with the request that you not bring others into the situation because they felt the problem was in the process of being resolved. To date this family has worked hard in therapy and all family members, including the father and daughter, seem highly motivated to continue the work in therapy. The father has agreed to a contract with you around the issues of abuse.

What would you do?

Why did you decide to do that?

What was the conflict for you in the situation?

In thinking about what to do, what did you consider?

Anything else you considered?

How did you decide what to do?

What made you decide to do that?

What were your duties or responsibilities in the situation?

What were the duties or responsibilities of others in the situation?

Did you make the right decision?

Why/why not?

What was at stake for you in the decision?

What was at stake for others?

How do you feel about it?

Is there another way to see the problem, other than the way you described it?

When you think back over the situation, did you learn anything from it?

What did you learn?

RATINGS OF THE PROBLEMS CONSIDERED

Please rate each of the problems you considered.

Degree of interpersonal relationship in the problem

Problem about client's sexual activity:

Very High	High	Moderate	Low	Very Low
5	4	3	2	1

Problem about family's concerns:

Very High	High	Moderate	Low	Very Low
5	4	3	2	1

Problem you provided:

Very High	High	Moderate	Low	Very Low
5	4	3	2	1

Your personal involvement

Problem about client's sexual activity:

Very High	High	Moderate	Low	Very Low
5	4	3	2	1

Problem about family's concerns:

Very High	High	Moderate	Low	Very Low
5	4	3	2	1

Problem you provided:

Very High	High	Moderate	Low	Very Low
5	4	3	2	1

Importance of the problem

Problem about client's sexual activity:

Very High	High	Moderate	Low	Very Low
5	4	3	2	1

Problem about family's concerns:

Very High	High	Moderate	Low	Very Low
5	4	3	2	1

Problem you provided:

Very High	High	Moderate	Low	Very Low
5	4	3	2	1

Difficulty of the problem

Problem about client's sexual activity:

Very High	High	Moderate	Low	Very Low
5	4	3	2	1

Problem about family's concerns:

Very High	High	Moderate	Low	Very Low
5	4	3	2	1

Problem you provided:

Very High	High	Moderate	Low	Very Low
5	4	3	2	1

APPENDIX B
GUIDE FOR INTERVIEWERS

GUIDE FOR INTERVIEWERS

Phone Contact to Set Up Interview

1. Have the phone contact form and a pen or pencil.
2. Obtain the individual's name.
3. Verify that the individual is a family therapist or does individual therapy.
4. Verify that the family therapist does strategic therapy or uses the techniques identified on the phone interview form.
5. If the individual does not meet the criteria for the study, explain that they do not fit the criteria for the study and thank them for their interest.
6. If the individual meets the criteria, schedule the interview at a place and time agreeable to both of you.
7. Explain that the interview will take at least an hour of uninterrupted time because of the need to concentrate on the interview questions.
8. Obtain clear directions to the meeting place and obtain a mailing address so the summary can be mailed.
9. The interview will usually be about one hour long, but schedule at least two hours so the interview will not be rushed.

Before the Interview

1. Prepare tape recorder, two extra batteries for the recorder, the proper questionnaire and an extra, 3 hours of tape, labels for the tapes, and two pens or pencils, and directions to the interview location.

2. The questionnaire should be numbered with the informant number. Use consecutive numbers starting with the number 1. Place your interviewer code after the informant number, i.e. 1A would code the first interview for interviewer A.
3. Arrive on time or arrange another time if a problem arises and you cannot keep the appointment.

During the Interview

1. Place the tape recorder as near the informant as possible. Set the recorder on "conference" with the volume on maximum. Be aware of room and outside noise that could interfere with the quality of the tape. Eliminate as much of this noise as possible.
2. Begin the interview schedule. Do not refer to the informant's professional identification in the interview and request that the informant do the same. Also request that the informant not use names of client's in the situation to maintain client confidentiality.
3. Check the tape recorder occasionally to be sure it is running. If you lose part of a response while turning the tape over, ask the informant to repeat the information.
4. Allow the informant all the time he/she needs to consider the response. Silence and patience are often quite effective in drawing out responses. Give the impression that you have all the time in the world.
5. Listen carefully to the responses and show interest in what they think. Phrases which encourage responsiveness should be utilized. These include "Please continue",

"Could you help me to understand a little more about---", "Could you elaborate on----", "Can you give me an example of---", and "What are some other ways you could think about that".

6. Always check to make sure the information in the primary and follow-up questions is addressed. If the informant has addressed the information in the primary question the follow-up questions may not be necessary. If the "why/why not?" choice does not seem appropriate, other probes may be used. Remember to phrase probes neutrally in a manner that does not suggest an answer to the informant. If you follow-up on a particular response, be sure to use the language of the informant. Do not rephrase. You should continue to probe the informant's responses until a reason has been given for the moral choice. Explanations such as "It's just something inside me," or "That's just the way I was raised," or "It seemed like the best thing to do at the time" are not really reasons and should be probed further.
7. If the respondent seems to hesitate, you may reassure him/her that the question is difficult and that there are no right answers, but that you would like to know what they think.
8. Have the informant complete the questionnaire before the interview.
9. Ask the informant whether they would like a summary of the results of the study. If they would, make a note on the piece of paper with their address.

After the Interview

1. Following each interview, immediately label each tape with the informant number.
2. Turn in the informant's name and address, completed questionnaire with informant number, and tapes with informant numbers attached to the primary investigator. The informant's name and address should be on a separate piece of paper so that it may be filed separately to protect confidentiality.
3. After the transcript has been typed, you may be asked to listen to the tape and proof the transcript if there were areas that were difficult to transcribe.

APPENDIX C
RATING MANUAL

RATING MANUAL

To do a rating, you must allow at least two hours time. You should do the ratings in a quiet room where you will not be interrupted. You will need two colored erasable pencils: red and blue. Read and study the entire rating manual before doing any rating. Rating should be done on a copy, not the original transcript. You will be provided with the appropriate copies to do the ratings. You will be provide with sample sections to practice your coding. Your coding on these practice interviews will be compared with others' coding the same material to increase the consistency in coding between coders. This process will be repeated and refined until the coders are rating the sample text in a similar manner consistently.

As you read, consider each coherent distinct thought in the response individually. A distinct thought may be a sentence or a phrase, or occasionally may be more than one sentence. For instance, the sentence "I understand that they have a situation which is very hard on them, but they should still obey the rules," contains two independent thoughts: (1) "I understand that they have a situation which is very hard on them," and (2) "they should obey the rules." However, the sentence "Kids really do love their parents even though they act like they do not," only contains one coherent thought, because the phrase "even though they act like they do not" cannot stand alone and make any sense. A complete thought may at times, be more than one sentence.

Consider whether the distinct thought is moral statement or not. A statement should be considered moral if it considers conflicting values and makes choices among

those values. Each time a distinct thought indicates that the self is thinking about a conflict, making a choice, or giving reasons for a choice, the distinct thought should be considered a moral statement.

Terms which may be clues to moral language include words, such as: desire, consider, choose, evaluate, commit, judge, ask, resist, refuse, try , explore, found, abstain, feel, learn, realize, think, question, decide, want, know, believe, and similar words. It is not necessary to find any of these particular words, nor does the appearance of the words necessarily indicate moral consideration. Instead, the context of the story (i.e., related statements preceding or following, the general tone of the interview, any other evidence that appears to assist in clarifying the intent of the statement of interest) should be considered to help decide whether or not an individual statement is a moral statement. A conscious decision to do nothing should be considered an active choice and therefore underlined.

Do not underline details that seem unrelated to the moral conflict. These would be asides, disconnected thoughts, or stories which are not directly related to the larger conflict or the decision to be made. If the informant describes someone else's perception of or statements about the conflict, the statement should be underlined only if the informant indicates agreement or disagreement with the statement. For instance, the informant's description of his/her colleague's attitude should not be underlined, unless he/she indicates agreement or disagreement.

Once you have identified a moral statement, you will need to decide whether the statement is a care or justice

statement, or whether it is not clear what orientation is being described. Care approaches will be identified by their emphasis on issues or relatedness, mutual dependence, and the obligation to avoid hurt or selfishness. Justice approaches will be identified by their focus on abstract principles, rationality, and the tendency to distance oneself from the individuals involved in a dilemma. The last five page of the manual clarify the care and justice approaches. Please carefully read and study these descriptions before doing any ratings. Be sure that you understand both concepts clearly. If you have any questions please do not hesitate to discuss them with the investigator.

Use a red pencil to underline care considerations. Use blue for justice. Be sure to consider the context for each statement (the statement proceeding and following and any other relevant information) rather than individual words. If a statement is surrounded by another color, think carefully about whether the informant really is changing the point of view before marking a different color. Short statements which give no reason should not be underlined.

Similar words may be used in either care or justice considerations, but the underlying understanding of the dilemma will be different in each approach as described on the last two pages of the manual. You will have to carefully consider all the information available to you and consider all the possible ways of interpreting each individual statement in order to correctly interpret this underlying meaning. Some statements will remain unclear even after careful consideration. These ambiguous statements should not be underlined.

It is not necessary to memorize the instructions. Refer to this manual as often as you need to as you make the ratings.

In summary, the procedure is to first read the whole interview for a general understanding. On the second reading, first identify each distinct coherent thought in the response. Then decide whether the coherent statement is a moral statement or not, using the guidelines from the manual. If it is not a moral statement, do not underline it. If it appears to be a moral statement, decide whether it is a clear care statement, a clear justice statement, or ambiguous. If it is ambiguous, do not underline it. If it is clearly an example of one approach, underline the care statements in red and the justice statements in blue.

CARE

Concerned with the complexities of attachment within relationships, attempts to find a balance to meet everyone's needs

Vulnerability is connected with abandonment

Tolerance of exceptions to the rules

Greater use of innovation

Inattention to details of rules

Trusts feelings, logic or reasoning may be used to identify individual needs or consequences for individuals

Strives to meet needs and to be inclusive

JUSTICE

Concerned with issues of fairness, individual rights, and adherence to standards or principles, principles may be in conflict

Vulnerability is connected with oppression & injustice

Tolerance of individual harm when necessary to allow adherence to principle

Greater regard for precedent

Elaboration of rules

Trusts logic, reasoning and logic focus on rules and principles, what is right or wrong

Strives for equity and consistency

Interested in personal details about the individuals in a particular situation

Metaphor is network or web, connection

Organizing dimension is attachment/detachment

Greatest evil is hurt

Moral question is "How to respond?"

Self perceives and responds, reliance on personal experience

Effort to teach understanding, argument should be avoided if possible, understanding is more important than agreement

Listening is important tool

Detached or impartial in decision making, personal details seen as irrelevant

Metaphor is hierarchy or balance, separation or individuality

Organizing dimension is inequality/equality of treatment

Greatest evil is injustice

Moral question is "What is just?"

Self judges, setting an example is a concern

Effort to reach agreement, through argument if necessary, or by appeal to authority

Respect is important tool

Detachment is seen as a problem, not a virtue

Responsive

Decisions tentative

Assumes a basis for agreement and understanding which is unlearned and without structure

Happiness or emotional satisfaction are the goals

Considers special needs of the individual

Relationships: Involve networks of relationships caring, responsiveness to needs

Responsibilities: Stem from relationships to others, vary according to the situation and person, awareness of need

Care us seen as a mercy, a decision to modulate strict demands of justice

Active

Decisions final

Assumes an external structure will be needed to reach agreement (e.g. logic, law, religious beliefs). Rules must be taught.

Independence and autonomy are the goals

Treat all persons the same regardless of special needs

Relationships: Involve hierarchies or authority, balance, tit for tat, role models

Responsibilities: Stem from rules of conduct, agreements, or form position, are invariant among situations and

persons, rules may need elaboration or exception for specific situations

Fairness: Arises when each person's needs are meant

Fairness: Arises when each person is treated equally or according to rules or agreements

Rights: Derive from relationships, considers the context

Rights: Derive from rules and the obligation to treat persons equally

Trust: Being sure the person will react in a loving and caring manner

Trust: Being sure the person will react in a fair and just manner, or will follow rules agreed upon

Decisions: Made by becoming involved with the feelings and needs of those involved

Decisions: Made by distancing oneself from personal involvement, using logic

Selfishness: Is a concern for the interpersonal harm it will cause to persons

Selfishness: Is a judged wrong, a cause of injustice

Wrong: Hurt, insensitivity, carelessness

Wrong: Violation of principles or rules

Guilt: Stems from causing

Guilt: Stems from violation

hurt or damaging the
relationship

Keywords: Hurt, sacrifice,
caring, relationship,
selfishness, isolation,
interdependence, need,
response, acceptance

of rules or principles

Keywords: Justice,
rationality, rights,
principles, independence,
obedience, autonomy,
fairness

Care Statement Examples

1. Considering how one person's attitude will affect others.
2. Talking about what a person needs is nearly always care.
3. The need to "walk in someone's shoes" or to understand is care.
4. Concerns about the effect of certain actions on the whole family are care.
5. Considering the special circumstances relevant to a person's age, experience, knowledge is care.
6. Trying to make a choice for the individual as the individual would want the choice made is care.
7. Wanting to know more details or gather more information before making a decision is care.
8. Concern about resolving conflicts in a manner that restores relationships or connections between people is care.
9. Concern that good will come to others or that hurt/suffering will be stopped is care.
10. Considering the interdependence of people in relationships or considering relationships as webs is care.

Justice Statement Examples

1. A concern with reputation or good name.
2. If a statement is supported because "That's the way I was raised." or a concern with teaching the person right from wrong.
3. Avoiding second thoughts, sticking to a course of action or decision regardless of consequences. Standing up for what one believes in.
4. Talking about something that would be "just as bad" as something else.
5. An attempt to "make it up," in other words to balance the scale or compensate.
6. "It's the Lord's will" and similar statements are justice.
7. Wanting to be an honest, upright, law abiding person.
8. Wanting to treat everyone equally.
9. Concerns about obligation and duty related to equality and fairness in relationships are justice.

Differentiating Care and Justice

1. Statements that talk about feelings of support, not being in it alone, knowing that others understand are care. If they just acknowledge that others have had the same experience while focusing on fairness issues, that is justice.
2. A focus on consequences for the individual, such as a jail term if they steal and how that will affect the relationships, is care. If the jail term is considered deserved punishment for wrongdoing, that is justice.
3. When considering the best thing for the individual, if the concern is the individual's emotional well-being or individual needs and wishes or how others will react to the individual that's care. If the concern stems from the therapist's position as the responsible person making judgements without reference to the individuals reaction, that's justice. This type of concern will often be unclear unless the additional elements indicating either care or justice are present.
4. If considering the individual's trust or confidence in the therapist, concern with the individual's emotional state is care, concern with maintaining the individual's obedience or respect is justice. This may also often be unclear.
5. Concern with consistency is care if the reason for the concern is to avoid confusing the individual or a concern about the individual's reaction. A concern with consistency, sticking with a decision not changing or doubting a decision reflects justice reasoning if these other concerns are not present.

6. When considering interactions between the therapist and client, the concern is justice if the person is considering the therapist as role model or teacher. The concern is care only if the concern is for how the client will feel or react.
7. Wanting the client or other professional to listen in order to obey or follow rules is a justice concern. Wanting them to listen in order to understand is a care concern.
8. A concern with weighing options is justice. However, this must be differentiated from considering the consequences for individuals which is a care concern.
9. A concern with balancing various needs is a justice concern if the emphasis is on balance or fairness, care if the emphasis is on considering individual needs.
10. "Black and white" is justice. "Shades of gray" is care.
11. Loyalty is usually care unless the loyalty stems from a sense of duty, respect for the person, or the person's position.

ETHICAL DECISION-MAKING AMONG FAMILY THERAPISTS
AND INDIVIDUAL THERAPISTS

by

SUSAN ANNE MURDOCH NEWFIELD, B.S.N., M.S.N.

A DISSERTATION

IN

MARRIAGE AND FAMILY THERAPY

Submitted to the Graduate Faculty
of Texas Tech University in
Partial Fulfillment of
the Requirements for
the Degree of

DOCTOR OF PHILOSOPHY

Approved

May, 1996

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This dissertation is dedicated to my father, Sam C. Murdoch, who gave me my first understandings of the ethic of care and my mother, Mary Anne Dickson Murdoch, who gave me an appreciation of aesthetics.

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APPENDICES

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ABSTRACT

Ethical decision-making is an important part of the daily practice of therapists. In recent years, several authors have made a strong assertion for addressing the ethics of family therapy models based on systems theory and cybernetics. The concerns expressed focus on the lack of consideration for the rights of the individual in a theoretical paradigm that focuses on systems. It is recognized in these concerns that existing ethical models utilized by professional organizations focus on individual rights, a perspective associated with Cartesian dualism and traditional psychology that focuses on the individual.

This study investigated the ethical decision-making of 30 individual and 30 family therapists to detect the types of decision-making currently being used by practicing therapists. Informants responded to three ethical dilemmas. Two of the situations were hypothetical and provided by the investigator. One of these dilemmas involved an HIV positive client who continued to have sexual relationships and the other was a family situation involving sexual abuse of the daughter. The third dilemma was a situation the informant had experienced in their own practice. Each of these interviews was assessed for decision-making style using content analysis. Kohlberg's justice reasoning that emphasizes the morality of rights and with treating all persons equally, and Gilligan's care reasoning, emphasizing relationships and the particular needs of others in specific relationship contexts, provide the conceptual foundations for this analysis.

The results of this study suggest that both family and individual therapists prefer care reasoning on all dilemma

types. The highest care scores were on the dilemma from the therapist's own practice. The second highest care scores were found on the family dilemma followed by the individual dilemma. Characteristics of informants or dilemmas did not provide clear explanations of the differences in reasoning found. This study suggests that therapists, whatever their theoretical orientation, are concerned with issues related to an ethic of care when making ethical decisions in practice. Suggestions for further research are given.

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CHAPTER I

INTRODUCTION

Statement of the Problem

In recent years, several authors have made a strong assertion for addressing the ethics of family therapy models based on systems theory and cybernetics (Green & Hansen, 1986; O'Shea & Jessee, 1982; Solovey & Duncan, 1992 Taggart, 1983; Wendorf & Wendorf, 1985). The concerns expressed by these authors focus on the lack of consideration for the rights of the individual in a theoretical paradigm that focuses on systems. It is recognized in these concerns that existing ethical models utilized by the professional organizations focus on individual rights, a perspective associated with Cartesian dualism and traditional psychology that focuses on the individual (Becvar & Becvar, 1988). Within this therapeutic context, the present study addressed the decision making process therapists utilize to resolve these dilemmas posed by the incongruence between practice theory based in cybernetics and traditional individually oriented values based in Cartesian dualism. A structured interview technique was utilized to elicit the ethical decision making currently being used by practicing family therapists and therapists who practice traditional individual therapies.

Family therapy is a way of viewing the world or punctuating experience. Within this world view are assumptions about families, individuals and the environment that distinguish it from the world view of traditional, individually oriented therapy. The therapist is concerned not about the individual and individual problems, but with relationships within the family system. The search for

understanding comes from the question of what is happening in this system of interactions and considers meaning within the context of interactions (Becvar & Becvar, 1988; Commission on Accreditation for Marriage and Family Therapy Education [COAMFTE], 1988).

When ethical decisions that have evolved out of a systems/cybernetics theoretical model are evaluated from the traditional epistemology of Cartesian dualism, they may appear to be lacking respect for the rights of the individual family members. It is in the arena of ethics that the family therapist most directly confronts the difference in expectations between the ethics and expectations established from the perspective of traditional individual therapy based in Cartesian dualism and therapeutic action developed from the perspective of cybernetics. The process of resolving this theoretical conflict places the therapist in the bind of following the traditional legal/moral definition of action and violating accepted family therapy practice or of ignoring the traditional legal/moral definitions and practicing congruent with family therapy's theoretical base.

One primary source for assisting practitioners with ethical decision making is the professional association's code of ethics. The American Association for Marriage and Family Therapy (AAMFT) is the largest professional organization for family therapists. Therefore, it would be appropriate for family therapists to utilize the 1991 AAMFT Code of Ethical Principles for Marriage and Family Therapists (AAMFT) for making ethical decisions related to family therapy. When this code is reviewed however, it becomes evident that it does not address the ethical dilemmas presented by a systems/cybernetic orientation to

therapy. The AAMFT Code of Ethical Principles provides the therapist with traditional legal/moral definitions to guide practice that evolve from a focus on individual rights.

T.C. Schneirla (Tobach, 1970) and Ludwig von Bertalanffy (1952, 1967) anticipated the problem of applying the ethics of individual therapy to work with larger systems in family therapy. Schneirla discussed levels of organization in which each level of organization is subsumed in each higher level of organization, and with this inclusion, it is modified. Due to these changes, each level produces its own laws and principles, and information. One level could not be used to predict at the next higher level because this new level contains different processes (Tobach, 1970). Von Bertalanffy (1952, 1967) also asserted that new laws appear at each level of organization and that social entities have rules of behavior that differ from individual mores. He clearly stated that traditional ethical codes that provide rules for individual behavior, would be immoral from the standpoint of responsible systems focused behavior.

Ethical decision making or moral reasoning is the method one uses to resolve conflicting values (Argyris et al., 1987; Runes, 1983). The concerns expressed by family therapists involve the resolution of the conflicting values of professional codes of ethics based on individual rights and practice models that utilize families and relationships as a focus for intervention strategies. The theoretical base for this study came from the work on moral reasoning done by Kohlberg (1981) and Gilligan (1977, 1982).

Lawrence Kohlberg (1969, 1981, 1984) was one of the first researchers to describe the process of moral reasoning. He developed what is now referred to as the justice model of moral reasoning. Moral reasoning guided by

justice focuses on the application of general principles to specific situations. Within the justice model, moral decision making is concerned with the morality of rights and treating all persons equally (Broughton, 1983; Reed, 1987). The justice perspective highlights issues of fairness, right and obligation (Flanagan & Jackson, 1987).

Carol Gilligan questioned Kohlberg's model and developed an alternate perspective to moral judgment that evolved from her concerns about the treatment of women in Kohlberg's model. Gilligan's theory focuses on what has been termed the care response. Moral requirements are viewed as arising from the particular needs of others in specific relationship contexts (Flanagan & Jackson, 1987; Gilligan, 1982). The ethic of care focuses on the relationships of the involved parties and the particulars of the situation, including the special needs of those involved (Flanagan & Jackson, 1987). When using the care perspective, one would consider the actual consequences of a decision for the involved parties, how the decision would affect the relationship, the context and specific individuals involved, the need to avoid hurt, and issues of altruism (Friedman, Robinson, & Friedman, 1987).

Many authors have criticized the traditional justice model focus of health care ethics. The perspective evolving from the justice model is guided by the assumption that decisions evolve from the ordering of ethical principles that strive to treat all individuals equally despite the context (Fry, 1989). Writings of Hare-Mustin (Hare-Mustin, 1980; Hare-Mustin, Marecek, Kaplan, & Liss-Levinson, 1979; Hines & Hare-Mustin, 1978) demonstrate the bias for justice ethics in traditional health care ethics when she questions the risks for the individual in family therapy and supports

the need to endorse independence and self-determination away from the family. These articles written by Hare-Mustin and her colleagues clearly indicate that a perspective that does not value individual rights over the rights of the whole can be seen as lacking an ethical perspective. Hare-Mustin's strong focus on individual rights would support the conclusion that her criticisms of family therapy evolve from a justice model of ethical decision making.

If, as Von Bertalanffy (1967) states, the application of traditional ethical codes to social systems "is like operating an atomic reactor with the technology of a Bushman" (p. 50), what are the alternatives? When the assumptions of family therapy, based in systems theory/cybernetics, are defined as concerns for the relationships between individuals and social systems, the moral decision making model of care seems most congruent. The care perspective views responsibilities as evolving out of relationships with others, and the concern for individual rights seen in the justice model of moral decision making is replaced by concerns for responsibility toward interdependent relationships (Gilligan, 1982). The key terms in the care model are connectedness, relationship, responsibility, interdependence, preventing harm, sacrifice, caring, and context (Lyons, 1983). These key words echo the ethical guidelines set forth by Segal (1986), von Foerster (1986a) and Bateson (1972) for systems/cybernetics paradigms. Each of these authors speaks of the responsibility of the individual to the system in a context where the welfare of the individual depends on the welfare of the system. It would appear that the utilization of the care model for ethical decision making in family therapy would provide theoretical consistency between family therapy

theory and ethical decisions. This study used interviews with family therapists and individual therapists to determine the ethical decision making perspectives that are being used by practicing therapists. The information obtained can be used to inform the development of professional codes of ethics and continuing education programs.

Definitions

For the purposes of this study, ethics was defined as the philosophical study of morality (Noddings, 1984). This included the study of judgments of approval and disapproval, rightness and wrongness, goodness or badness, virtue or vice, and most importantly for this study, the desirability or wisdom of actions, dispositions, ends objects, or states of affairs (Frankena, 1983). Within this definition, ethics is often used in three different ways that represent different issues for understanding the information presented. The three uses are: "(1) a general pattern or 'way of life,' (2) a set of rules of conduct or 'moral code,' and (3) inquiry about ways of life and rules of conduct" (Edwards, 1972, pp. 81-82). As the term ethics is used by the American Association for Marriage and Family Therapy, it refers to a set of rules of conduct or a moral code; however, since the purpose of this study was to understand the ethical processes currently being utilized by marriage and family therapists, the third understanding of the term was used in an effort to discover how family therapists and psychologists make ethical decisions.

Cartesian dualism refers to the philosophy of Descartes that establishes a separation between mind and matter. This split results in a conceptualization of humans as separate

from the environment and a world view that establishes an individual/family distinction and separates the individual from the family (Bateson, 1972; Keeney, personal communication, 1987). These phenomena are conceptualized as decontextualizing the individual from the family and the family from the larger social systems of which they are a part (Keeney, personal communication, 1987).

Systems theory refers to the body of knowledge that defines the structural rules that are valid for all systems (Simon, Stierlin, & Wynne, 1985). Discovery and description of these rules can be seen in the works of T. C. Schneirla and von Bertalanffy. Schneirla (Tobach, 1970) described levels of organization and von Bertalanffy (1952) supported this theme with his description of quantitative changes from one level of organization to another that result in qualitative differences. The general systems rule becomes an understanding that the system is a whole which contains differing levels of organization. Each level of organization then has its own rules because of the quantitative changes that occur from one level of organization to another.

A system is understood to be an ordering of elements into a unified whole (Simon et al., 1985). As general systems theory (GST) is applied to family therapy, unique understandings about the individual and the family emerge. This specialized application of GST at the level of the family is referred to as family systems theory (FST). The individual and family are seen as co-evolving with their context. This becomes the complementary interacting patterns of individual-in-context/family-in-context or individuals and families are seen as part of their interactional

ecosystem (Keeney, personal communication, 1987; Segal, 1986; von Foerster, 1984; von Galsersfeld, 1984).

As defined by Wiener (1974), cybernetics is the study of communication and control. Beer (1974) refines and updates this definition and refers to cybernetics as "the science of effective organization" (p. 2). Cybernetics of cybernetics or second-order cybernetics (von Forester, 1974) is the more appropriate conceptual framework for the social sciences because it provides the complexity to address cognition, dialogue, and social-cultural interactions (Keeney, 1983). Von Foerster (1974) defines cybernetics of cybernetics as the cybernetics of observing systems, which when transferred to family therapy becomes a way of understanding the observer's role in the system. The observer becomes part of the observed system (Keeney, 1983).

A family therapist assists a family system in evolving alternative ways to maintain itself that allow correction of problematic patterns (Keeney, 1983). For the purposes of this study, family therapists were defined as people who describe themselves as utilizing a theoretical perspective that is consistent with family systems theory and cybernetics and involved in doing therapy an average of 10 hours a week. Since the therapeutic techniques most often seen as unethical by critics of family therapy, including paradox, the "benevolent lie," reframes, and other interventions that Lindley (1987) refers to as manipulation, are most often associated with strategic therapy (DiNicola, 1988; Doherty, 1985; Hare-Mustin, 1980; Hines & Hare-Mustin, 1978; Lindley, 1987; Solovey & Duncan, 1992; Wendorf & Wendorf, 1985), the definition of family therapists included only those persons with the theoretical perspective of family systems theory/cybernetics who also identified

themselves as using the techniques of paradox, reframing, metaphoric task assignment, invariant prescription, prescribed rituals, and/or directives.

Individual therapists referred to persons who were currently involved in clinical practice an average of 10 hours a week and were not using the techniques related to strategic family therapy. The individual therapists utilized theoretical orientations that focused on individuals and did not include concepts related to systems or cybernetic theories.

Emergence of the Problem

Recognizing that family therapy did present a unique way of viewing problems, several authors attempted to address ethical issues related to family therapy. The initial writings of family therapists about ethics dealt with the practical concerns that arose when they saw more than one person in therapy at a time. These early authors discussed the types of topics that should be discussed when multiple family members were in the room, the therapist's role in keeping family secrets, and concurrent family and individual therapy for family members (Wendorf & Wendorf, 1985). Ethical issues that were specific to particular ways of doing therapy were also addressed. This included discussions of the use of paradox, the "benevolent lie," which are techniques that are primarily associated with strategic therapy, and not forcing insight (Wendorf & Wendorf, 1985). These interventions were called into criticism because it was felt that they did not respect the individual. The concerns expressed focused on what was felt to be 'manipulation' without the direct consent of the client (Lindley, 1987). These authors did not, however, consider

the differences between the theoretical assumptions of family therapy based in cybernetics/systems theory and the traditional ethical paradigms concerned with the welfare of individuals with which they were evaluating family therapy interventions (Taggart, 1983). The difficulty that arises from this oversight could be likened to using the qualities of a perfect apple to evaluate the qualities of an orange.

In an attempt to resolve the issues of the epistemological inconsistency between family therapy theory and traditional values, Taggart (1983), O'Shea and Jessee (1982), and Wendorf and Wendorf (1985) presented ethical guidelines that were more consistent with systems/cybernetic epistemology. These authors perceived the primary inconsistency in family therapy theory and the ethical systems utilized to evaluate family therapy as epistemological incongruence. Traditional Western epistemology, which forms the basis of the ethical system, focuses on the individual separate from other humans and the context in which they live (Taggart, 1982). The epistemology of family therapy focuses on the connectedness and relationships between individuals and between individuals and other systems.

O'Shea and Jessee (1982) offer a discussion of the various practical problems related to the values of therapy guided by systems/cybernetic thinking that evolve from the interaction between the two differing epistemological perspectives. At the conclusion of their discussion, they determine that the conflicts will continue to plague the systems therapist and call for more discussion and consideration of these issues by systems therapists. The authors identify ethical problems that evolve from the

differing world views but offer little direction for systems therapists in resolving this ethical confusion.

Taggart (1983) discusses the theoretical implications of systemic ethics and strongly asserts the need to align ethics with practice since these ethics do affect the therapist's action. Taggart (1983) further asserts that if the conflict of ethics is not addressed, a continued alienation between the therapy system and the ethics that guide action will exist. This split will continue the pattern that is similar to the traditional Western epistemological pattern where ethics are seen as originating outside the system under consideration. Evolutionary ethics is presented by Taggart (1983) as an ethical system that would be consistent with systems/cybernetics epistemology. Although Taggart (1983) presents a section on pragmatics of systemic values, his analysis is of one case and does not provide the reader with the information needed to begin their own process of analysis. The concept of evolutionary ethics is never clearly defined beyond more than a few vague examples.

Wendorf and Wendorf (1985) present a discussion of ethics and systems/cybernetic thinking. In this discussion, they provide the reader with specific applications of their ethical guidelines as they relate to a therapy context defined by the problem presented by the family. Wendorf and Wendorf (1985) present this as their personal ethical perspective and do not attempt to relate this perspective to the broader context of all family therapy.

More recently Becvar and Becvar (1988) addressed ethics from a systems/cybernetic perspective and presented the dilemmas faced by a systems/cybernetic approach to therapy. This discussion of ethical dilemmas was presented in a

manner that serves more to stimulate thought on the issues than to provide the therapist/student with information that would assist in the process of making ethical decisions that are consistent with the systems/cybernetic world view.

Krull (1989), in an effort to assist therapists with ethical decision making, presents her ethics of tolerance that she evolves from the concepts of recursion as the ethical paradigm that is most consistent with systems/cybernetics theory. The model for ethical decision making presented by Krull (1989) parallels the morality of response and care of Gilligan (Gilligan, 1982; Lyons, 1983). Both authors present ethics as contextual in that the relevance of the ethical decision is based on the context of the decision and/or relationship and is related to issues such as care and tolerance.

The problems with the differences between practice theory and the current ethics being utilized for evaluating these practices for therapists are validated by recent research. Green and Hansen (1986), Ratliff (1988) and Brock and Coufal (1989) found, in their independent surveys of family therapists, that these practitioners are struggling with the ethical issues that are unique to working from a systems/cybernetic perspective. The conclusions of these studies suggested more information on ethical decision making related to working from a systems/cybernetic perspective was needed. Even more recently, Wylie (1989) discussed the ambiguities of ethics in family therapy and concludes that current ethical formulas do not begin to address the complex ethical dilemmas confronting practitioners.

In the review of research on the ethical decision making of family therapists, it is evident that efforts have

not been made to assess the process of moral reasoning or ethical decision making used. Current research in this area has focused on the therapists' application of the moral principles defined within the context of traditional Western ethics (Brock & Coufal, 1989; Green & Hansen, 1986; Ratliff, 1988). Lawrence Kohlberg (1969, 1981, 1984) and Carol Gilligan (1977, 1982) offer two perspectives with which to evaluate the process of moral reasoning.

Kohlberg (1969, 1981, 1984) describes principles utilized to organize moral problem solving as primarily based in justice reasoning. Justice reasoning is based on the application of general principles to specific situations. As implied by the title, justice reasoning is concerned with treating all persons equally. This goal is achieved by objectively assessing the values with the recognition that there are fundamental human rights that must be upheld in all situations.

Gilligan (1977, 1982) presents an alternative set of principles for moral judgments that she has termed the care approach. Care reasoning bases decision making on meeting each person's needs while avoiding hurt. These principles focus on the context and relationships involved in the situation.

In addition to the theoretical problems that evolve from applying ethics developed for an individual model of therapy to a family systems perspective, a portion of the problems identified with current ethical paradigms and ethical decision making in family therapy may be the result of the research designs utilized. To date all of the research in family therapy ethics (Brock & Coufal, 1989; Green & Hansen, 1986, 1989; Morrison, Layton, & Newman, 1982) has utilized the presentation of hypothetical dilemmas

to elicit the ethical decision making processes of therapists. Kerber (1986) suggested that the impersonal character of the hypothetical dilemmas presented to subjects by researchers might elicit a justice response. These responses tend to be detached, logical and impartial or more objective in their nature because the decision maker is distanced from the details of the problem (Gilligan, 1982). Gilligan (1982) suggested that research designs utilizing a personal dilemma would more frequently elicit a care response. The writings of Kerber (1986) and Gilligan (1982) would suggest that family therapists may be using a moral decision making process in their daily practice that is not reflected in their responses to the hypothetical dilemmas that are currently being used in family therapy research on ethical decision making.

Many authors have attempted to develop models of ethical decision making. Despite the development of these models, family therapists continue to suggest that current ethical guidelines do not begin to address the complex ethical dilemmas they confront in their practices. This study provides the basis for the development of ethical decision making guidelines for family therapists by determining the methods currently being used by these therapists to make decisions when working with family systems and comparing their decision making processes with those of individually oriented therapists.

Future Outlook

Madanes (1989) takes a very strong stand on the need for an increased awareness of values in the practice of family therapy. She believes that the direction of the next decade in family therapy will be determined by this renewed

emphasis on values. This renewal is necessitated by the diversity in theoretical perspectives in the practice of family therapy and the complexity of problems currently being addressed by family therapists (Madanes, 1989). If the profession does not develop values that provide a clear direction, Madanes (1989) feels we are at risk for violating what she believes is the first consideration of the therapist, which is to do no harm.

Finally, there is an ethical crisis within the profession of family therapy. As discussed earlier, several researchers (Brock & Coufal, 1989; Hansen, 1986; Ratliff, 1988) have found that family therapists do not find current ethical guidelines offered by AAMFT useful in resolving the myriad of ethical issues they confront in their practice. Without the development of a clear ethical direction or the discovery and definition of the ethical decision making processes family therapists are using, these therapists will increasingly rely on their personal ethical systems and remain vulnerable to the criticism that family therapy lacks guidelines for ethical behavior.

Purpose of the Study

Review of the current writing in family therapy ethics demonstrates three trends. The first direction is research on therapists' application of the current ethical guidelines provided by AAMFT and finding that therapists are having difficulty defining the ethics of their practice with these guidelines. Presentation of alternate ethical paradigms is the second major emphasis in the literature. These paradigms do provide some direction for coordinating ethical theory and practice theory, but do not address the pragmatics of the complex ethical dilemmas of practice. The third area of

discussion represents a debate about the ethical guidelines provided by AAMFT. The primary focus of this discussion is related to dual relationships and the possibility of eliminating them from "real world" situations with students, colleagues, and clients.

Assumptions

Work of Kohlberg (1981) and Piaget (1965) supports the perspective that the person's assumptions function as a filter for viewing ethical issues and therefore affect not only the decision made, but what becomes a dilemma. The basic assumption of this study was that the theoretical perspectives of practicing therapists are important in that these therapists' views of the world guide their actions. This assumption was reflected in the research design by eliciting real-life ethical dilemmas of moral conflict and choice from the lives of the informants.

It was assumed that the responses obtained from the sample of family therapists utilized in this study typified those family therapists who use the identified techniques. Data was obtained from family therapists in a national sample. Therapists included in this sample were from West Virginia, Georgia, Florida, Maryland, Pennsylvania, Iowa, Illinois, Texas, Mississippi, Nevada, and Michigan.

The study utilized a structured interview technique to elicit real-life narratives of moral conflict and choice from the informants. It was assumed that this approach provided opportunities for the informants to share personal approaches to moral reasoning without restrictions or concern with formal theoretical constraints and, therefore, provided data that was more consistent with the informant's perceptions of ethical dilemmas and their usual decision

making process (Argyis et al., 1987; Gilligan, 1982). When informants are allowed to present real-life moral dilemmas, it was assumed that the moral decision making process was more consistent with their usual manner of making decisions in their practice than was indicated in previous research. Gilligan (1982) has argued that the more personal the dilemma, the more responses are concerned with an understanding of relationships and responses in relationships. This is in contrast to the concern with the detached applications of the rules and the fair treatment of each person seen in responses elicited when hypothetical dilemmas are presented to informants (Lyons, 1983). Clopton and Sorell (1993) found that for parents, personal relevance of the dilemma was significantly correlated with care scores in moral decision making situations related to parenting. There was no significant relationship found between gender and care scores (Clopton & Sorell, 1993). Their data supports the argument of Hare-Mustin and Marecek (1988) and Mednick (1989) that gender differences in moral reasoning may be the result of the type of moral problem rather than stable gender attributes.

Previous work on moral choice suggested that there would be differences in the decision making of family and individual therapists. Family therapists would demonstrate a preference for care reasoning and individual therapists would demonstrate a preference for justice reasoning. This difference in reasoning would evolve from the theoretical differences in the theoretical models used for guiding therapy practice.

CHAPTER II

LITERATURE REVIEW

Review of the literature on family therapy ethics reveals an interesting split. While the leaders in family therapy argue that family therapy is developed from a theoretical framework that is distinct from individual psychotherapy, the discussions and research of family therapy ethics are founded on a tradition of individual ethics based on justice for individuals (Green & Hansen, 1986; O'Shea & Jessee, 1982; Solovey & Duncan, 1992; Taggart, 1982; Wendorf & Wendorf, 1985). This chapter presents a review of the family therapy and individual therapy ethics literature to provide the reader with perspective on the evolution of family therapy ethics in the context of health care ethics. A review of the ethical decision making literature will be presented to provide a foundation for the research methods utilized to assess the ethical decision making of family and individual therapists.

First, a review of the family therapy literature on ethics is presented to provide the reader with a perspective on the ethical criticisms of family therapy. An examination of the ethical decision making of psychologists, who are individual therapists, will also be provided to facilitate an understanding of the issues related to ethical decision making in the general literature on therapy. This will contribute to an understanding of the context from which family therapy ethics was developed and is critiqued by other therapists. The need for congruence between practice theory and ethical paradigms is presented and the deficits in current family therapy ethical paradigms are explored.

Second, a review of research methods for assessing ethical decision making is presented. This provides the theoretical framework for the assessment of the ethical decision making styles currently being utilized by family therapists. Exploration of the ethical decision making of family therapists and individual therapists is presented as an initial step in resolving the conflicts between family therapy practice theory and ethical paradigms utilized to evaluate and inform these theories.

Family Therapy Ethics

Historical Perspective

When the founders of family therapy began working with individuals-in-context, they were violating the basic belief and values of psychotherapy (Becvar & Becvar, 1988; O'Shea & Jessee, 1982; Wendorf & Wendorf, 1985). Becvar and Becvar (1988) provide an analysis of the differences in world view between the theoretical frame work of family therapy and that of individual psychology. The Becvars find the differences in world view so strong that they refer to the views of family therapy as countercultural (Becvar & Becvar, 1988) because they are so inconsistent with not only the views of traditional individual therapy, but also the world view of the American society. The traditional individual psychology world view values linear cause/effect, subject/object dualism, individualism, reductionism, value-free science and laws with a lawlike external reality (Becvar & Becvar, 1988). Within this framework the primary dualism is the individual versus the family (individual/family), stripped of context (Keeney, personal communication, 1987). This difference in world views has naturally resulted in a concurrent questioning of the values

and ethics of family therapy (Goldberg, 1993; Hare-Mustin, 1980; Hare-Mustin, Marecek, Kaplan & Less-Levinson, 1979; Hines & Hare-Mustin, 1978; O'Shea & Jessee, 1982; Taggart, 1982).

The criticisms of family therapy ethics began with concerns about the rights of individuals within the context of family therapy (Hare-Mustin, 1980; Hare-Mustin et al., 1979; Hines & Hare-Mustin, 1978). Hare-Mustin (1980) and her colleagues were concerned about the fate of the individual within a family therapy context that professed to promote and maximize the growth of "the family." Would individual confidentiality and individual growth be sacrificed for the needs of "the family?" Clearly, these concerns reflect the world view of traditional individual psychology where individualism and reductionism are valued.

Hines and Hare-Mustin (1978) initiated the discussion of the differences in ethical decision making that occur when the therapist is working with a family, as opposed to an individual. The issues explored in this article included meeting the growth needs of the entire family, as opposed to individuals' needs, requiring that the entire family be treated, confidentiality, and the impact of the therapist's values on the therapy. Hines and Hare-Mustin (1978) expressed concern that individuals were at risk of having their rights violated in family therapy. Hare-Mustin (1980) continued this challenge to family therapy in an article titled: "Family Therapy May Be Dangerous for Your Health." As the title clearly suggests, the author was again expressing concern for the rights of individuals in family therapy.

Concern for the rights of women in family therapy was expressed by Hare-Mustin (1978) when she advocated for a

feminist family therapy approach to resolve socialization practices that reinforce traditional sex roles of man the doer and woman the nurturer in the context of family therapy. The obstacles that promote the decrease in respect for the rights of women in family therapy were seen as (a) the existence of socially reinforced sex roles in the family; (b) the experience of the therapist in their family of origin and educational processes that make it difficult to perceive alternatives to the stereotyped sex roles; (c) the family's perception of the problem that is rarely defined as a problem with traditional sex roles (Hare-Mustin, 1978). Hare-Mustin (1978, 1980) and Hare-Mustin, Marecek, Kaplan and Less-Levinson (1979) viewed family therapy ethics as a subset of health care ethics based on the concern for individual rights and justice and advocated strongly for the protection of these individual rights.

Becvar, Becvar, and Bender (1982) provided further cautionary notes for the family therapist that evolved from similar concerns about the hazards of utilizing a theoretical framework that is inclusive of relationships and moves away from concern for individuals. These authors were most concerned about the risk of over-pathologizing society or using systems theories that define dysfunction in relationships in the broadest terms to include almost everyone. The primary theme was to go with caution and recognize the limits of family therapy theories and to "Let us first do no harm" (Becvar, Becvar, & Bender, 1982, p. 385).

Margolin (1982) continued the individual rights focused critique of family therapy ethics initiated by the previous authors (Hines & Hare-Mustin, 1978; Hare-Mustin, 1980; Becvar, Becvar, & Bender, 1982). She encouraged the

therapist to promote the welfare of each family member and to guard against improvement of one family member at the expense of another. Although she recognized that the focus of family therapy is the relationship between family members, she asserted that it was the therapist's responsibility to advocate for individual family members who could not accurately represent themselves. So again the importance of the individual's rights are asserted without recognizing the incongruence between the ethical principles being applied and the theoretical paradigm of family therapy.

Current Development of Systems Ethics

These initial, now classic, articles stimulated a great deal of discussion about the ethical principles of family therapy that evolved initially into a response by Wendorf and Wendorf (1985) and an edited volume on the values, ethics and legalities of family therapy (L'Abate, 1982). Two relevant articles in L'Abate (1982) addressed the values clash between family therapy and traditional individually oriented perspectives. O'Shea and Jessee (1982) initiated the discussion in L'Abate (1982) by presenting a review of the problems encountered when the family systems approach interacts with an American cultural ideology that emphasizes self-sufficiency, individual accountability and individual rights over group preferences. They discussed how ethical issues, therapist, family, and societal values, and professional codes of conduct merge in practice to present the therapist with a variety of problems. O'Shea and Jessee (1982) did not provide the therapist with guidelines or

information with which to negotiate this mine field except to advise that the profession continues discussion of the issues.

Taggart (1982), in the second chapter of L'Abate (1982), strongly argued the need to bring values under the same systems epistemology that informs family therapy. Taggart provided an excellent review of the problems encountered when an attempt is made to develop an ethical paradigm that is consistent with the theoretical framework used by family therapists. This discussion included the differences between linear and systemic values and critiqued those authors who did not consider this epistemological difference when they were critiquing family therapy ethics. Taggart presented an alternative that he termed evolutionary ethics. This article provided little guidance for the application of evolutionary ethics to family therapy practice situations.

Wendorf and Wendorf (1985) critiqued the literature on family therapy ethics and further supported the argument for a systems focused ethical paradigm. They argued for the need to use a wider lens than previous perspectives of family therapy ethics in making ethical decisions. Wendorf and Wendorf advocated for a model that considered the influences of not only the family system, but also the culture. For example, when they discussed secrets, they indicated that the therapist could decide when to keep or reveal a secret using a systemic way of thinking. They did not present principles or rules that would guide this decision making. This article, like previous articles, left therapists with a strong argument for the need for ethics that are consistent with the epistemology of family therapy, but again fell into the trap for which they criticized their predecessors, not

providing direct application of this different ethical lens to real clinical problems.

In discussions of family therapy ethics, the work of Boszormenyi-Nagy is often cited as providing ethical principles for the family therapist (Boszormenyi-Nagy, 1985; Wendorf & Wendorf, 1985). The paradigm presented by Boszormenyi-Nagy is termed relational ethics and has as its guiding principle interpersonal consequence (Boszormenyi-Nagy, 1985). Boszormenyi-Nagy discussed this principle as acting within the family with responsibility for the consequences to the next generations of the family under consideration. As Wendorf and Wendorf (1985) pointed out, relational ethics, when presented in this manner, is more an ethic for a family rather than a set of principles that can be used to guide family systems therapists in their work. So again the therapist is left to personal values and interpretation to guide ethical decision making in family therapy.

In the ongoing attempts to guide family therapists through the murky waters of systems ethics, several books have been written. The three that specifically address family therapy ethics are: Issues & Ethics in the Helping Professions (Corey, Corey & Callanan, 1984), Ethical, Legal and Professional Issues in the Practice of Marriage and Family Therapy (Huber & Baruth, 1987), and Ethical Issues in Family Therapy (Walrond-Skinner & Watson, 1987). Corey, Corey, and Callanan (1984) addressed the differing theoretical positions of individual and family therapy by aligning with Margolin (1982) and asserting that ethical family therapy is a balancing act between maintaining the individual's best interest while acting as a family advocate. The principles they used to guide this balancing

act are the traditional ones that evolve from individual therapy, i.e., guarding individual rights and promoting justice. They did not offer the family therapist principles that would be congruent with a systems theory perspective nor did they indicate that there was a need to develop a system of ethical principles that was more congruent with the epistemology used by family systems therapists.

Huber and Baruth (1987) acknowledged the ethical problems encountered when practicing systems focused therapy in a culture that is highly individualistic where each person's rights take precedence over the relationship system. They offered the therapist the option of identifying the system as the client and pursuing relationship goals unless the safety of an individual is at stake. The therapist then would advocate for the individual until the danger is resolved. Huber and Baruth concluded that the therapist ought to provide maximum benefit for the greatest number of persons. This provides a guiding principle based in utilitarian ethics. Utilitarian ethics adds another level of complexity to the therapist's decision making, for now maximum benefit must be defined. This issue represents one of the greatest debates within utilitarian thinking, what is maximum benefit and who is to define it (Beauchamp & Childress, 1989)? Although Huber and Baruth recognized the need for an ethical perspective that accommodates to a systemic paradigm, they offered little of a practical nature to the practicing family therapist.

Walrond-Skinner and Watson (1987) edited a series of articles related to family therapy ethics. This volume presented articles that supported the traditional individual focused ethical paradigms. There was little recognition of a

need to align ethical perspectives with the systems oriented theories used by family therapists.

An exception to the predominant view is Carpenter (1987) who admitted that family therapy would be less difficult in a culture that is less aggressively individualistic. He cites China as an example of a culture that assumes the individual will put the needs of the family and community above personal desires. Carpenter concluded, however, that the difficulties in the congruence between the therapist's and client's paradigms could be resolved by questioning the validity of the model that runs counter to the wishes of the client. To support his assertion that systemic thinking should be de-emphasized, he posed the question: To what extent does the systems model represent real life? This question appears to call into question the usefulness of systemic thinking in therapy.

The importance and purpose of utilizing systemic thinking as a method for approaching problem resolution is answered in the literature by several authors who have indicated that the systems/cybernetics paradigm presents a model that more accurately describes the interactions in the real world (Bateson, 1972; Bertalanffy, 1952). The question posed by Carpenter also ignored the process of paradigm shift described by Kuhn (1970) that attributed a change in paradigms to scientists confronting situations where the traditional explanations no longer work. At this point Kuhn (1970) proposed that a paradigm that better fit the puzzle or problem was adopted. This process describes the transition from individual oriented therapies that began in the 1940's to a system/cybernetic model of family therapy practiced presently (Becvar & Becvar, 1993).

Carpenter's conclusion is also incongruent with the discussion of cases he presented. Each of the case examples that was presented addressed the importance of understanding the impact of change in one individual on their social network. He clearly used systems thinking when he considered the impact of the resolution of one spouse's symptoms on the other spouse and the implications this had for the relationship, recognizing the importance of understanding the larger implications for the work of therapy.

Also in Walrond-Skinner and Watson (1987), Haldane (1987), Treacher (1987), and Lindley (1987) argued, in their individual chapters, that the fundamental concern for family therapists should be autonomy, freedoms, rights and responsibilities of the individual. They were most critical of the indirect techniques of strategic therapy. This critique was based on a concern for the apparent lack of respect for the individual's autonomy. They found it unconscionable that the individual should give up autonomy for the good of society as a whole. This argument was based on the impression that the individual is not compensated by this personal sacrifice (Lindley, 1987). Although Haldane, Treacher, and Lindley professed a belief in systems theory in their work, their assertion that the individual does not benefit when the social system is bettered denies a basic tenet of systems/cybernetic theory that asserts the system and individual are one and the same, and improvement in one results in an improvement in the other (Segal, 1986) from the perspective that all parts of the system interact to make the whole. Becvar and Becvar (1993) conceptualized this relationship between the individual and the social system from the perspective of systems theory as each person being concurrently subjects and objects and thus everyone is

involved in each other's destiny. Von Foerster (1986a) described this relationship in a very concise manner when he stated his moral imperative for systems theory. This moral imperative was: "A is better off when B is better off" (Segal, 1986, p. 4).

Haley (1977) discussed the ethics of a strategic approach that demonstrated an understanding of the need to promote consistency between the theoretical clinical methodologies and the ethical paradigm. His ethical orientation evolved from a respect for the boundaries at different system levels. Within this paradigm, Haley thought it was just as unethical to violate the boundary between the conscious and unconscious mind as it would be to violate the boundary between the context of therapy and the community by sharing what happened in a therapy session with the local newspaper. The indirect methods utilized in strategic therapy allow the client to control the flow of information from the conscious and unconscious. This perspective allows information the client needs to remain outside awareness to stay unrecognized while change occurs. Haley (1976) believed that the contract between the client and therapist was for change, and ethically change can occur without violating boundaries, including the internal ones, for these boundaries serve to protect the individual.

Walrond-Skinner and Watson (1987) offered family therapists a discussion of ethics from a variety of perspectives. As the review of these articles points out, they provided critique of the current ethical decisions being made by therapists, but provided little direction for resolving the conflicts of making ethical decisions in a manner that is congruent with a systems perspective.

Clearly, the authors represented in Walrond-Skinner and Watson used the traditional individual rights oriented ethical paradigms.

Woody (1990) attempted to build an ethical decision making model for family therapists. Her model was based on a multifaceted approach to decision making which provides a comprehensive analysis of the situation to facilitate the development of a defensible decision. The five areas identified by Woody as necessary are: (a) theories of ethics; (b) professional codes of ethics; (c) professional theoretical premises; (d) sociolegal context; (e) personal/professional identity. She chose the ethical theories of utilitarianism and contract theory to address two levels of moral thinking. These levels were intuitive and critical. She indicated that contract theory was the application of intuitive thinking that combines ingrained ethical rules related to professional duty and conduct. When a conflict occurs at this level, Woody recommended that the utilitarian theory of ethics could then be applied. This would apply the principle of the greatest good and least harm to resolving the dilemma.

The application of utilitarianism to ethical decision making presents the practitioner with the problem of identifying what is the greatest good. In their text on biomedical ethics, Beauchamp and Childress (1989) described the difficulty in determining the values that should be used to make a decision about what is greatest good. This is compounded with the difficulty in predicting future outcomes. Although Woody (1990) did not define greatest good, she did indicate that the values of the therapist's theoretical framework are involved in the ethical decision making process. She cautioned, however, that the theories

should not be used to shelter the therapist from the realities of the larger external environment. According to Woody, debates based on the validity of therapeutic approaches would not resolve the fundamental value differences between the various perspectives. Each practitioner may perceive a favored theory as a collection of empirical facts rather than preferred hypotheses, making it difficult to make a final determination of ethics from within a theoretical approach. To resolve theoretical blindness, Woody (1990) recommended that ethical decision making within the theory be subjected to the scrutiny of universal ethical principles and the organizational codes of ethics. This recommendation returns the therapist to the original dilemma: what are the values to determine the greatest good?

Krull (1989) also attempted to develop an ethical perspective for family therapy that she termed the ethics of tolerance. This ethic is based on Krull's belief that systemic thinking increases one's willingness to be open to the perspective of others and to see one's own perspective as not an absolute truth. She described three recursive levels of ethical thinking or multiversa ethics. Level 0 reflects the cultural principles. Level 1 is removed one level and enables one to make comparisons between various ethics. Meta-ethics or level 2 makes the observation that there is no absolute ethic, thus the comparisons made at level 1 can be viewed from the perspective that every system of values is equally true because there are no absolute criteria to judge one system as better than the other. This would appear to be a justification for any behavior, but it is here that Krull utilized the concept of recursion to develop a meta-meta-level or level 3. On level 3 she

reminded the reader that the idea that there is no absolute ethic must not be considered absolute either, and all principles are connected to the cultural context of level 0. Krull suggested that this recursive process constantly challenged one's ethical premises and that this process facilitated the development of a higher understanding of ethical premises. She thought that this ethical process was so much a part of systemic thinking that when one adopted this theoretical paradigm, one would be making ethical decisions from the principle of tolerance because of the recursive self-reflective nature of system thinking.

When Krull (1989) discussed the principles that would guide ethical decision making, she indicated that these would be culture specific. This places the family therapist back in the dilemma of making ethical decisions that are consistent with the perspective of family systems theory, and valuing the system in a culture that most values individual rights and responsibilities. Thus, she has apparently used the process of systems theory to develop her ethical paradigm but did not include the concepts of valuing of relationships (which is also process). Examples of the application of her model provided by Krull support this inconsistency. In these examples, Krull (1989) demonstrates tolerance for other value systems, i.e., nonfeminists by feminists, but does not demonstrate a valuing of systems that in some manner base their decisions on relationship values. Clearly, the ethic she is demonstrating is one of tolerance despite how the value system views relationships.

Recognizing the difficulty of resolving the conflicts between the welfare of individuals and the family, Zygmund and Boorhem (1989) proposed an ethical decision making model based on Kitchener's (cited in Zygmund & Boorhem, 1989)

model of ethical decision making. This model provided two levels of ethical decision making: the intuitive level and the critical-evaluative level. The critical-evaluative level is further divided into three levels: ethical rules, ethical principles, and ethical theory. When an ethical dilemma cannot be resolved at one level of ethical reasoning, the next higher level is to be used. Zygmund and Boorhem (1989) cited the AAMFT Code of Ethical Principles as an example of ethical rules that can guide the family therapist. When these rules do not resolve the conflict, the ethical principles of autonomy, nonmaleficence, beneficence, fidelity, and justice are to serve as guides. These principles are to take precedence over personal and group values. When ethical principles conflict, Zygmund and Boorhem recommended that the therapist use the ethical theories of universalizability and balancing to resolve these conflicts. As used by these authors, universalizability describes behavior as ethical only if it can be unambiguously generalized to all similar cases, and the balancing principles require that the decision produce the least amount of avoidable harm to all involved.

In their article, Zygmund and Boorhem (1989) did not provide clear direction for resolving the value conflicts between the family and individuals within the family. Their ethical decision making model utilized traditional principles and ethical theories that assert the values of individual rights. They did not make a distinction between ethical decision making to meet the needs of individuals and ethical decision making that addresses the unique issues of systemic thinking, although they asserted that this was the purpose of their article. Zygmund and Boorhem appear to add little to the need for an ethical paradigm that is more

consistent with systems epistemology. This issue was also addressed by O'Shea and Jessee (1982), Taggart (1982), Wendorf and Wendorf (1985).

To date, the attempts to assist the family therapist in making ethical decisions that are consistent with systems/cybernetic theory return to an ethic of justice and individual rights or provide critiques of what is being done without demonstrating a clear alternative. Until there is an ethical decision making process that resolves these theoretical differences, family therapy will continue to struggle with these issues. This problem is reflected in the current debate about the professional code of ethics for family therapists developed by the American Association for Marriage and Family Therapy.

Professional Ethical Codes

The code of ethics of the professional association, as Zymond and Boorhem (1989) and Woody (1990) suggest, can guide the therapist in ethical decision making. This process is not as easy as it might first appear. A code of ethics for family therapists was developed by The American Association for Marriage and Family Therapy. The most recent revision of this code was in August 1991. The code is considered binding for all the members of the Association (AAMFT, 1991). This was a revision of the 1988 Code of Ethics and included the following changes: (1) addition of sexual orientation as a category in the antidiscrimination clause; (2) revision of the dual relationships category that specifies that if a dual relationship cannot be avoided, the therapist must take appropriate precautions to maintain professional judgement to prevent exploitation; (3) clarification of those actions that are an automatic

violation of the code and make a member subject to termination of membership. These actions include (a) conviction of felonies, (b) misdemeanors related to the professional role, (c) behavior that could lead to legal convictions, (d) disciplinary action by other professional associations, (e) loss of license or certificate or discipline by a state regulatory body, (f) impairment, and (g) failure to cooperate with an investigation of an ethical complaint; (4) expansion on the ethical guidelines for supervision, including the cautions against dual relationships and sexual harassment; (5) specification of how financial matters should be handled; (6) guidelines for researchers; and (7) guidelines for advertising (Preister, 1991).

The role of professional codes of ethics has been addressed by several authors. Beauchamp and Childress (1989), Engelhardt (1986) and Veatch (1981, 1989) have discussed professional codes of ethics as rules of conduct of the professional group. Within this context several dilemmas evolve.

The first problematic area discussed by Engelhardt (1986) and Veatch (1981, 1989) is the paternalistic assumption by the organizations developing professional codes that they are protecting the welfare of the affected parties (consumers), although they have not included information from these persons in the development of the codes. This makes the commitment unilateral and not reciprocal. While developing codes to protect the rights of consumers, these professional organizations have eliminated the other party in the deliberations. This is most problematic for those who view ethical codes as contracts or covenants. Contracts and covenants assume an exchange

between the parties involved that articulates the moral duties as agreed upon by both participants (Veatch, 1989). This lack of mutual agreement can create conflict when those to which the benevolent actions are to be directed do not care about or desire these actions.

The second area that Beauchamp and Childress (1989) and Engelhardt (1986) discussed was the conflict between viewing professional codes of ethics as ethical guidelines rather than a description of role-specific duties or guidelines for decision making. Engelhardt (1986) and Veatch (1981, 1989) discussed the development of professional codes as a set of rules as opposed to a set of guidelines. In a situation where these codes are viewed as rules or, in extreme cases, essentially laws, violations can cause legal action to be taken.

Engelhardt (1986) develops this confusion between codes of etiquette and moral codes further. He discussed professional codes of ethics as codes of etiquette because they do not address moral issues per se, but present the professional with rules about relationships with other professionals and clients.

Similar concerns were also expressed by Veatch (1981) and Beauchamp and Childress (1989). Beauchamp and Childress (1989) attempted to clarify this point of confusion by identifying the criteria they utilize to differentiate between ethical codes and codes of conduct. The primary criteria they use, which is referred to by the other authors, is the ability for the claims made by the code to utilize universal moral principles as their base. Beauchamp and Childress (1989) suggested these principles be veracity, respect for autonomy, and justice. Veatch (1981) suggested

the use of social contract theory to arrive at a basis for making ethical decisions that would commonly be recognized as valid.

Engelhardt (1986) presented his version of the social contract for resolving dilemmas. He discussed the concept of moral communities that establish commonly agreed upon moral contracts. Engelhardt (1986) argued that within these communities, the right does not exist to force compliance for it is also important to respect the beliefs of one another.

The problems with professional codes of ethics described by Beauchamp and Childress (1989), Engelhardt (1986) and Veatch (1981, 1989) could be anticipated if one applies the concepts of logical typing described by Bateson (1972) or levels of organization as described by Schneirla (Tobach, 1970). Both Bateson and Schneirla addressed the complications that arise when levels of abstraction are confused or, as Bateson asserts, when one confuses the map with the territory. Schneirla (cited in Tobach, 1970) asserted each level of organization is subsumed by higher levels of organization and is modified by this process. This implies that rules applied at one level of analysis are not useful in describing process at another level of organization. Schneirla's position is supported from a different perspective by the theory of logical types (Bateson, 1972) which, when applied, prevents the confounding of different logical levels (Keeney, 1983). When applied to ethics, this would address the problem of professional codes of ethics (one logical level) being applied as if they were moral codes (another logical level) when in fact they represent rules of behavioral conduct.

The complexity of the interaction between professional codes of ethics and morality is further complicated when one considers that the traditional ethical models utilized to resolve professional dilemmas evolve from a tradition of theorizing that is justice based and approaches ethical decision making from the perspective of applying hierarchically arranged levels of principles that do not consider the context within which the decision making takes place (Fry, 1989). The justice model of ethical decision making has as its primary focus the rights of the individual (Gilligan, 1982). When the AAMFT (1991) Code of Ethics is reviewed, it becomes clear that the perspective presented is the traditional individual rights focused legal/moral approach. The therapist is cautioned to "respect and guard confidences of each individual client" (AAMFT, 1991, p. 2). The unit of service is described as individuals and families, and therapists have the responsibility to respect the rights of those persons seeking their assistance. The code continues to address various other issues related to the relationship between the association member and clients, supervisees, students, employees, and the association. Only when it discusses issues of confidentiality does this code indicate that ethical decision making may be more complex because the client may be more than one person. At this point, as noted above, the therapist is advised to protect the rights of each individual client. There is no recognition that ethical decision making may need to be altered because of the systems focused theoretical perspective of family therapy practice. This oversight is particularly striking since the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) indicates that the theoretical foundations of marital and

family therapy are systems and cybernetics theory (COAMFTE, 1988).

It would appear that at a theoretical level, AAMFT recognizes the importance of systems/cybernetics theory in the practice of marriage and family therapy, as is evidenced by recognition of this theory as the foundation of marital and family therapy by the CAMTE. On a more practical application level, AAMFT remains linked to the linear perspective of ethical models that are justice-based theories of moral reasoning.

Research on Ethical Decision making of Family Therapists

Current research on the ethical decision making of family therapists supports the conclusion that this split in AAMFT's perspective is problematic for the practicing family therapist (Brock & Coufal, 1989; Green & Hansen, 1986, 1989; Ratliff, 1988). The fact of this confusion is supported by ongoing dialogues among family therapists about the usefulness of AAMFT's Code of Ethics (Coyne, 1989; Doherty, 1985; Ryder & Hepworth, 1990; Tomm, 1992, 1995; Wylie, 1989).

In 1986, Green and Hansen asked seventy-five family therapists to complete a questionnaire that asked what ethical dilemmas they faced and how helpful were the AAMFT ethical guidelines with these dilemmas. Of the eight dilemmas that the therapists identified as most often faced, six were not addressed in the AAMFT Code of Ethics for 1984. These items were (a) treating a family if one member does not want to participate, (b) feeling confident of your training and/or qualifications, (c) seeing one family member without the others present, (d) informing clients of values implicit

in the mode of therapy, (e)dealing with parental requests for information differently from children's requests for information, and (f)sharing your values and biases with families. The primary conclusion of the study was that family therapists were facing ethical dilemmas that were not covered in the AAMFT guidelines and that these dilemmas were faced significantly more often than those covered in the guidelines. The recommendation that evolved from this study was that the guidelines need to be revised to better address the needs of family therapists (Green & Hansen, 1986).

If the current AAMFT (1991) Code of Ethics is reviewed, little has been done to address the concerns that family therapists identified in 1986 as problematic. The only area elaborated is the section on confidentiality. This section states that client confidences cannot be disclosed unless mandated by law or if a waiver has been obtained from all family members who are legally competent to execute such a waiver. This, however, does not address the concern identified in Green and Hansen's (1986) research related to parent's and children's requests for information.

In 1989, Green and Hansen expanded on their earlier study by increasing the sample size to 202 and assessing not only those issues family therapists find problematic, but also asking what they do when faced with these dilemmas. The instrument used to survey the population of AAMFT clinical members presented sixteen clinical vignettes, eight of which were developed from AAMFT's Ethical Principles for Family Therapists (1984) and eight of which were developed from issues expressed in the literature on ethical dilemmas in family therapy. Besides identifying whether they had experienced the situation, the informants were asked to select a response to the dilemma from a series of

alternative responses to the situation. Each vignette also had a place for alternative write-in solutions to the dilemmas.

The three dilemmas that the therapists rated as most important were reporting child abuse, family versus individual needs, and responding to a mother's request for data obtained on her minor children as part of a research project when the children have indicated that they do not want their mother to see this information. The only issue addressed by the AAMFT Code of Ethics (1991) relates to the sharing of information obtained as part of research. The code (1991) indicates that when the possibility exists that others, including family members, could obtain access to this information, the possibility, with the plan for protecting confidentiality, should be explained as part of the informed consent procedure.

Reporting of child abuse is a legal, as well as ethical, issue because it is legally mandated to be reported in all states (Huber & Baruth, 1987). The informants in this study responded to this dilemma based on their relationship with the family, as well as considering the legal requirements. Most of the respondents said they would report the abuse in spite of a promise from the father to never do it again. However, respondents also indicated that they would work with the family to report the abuse while they provided support to the family, and that they would work with the authorities to keep the father in treatment. These respondents demonstrate the tension family therapists feel between responsibilities to traditional, individually focused ethical ideals and to the family system.

This tension is further highlighted in the therapists' responses to the family versus individual needs dilemma.

Responses to this problem focused on the need to preserve the relationship with all members of the family system while not maintaining the secret shared by the wife about her affair.

In addition to the apparent need for the respondents to make decisions in a manner that would maintain families in treatment, Green and Hansen (1989) felt that the other significant finding of their study was that what were ethical dilemmas for some family therapists were considered treatment issues, for others. When the dilemmas were seen as treatment issues the informants would define the problem as a matter of technique preference rather than a choice between the right and wrong action to take. These authors concluded that this resulted from the variety of therapeutic approaches within the systems perspective. If, as Green and Hansen (1989) reported, many therapists perceive what were developed as ethical dilemmas as issues of treatment or theoretical choices, it would appear that there is a difference in the perceptions of what truly defines an ethical decision between practicing family therapists and researchers. The understanding of what practicing family therapists do define as ethical dilemmas are difficult to discern from previous research because the designs involved the researchers defining the dilemma and the informants selecting what they felt was the best response to the situation from the options provided by the researchers (Brock & Coufal, 1989; Green & Hansen, 1986, 1989; Ratliff, 1988).

Brock and Coufal (1989) surveyed 1,000 randomly selected members of AAMFT to obtain data on how closely family therapists follow AAMFT's ethical standards in their daily practice. The subjects were presented with

ethical/legal situations and then responded to how often they did this in their practice. The responses were placed on a five-point scale where the choices ranged from never to always. These authors found the greatest discrepancies between legal/ethical standards and therapists' responses in the area of legal requirements. Respondents indicated that at least 40 percent of the time they do not warn the potential victims of their clients' threats, at least one-third of the respondents sometimes do not report child abuse, and 82.9 percent rarely or never report a client's crime disclosed in therapy.

It is impossible to discern the reasoning behind these choices because the survey did not provide the respondents with an opportunity to describe their decision making process. In the areas of therapist-client relationship and controversies, which included items about AIDS and sexual relationships with clients, the therapist's responses were congruent with the accepted standards. Of the respondents, 92.5 percent said that they have never become sexually involved with a former client within one year of termination, and 72.9 percent indicated that they would never, rarely, or sometimes inform a client's partner that the client is HIV positive. Again, the design of the study makes it difficult to assign meaning to this information because the process for making these decisions was not obtained. It could be, as Green and Hansen (1989) found, that the therapists framed some of these issues as treatment issues rather than ethical dilemmas.

Ratliff (1988) surveyed 167 members of the Texas Family Therapy Association to assess their responses to the family therapy dilemmas she developed. The responses to these dilemmas were recorded on a seven-point Likert-type scale.

After reviewing her data, Ratliff (1988) concluded that family therapists are divided on how to resolve the dilemmas presented. Some of the most striking divisions occurred in areas that AAMFT has set clear standards. The dilemma that reflects therapists' response to one of the most controversial AAMFT guidelines is one that asks about reporting engaging in a social relationship with an ex-client. Forty-nine percent of the respondents said they would probably not report this situation, 10 percent said they were not sure, and 47 percent indicated they were likely to report this situation. AAMFT (1988, 1991) clearly indicates in its guidelines that dual relationships are to be avoided. This recommendation was in place at the time the study was conducted and has been strengthened in the AAMFT Code of Ethical Principles (1988, 1991) recent revisions. Almost all of the respondents to this study requested copies of the study to gain a better understanding of how their colleagues were responding to the dilemmas. The recommendations that evolved were to develop research that would provide more detailed information about the factors that are influential in making ethical decisions. This recommendation parallels that made by Stanton (1988) in The State of the Art in Family Therapy Research: Controversies and Recommendations. In his recommendations, Stanton (1988) stated: "the conceptual and operational bases for making clinical decisions are greatly in need of investigation" (p.28). As editor of this volume, Wynne (1988) noted that there was a strong consensus among the contributors that the use of exploratory, as opposed to confirmatory, research needed to be expanded to answer the yet unanswered questions in family therapy.

The recommendations of Ratliff (1988), Stanton (1988) and Wynne (1988) support the use of an exploratory methodology to further examine the ethical decision making process of family therapists. The methodology described by Brown (1988) provided such an approach for reading narratives about moral conflict and choice. Brown (1988) and her colleagues combined a semi-structured interview with content analysis for care and justice ethical decision making perspectives. The approach utilized by Brown (1988) parallels content analysis. Application of these qualitative methods to ethical decision making of family therapists would provide the perspective suggested by the writings of Ratliff (1988), Stanton (1988), and Wynne (1988).

Concern about AAMFT's position on dual relationships has generated debate in the literature that would support the professional ambivalence about these relationships expressed in Ratliff's (1988) study (Goldberg, 1993, Ryder & Hepworth, 1990; Tomm, 1992, 1995). Ryder and Hepworth (1990) responded to the 1988 AAMFT Code of Ethical Principles from their concern about the extension of the dual relationship prohibition beyond sexual misconduct to vaguely defined relationships that could be presumed to include nonromantic relationships. These authors asserted that the AAMFT legislation about dual relationships oversimplified the natural complexity of relationships. They identified the problem as an issue of exploitation and power rather than dual relationships in general. Ryder and Hepworth (1990) concluded that when relationships are legislated, in the manner attempted by AAMFT, the natural complexity of relationships is driven underground, and the development of the problems they are attempting to avoid is potentiated.

These authors expressed their greatest concern over how this could influence supervisor relationships that they perceived as having the goal of moving the supervisee/graduate student into a collegial relationship. As with any collegial relationship, this could also evolve into a more personal relationship. These authors found this prohibition against dual relationships most curious in a profession that has as its focus the understanding that paradox and contradiction are central features of human relationships.

More recently Tomm (1992, 1995) responded to the prohibition on dual relationships by AAMFT. He asserted that by prohibiting all dual relationships, the AAMFT Ethics Committee is confusing dual relationships with exploitative relationships and ignoring the benefits that can evolve from non-exploitative dual relationships. Tomm recommended that the Ethics Committee clarify the types of exploitation that occur in all relationships, primary and dual. He saw this as a method for resolving an imbalance of power in relationships that could evolve if oversimplification of relationships was not addressed in a direct manner. Tomm emphasized the importance of working on issues of power and exploitation from within the complexity of relationships rather than legislating relationships from without.

This perception of an ethic that evolves from the relationship is similar to the ethic of care described by Gilligan (1982). The subjects in her research saw moral problems as problems of care and responsibility in relationships, rather than as rights and rules from outside relationships.

Wylie (1989) presented a discussion of the complexity of the ethical dilemmas facing family therapists. He began by reviewing the multitude of ethical complexities of family

therapy, which included the power issues in therapy, the ethical issues of the interactions between individuals and family groups, the complexity of differentiating between ethical and treatment issues, the use of touch in therapy, and the interaction between social issues and family therapy. Wylie concluded, after assessing the needs of family therapists, that the daily issues confronted by the therapist in practice overflow the narrow guidelines provided by professional codes. He found the issues to be related to the ethical perspective of the therapist. This conclusion would place ethics in the relationship between the therapist and the family. As Wylie (1989) states: "The line between self and other, my needs and your needs, is perhaps in no other profession so difficult to distinguish and so critical an ethical requirement" (p. 33). Wylie addressed the same relationship complexity discussed by Tomm (1992) and like the conclusions reached by Tomm, indicates a need for an ethical perspective that can inform decision making within the context of relationship.

Ethical Perspectives of Psychology

The American Psychological Association (APA) provides the code of ethical principles for psychologists, and members of the organization are bound to these principles (APA, 1981a). Additionally, the APA has developed Specialty Guidelines for the Delivery of Services by Counseling Psychologists (1981b). Since psychology practice encompasses a broad range of services beyond counseling, the ethical principles reflect this diversity. The major areas of concern are related to research, evaluation, testing and the supervision of persons assisting with these projects (APA, 1981a).

The Specialty Guidelines (APA, 1981b) discuss issues related to the provision of quality counseling services. Responsibilities in these special directives include a description of the role of the professional counseling psychologist (psychologist with a doctoral degree from an accredited program or a program that meets APA guidelines). Additionally, the practitioner is presented with guidelines for relationships with other professionals, as well as clients. The principles that address client/therapist relationships relate to providing quality services and validating that these services are documented appropriately. The guideline that addresses the welfare of the consumer is in the general ethical principles (APA, 1981a). In this principle, the psychologist is advised to avoid dual relationships to protect professional judgment and avoid the possibility of exploitation. This section also states that "sexual intimacies with clients are unethical" (APA, 1981a, p.3). In the annual reports of the APA Ethics Committee for the years of 1990 and 1991, this guideline represented the largest percentage of cases opened.

Data supporting the general difficulty practicing psychologists have with dual relationships was obtained by Pope and Vetter (1992) in a national survey of 679 psychologists. These psychologists identified 703 situations that were ethically challenging or troubling, and of these situations, dual relationships accounted for 116 (17%) of the problems identified. This was the second most commonly cited item. The area rated first in the number of incidents related to issues of confidentiality ($n=128$; 18%). It is interesting to note that in their research, Pope and Vetter (1992) included sexual issues as a separate category. This accounted for 28 incidents or 4% of the total

identified problems. Most authors consider sexual issues as dual relationship concerns, and if these numbers are combined with the dual relationship numbers, then dual relationships would be the most commonly identified problem in this sample. Since dual relationships appear to be the most problematic for therapists, it is not surprising that several authors have written and done research in this area (Borys & Pope, 1989; Holroyd & Brodsky, 1977; Miller & Lee, 1989; Pope, 1991; Stake & Oliver, 1991).

Research on the attitudes of psychologists toward sexual contact and touching between therapist and client was conducted by Holroyd and Brodsky (1977) and Stake and Oliver (1991). In 1977, Holroyd and Brodsky found in a national survey of 703 Ph.D. psychologists that 70% of male therapists and 88% of the female therapists thought erotic contact would never benefit opposite-sex clients. Twenty-seven percent of the therapists in this sample engaged in nonerotic touching with opposite-sex clients. After reviewing the responses of their subjects, Holroyd and Brodsky (1977) concluded that male therapists are most often involved in erotic contact, female clients are most often the objects, and therapists that disregard this boundary once are likely to repeat. These observations were related to Butler's (1975) observations that therapists who have sexual relationships with clients are meeting their own needs. The needs identified included being needy, lonely, frightened of intimacy, or needing to maintain a dominant position in the relationship. Based on this data, Holroyd and Brodsky (1977) concluded that the concerns of feminist psychologists that erotic contact with patients is based on therapist needs for power or sexual gratification and does not meet therapeutic goals were justified.

In 1991, Stake and Oliver surveyed psychologists to obtain a clearer picture of what is considered acceptable and unacceptable behaviors with clients. The results of their study indicated that if kissing is considered sexual misconduct with clients, then 7.3% of this sample had engaged in misconduct. If erotic contact is not defined in this manner, then only 2.2% of the sample had engaged in sexual misconduct. They concluded that it was appropriate to include kissing as sexual misconduct since the majority of respondents in this and previous studies identified it as misconduct rather than nurturance. Stake and Oliver (1991) concluded that the incidence of sexual misconduct from their study makes this an area for continued professional concern.

Pope (1991) reviewed the literature and the attention that licensing boards and other agencies devote to dual relationships. He also discussed sexual and nonsexual dual relationships and the common beliefs and strategies that promoted both types of relationships. He concluded, after the literature review, that dual relationships regardless of type, cannot be beneficial. Pope (1991) cited selective inattention as a way in which dual relationships and other forms of unethical behavior are made tolerable. He felt this occurs because the therapist involved blocks out awareness of the duality of the relationship or justifies the relationship by suggesting that it would be beneficial for the patient. Pope also indicated that the ease with which colleagues of a therapist screen out and become selectively inattentive to the situation contributed to the perpetuation of dual relationships. This professional inattention is supported by the prevalence of dual relationships and a tradition of dual relationships, especially in the area of bartering for services. Pope concludes that the potential

for harm to clients in dual relationships remains high enough that neglect of this issue by the profession is very difficult to justify.

Miller and Lee (1989) examined the ethics involved in establishing friendships after termination of therapy. These authors concluded that post-therapy friendships or the possibilities of such a relationship contaminate the therapeutic relationship and should not occur. They base their argument on the possibility of countertransference issues and inequality of power in the therapy relationship. The position presented by Miller and Lee (1989) is in direct contrast to the arguments of Tomm (1992), presented earlier, about the problems that arise when the complexity of interpersonal relationships is ignored and exploitation is confused with dual relationship. Again the issues of paternalism and the role of professional ethics discussed in Engelhardt (1986) and Veatch (1981, 1989) are also brought into discussion, for Miller and Lee conclude that clear guidelines for the therapist should be developed to set limits on this behavior. They also recommended that applicants to doctoral psychology programs be carefully screened and that personal therapy for therapists be required. Clearly, Miller and Lee assumed the traditional position that the client should be protected from the therapist and reinforced the negative connotation that the mental health client is too weak, "crazy" or otherwise dysfunctional in all situations to make rational decisions about their relationships with the therapist.

Borys and Pope (1989) surveyed 1600 male and female clinicians from the American Psychological Association, the American Psychiatric Association and the National Association of Social Workers for a total sample of 4,800

about dual relationships. It is interesting that they did not survey marriage and family therapists because "this group does not have a well-organized national association with a membership list" (Borys & Pope, 1989, p. 284). This statement is in error because AAMFT was established in the 1940's and was publishing a directory of service providers in the 1980's (AAMFT, 1980). The participants were randomly assigned to one of two groups, ethics and practices. The ethics form provided a scale and respondents indicated their beliefs regarding the degree to which they considered the behavior as ethical. The practices form provided a frequency scale and respondents indicated the proportion of clients with whom they had engaged in the listed behaviors.

When the ethical belief responses were reviewed, it was found that all dual relationship behaviors, all behaviors involving sexualized relationships, and all behaviors involving extra fee financial relationships had lower ratings, or were seen as less ethical than behaviors involving incidental involvements, social involvements and special fee arrangements. Female therapists and psychodynamically oriented respondents rated dual professional roles as less ethical than did other categories of respondents. Respondents who live and work in the same small town rated these relationships as significantly more ethical than did respondents in other practice areas.

Behavioral frequency ratings demonstrated that psychodynamically oriented clinicians had the lowest frequency of involvement in dual relationships. Borys and Pope (1989) attributed this difference to psychodynamic training that stressed an informed awareness of a role that should be clear, nonexploitative, and therapeutically oriented, as well as preparing the therapist to recognize

their own needs, motives, and desires and separate these out from the relationship with the client. Male respondents reported engaging in social financial involvements and dual professional roles with clients more than did female therapists. The data also suggested that male therapists tended to engage in nonsexual dual relationships more with female clients than with male clients.

Borys and Pope (1989) recommended that educational programs address the issues of dual relationships more directly with students and faculty. This would involve setting clear standards for professional behavior, discussing the consequences of this behavior, acting appropriately against students and faculty who violated the standards that prohibit exploitative relationships, and provision of a safe environment for those who report violations of the standards. These authors concluded that the best summarization of their research is the principle "Do not exploit" (Borys & Pope, 1989, p. 292).

It is interesting that Borys and Pope (1989) concluded that the problem was related to exploitive relationships and did not include all dual relationships. This parallels the argument of Tomm (1992) when he asserted that it was important to recognize the complexity of relationships and that family therapists should focus on exploitive relationships, dual or otherwise.

In an attempt to understand clinical ethical decision making, Smith, McGuire, Abbott and Blau (1991) surveyed mental health professionals to assess the reasons they used to resolve professional ethical conflicts. Their findings indicated that although the clinicians evaluate what should be done according to professional ethical guidelines, they may not always be willing to implement the ideal as

presented in the professional ethics guidelines. These authors found that the psychologists' response to a situation more likely evolved from personal values and practical considerations than professional ethical guidelines. Smith et al. felt that their study confirmed the observation that professional codes of ethics are not always adequate and suggested that future research be directed at identifying specific ethical principles and reasoning processes that underlie areas of professional decision making and behavior that are not directly addressed by the professional codes of ethics. These areas might include privacy issues with minors and families, limits of personal competence and informed consent (Smith et al., 1991).

Research in the ethical decision making of psychologists presents issues similar to those identified by family therapists and supports the need to utilize alternative methods for understanding this process. This finding supports the recommendations made by Stanton (1988) for family therapy research. Stanton (1988) suggested that the processes for making decisions in family therapy are greatly in need of investigation and indicated that exploratory research would be a useful method to increase this understanding.

It is interesting that several authors have recognized the special ethical dilemmas of psychologists working with families (Alessi, 1989; Hansen, Green, & Kutner, 1989; Jensen, Josephson, & Frey, 1989). Jensen, Josephson, and Frey (1989) addressed the problems that occur when there are competing "best interests" among family members. The solution these authors proposed involved informing the family at the beginning of therapy that the process could impact individual needs in the system. It was felt that this

informed consent provides an opportunity to discuss the hazards of the therapeutic process with the client, provides the client with an opportunity to participate in the decision making about the therapy, and assists in the development of a therapeutic alliance. These authors did not recognize the need for a different, systems focused approach to these ethical dilemmas posed by working with families.

Alessi (1989) and Hansen, Green and Kutner (1989) acknowledged that the ethical guidelines established by the American Psychological Association (APA) are more appropriate for those psychologists practicing individual therapy and that family therapy practice may require an ethical model developed from a systems perspective. Neither of these articles proposed a model of ethical principles that evolved from systems theory. Hansen, Green and Kutner (1989) proposed that the psychologists have a clear understanding of the potential problems before they started working with families and develop appropriate policies to prevent difficulties they foresaw within the context of the system. They also recommended that the psychologist obtain appropriate training and supervision when working with families, see the whole family as much as possible, establish clear guidelines with the family before the beginning of treatment about confidentiality between family members and other systems in the community (i.e., schools), and that the referring agencies have a clear understanding of issues of confidentiality. Alessi (1989) proposed that the key to clarifying the ethical problems of working with families is to have clear goals. He felt that these goals help to clarify rights, issues about what problems should be addressed, choice of therapeutic techniques, and the progress of treatment that in turn produce ethical therapy.

Neither Alessi (1989) nor Hansen, Green and Kutner (1989) provided ethical guidelines derived from a systems perspective. They did however present psychologists with a basis for questioning the basic assumptions of APA ethical principles when applied to family systems. This supplements the same process presented by family therapists who are questioning the appropriateness of ethical principles that do not evolve from a systems perspective being applied to systems oriented therapy.

It would appear that individually oriented psychologists have the most difficulties in making ethical decisions related to dual relationships (APA, 1990, 1991; Borys & Pope, 1989; Miller & Lee, 1989; Pope, 1991; Stake & Oliver, 1991). The resolutions that are currently being offered are reflected back to the ethical principles established by APA based in traditional justice ethics (Casas & Thompson, 1991). As was discussed in the section on family therapy ethics, the justice based ethical paradigm appears to diminish the complexity of interpersonal relationships and thus continues to provide little guidance for practicing therapists with the complex decision making in relationships. Psychologists who practice individual therapy are faced with the same relationship dilemmas family therapists confront when working with the family as client.

This might indicate, as Casas and Thompson (1991) suggested, that individually oriented psychologists would find more relevant guidance with their ethical decision making if they moved away from the individual rights focused justice model and adopted an ethical perspective that combines the aspects of a justice perspective with a relationship focused perspective. Casas and Thompson (1991) referred to the work of Noddings (1984) and Gilligan (1982)

for the model of relationship focused ethical paradigms. As is suggested by the research of Stake and Oliver (1991), the ethical behavior displayed by psychologists who practice individual therapy may be based in an ethical paradigm that demonstrates a care perspective. This would suggest that the theoretical orientations of individual focused therapy models that emphasize the rights of individuals do not contribute to ethical decision making of the psychologist as much as the interpersonal relationship the therapist has with the client.

Ethical Decision Making

Ethics or morality provide guidelines for resolving conflicts in human interests to optimize the benefits of persons living in social networks (Rest, 1986). Rest (1986) proposed that a moral system is working well when persons appreciate that their interests are being considered, when they see that the distribution of burdens and benefits is shared equally, and when they choose to remain a part of the system because they perceive that the mutual benefits of living together are being optimized.

Ethical decision making or moral reasoning is the method one uses to resolve conflicting values (Runes, 1983). Empirical studies to describe ethical decision making have primarily focused on justice-based theories of moral reasoning from cognitive psychology or a contextually based mode of moral reasoning based on the principle of care to interpret their findings.

Justice Perspective

The justice model of ethical decision making is represented in the work of Kohlberg (1969, 1981, 1984). The

philosophical foundation for the justice tradition is best represented by the philosophical traditions of John Locke and Immanuel Kant. The driving concern in these theoretical frameworks is the preservation of individual moral and personal autonomy. A justice perspective is strongly individualistic, morally preparing people to care for themselves while protecting them from the demands of others and the state (Kittay & Meyers, 1987).

Kohlberg (1969, 1981, 1984; Reed, 1987) proposed five stages of moral development based in a cognitive developmental perspective. These stages are placed in three levels of moral reasoning. The levels of moral reasoning are conventional, post-conventional, and conventional. Each of these levels is divided into two stages, producing six stages. This perspective focuses on reasoning about moral behavior and not the behavior itself. Kohlberg assumed this position out of a belief that the meaning of the situation to the individual was a much better indicator than behavior of developmental processes. This position was motivated by awareness that the same behavior could be seen at different developmental levels and yet the reasoning behind the behavior could be very different. The focus of Kohlberg's stages is the individual's social perspective (Lerner, 1986; Reed, 1987). This development progresses toward the inclusion of larger social systems in the perspective, while the individual's ability to abstract is also increasing.

Within the justice model of ethical decision making a moral problem is defined by the need for reciprocity between separate individuals, and decision making evolves into mediating conflicting claims in relationships or attempting to resolve issues in a manner that treats each participant fairly according to the rules. Decisions are based in a

system of logic that values impartial decisions based in rules perceived to promote justice (Gilligan, Lyons & Hanmer, 1991). The autonomous independent self of the justice perspective is in direct contrast to the interdependent self perceived in the care perspective.

The study on which Kohlberg based the development of his theory included controls for social class, age, and sociometric factors. Females were not included in this sample. The omission of women was briefly addressed as a way of decreasing the number of variables that needed to be considered (Colby, Kohlberg, Gibbs, & Lieberman, 1983).

Evaluation of Kohlberg's conclusions and research design should be tempered with understanding of the social context in which he was working. The primary world view or epistemology was the justice orientation that valued abstract, logical thought disconnected from contextual considerations (Eichler, 1988; Keller, 1985). Since epistemologies determine the boundaries of what one knows, thinks or decides (Keeney, 1983), Kohlberg was rightly influenced by the predominate world view of his time. Because these world views determine ways of knowing it becomes quite difficult to remove oneself from this perspective and consider alternate explanations for observations or for theory development (Keeney, 1983). Understanding the influence of epistemologies provides the foundation for a reconsideration of the current assumptions of ethical-decision making and can be discussed in greater depth after a discussion of the care perspective (Flanagan & Jackson, 1987).

Care Perspective

The care perspective is represented by the work of Gilligan (1982; Kittay & Meyers, 1987). This perspective was developed by Gilligan to address the concerns of women in the development of ethical decision making theories that she felt were not represented in the justice perspective. Gilligan's criticisms of the justice perspective evolved from her understanding that women appeared to consistently display deficient moral development when Kohlberg's criteria for moral development were applied to their ethical decisions. She perceived this outcome as a paradox, for the traits that have traditionally defined women as good, caring and sensitive to others needs, were now making them appear inadequate in mature moral development (Gilligan, 1982). Gilligan and her co-workers have adjusted their perspective to acknowledge Kohlberg's justice model as appropriate for addressing that aspect of moral conclusions related to the ethics of justice and rights and the ethic of care as appropriate for issues related to care and responsibility (Benhabib, 1987).

The theoretical framework for the care perspective has evolved from the work of Gilligan (1982) and Noddings (1984). The primary themes presented in the work of Gilligan and Noddings are of interconnected relationships, nurturance, caring, emotional responsiveness, and understanding of situations in context (Kittay & Meyers, 1987; Walker, 1989). Murdoch is often cited as the person who set the precedent for this perspective with her work to establish a moral epistemology of love or unselfish, concentrated attention (Murdoch, 1992; Walker, 1989). Murdoch rejects the objective decision-maker of Kant (1959) that is central to Kohlberg's (1981) model of moral

development and advocates a moral philosophy that places love in the center of the ethical life (Lyons, 1988; Murdoch, 1992).

The primary themes that predominate Gilligan's theory of moral reasoning are related to interpersonal responsibility and increased understanding of relationships (Gilligan, 1982). This increased understanding of interpersonal relationships is combined with increased sophistication in caring for oneself without neglecting others. The concepts of responsibility and care are primary in Gilligan's understanding of the moral domain (Gilligan, 1982).

Theoretical Perspectives on Ethical Decision Making

The tradition of seeking a moral perspective that considers more than a deductive approach, as utilized by Kohlberg (1981), to moral decision making is not a new phenomenon. Plato, Aristotle and Hume emphasized the importance of love and virtue over justice in moral deliberation (Kittay & Meyers, 1987; Murdoch, 1992). Aristotle and Plato considered contextual and circumstantial features to be crucial in ethical decision making (Benhabib, 1987; Murdoch, 1992). Hume emphasized the importance of emotion and personal concern as the base upon which ethical decisions are made. Hume indicated that reason alone could not motivate moral action. The understanding and consideration of relationships were central to his ethical perspective. Haan (1978) cited the work of Rawls and Habermas, who focus on dialogue as a method of resolving moral conflict, to support her use of an interpersonal approach to ethical decision making.

Contemporary ethicists, Alistair McIntyre and Bernard Williams, continue the emphasis on the personal point of view that contrasts with the more formal traditions (Benhabib, 1987). Support for a contextual relationship focused ethical paradigm can be found in historical and contemporary ethical theory. This parallels the work currently being done by and her colleagues (Gilligan, 1977, 1982; Gilligan & Attanucci, 1988; Gilligan, Lyons, & Hanmer, 1990). Instead of basing moral decisions on the assumption that the rules valid for the generalized other are also valid for the individual in context, Gilligan perceives dilemmas in a contextual voice that is aware of the perspective of the concrete other (Benhabib, 1987).

Current Perspectives on Justice and Care Orientations

The debate about moral decision making between the perspectives of justice and care continues. Kohlberg recognizes a care position directed to relations of special obligation such as family and friends (Benhabib, 1987; Friedman, 1987). Friedman (1987) points out that although Kohlberg acknowledges an ethic of care, he continues to assert the primacy of the justice perspective based on the belief that an understanding of these special relationships should only supplement the generalized obligations of the justice perspective. Kohlberg (1983) supports the approach with the recognition that when differences are seen between men and women in ethical decision making, this can be accounted for by differences in education and experience in social institutions. Men and women with the same educational backgrounds and experience in social institutions demonstrate the same ethical decision making considerations.

Friedman (1987) asserted that the arguments used by Kohlberg (1983) to support his position at best only serve to support the traditional western perspective that the world of interpersonal relationships, traditionally relegated to women, is of lesser moral importance than the male dominated world outside the home. The justice perspective focuses on the social contracts between abstract persons that do not require a personal relationship. In her critique of the justice model Friedman went beyond the traditional arguments that Kohlberg's framework is biased against women and addressed metaethical and methodological considerations.

Friedman's (1987) most pressing disagreement evolved from Kohlberg's (1983) claim that the primacy of justice is supported because he succeeded in elaborating stages which parallel Piagetian cognitive tradition. Friedman took issue with Kohlberg's assertion from the perspective that there is no evidence that a moral system should be presented in Piagetian terms to be valid, and certainly this issue cannot be resolved by assuming that this is the appropriate framework for a theory of ethical decision making.

Finally, Friedman (1987) argued that, although Gilligan did not emphasize it, the care model of ethical decision making provided a framework for understanding the broader contextual framework of the ethical dilemma. She cited Kohlberg's Heinz dilemma as an example. Friedman asserted that the true problem in the Heinz dilemma was the larger social issues involved in the delivery of health care. Although Kohlberg's choices focused on the relationship between Heinz and the pharmacist, the underlying issue was the inadequacy of health care resources for the poor, a problem that could only be seen when a contextualized

version of the dilemma was presented. When the broader contextual perspective of the care model was used to resolve the dilemma, a foundation was provided for understanding reasoning in complex, richly detailed situations.

Gilligan's wisdom of placing the data she had in a gender paradigm has been questioned by others (Broughton, 1983; Flanagan & Jackson, 1987; Nails, 1983). This questioning has been based both in the review of research on ethical decision making and theoretical review.

Gender of Informant

Hare-Mustin and Marecek (1988) and Nails (1983) cautioned that Gilligan's (1982) ethic of care could have inadvertently been influenced by an exaggeration of the importance of gender as producing the differences seen between males and females in her samples. The differences described by Gilligan could be attributed to a variety of other variables. The contribution of other variables to this difference has been demonstrated by the research done by Clopton (1989), Walker (1989), and others (Pratt, Golding, Hunter & Sampson, 1988; Peter & Gallop, 1994).

Nails (1983) referred to Gilligan's (1982) ethic of care as social-scientific sexism that could increase the risk of paradoxically supporting the sexism Gilligan is purported to criticize. This author asserted that the manner in which Gilligan presented her material could be used to show the inferiority of women unless it can be proved that males go through a similar development, the ethic of care is proven to be superior, or all of the assumptions about ethical decision making are proven to be invalid.

Hare-Mustin and Marecek (1988) indicated that in husband-wife conflicts the wives usually emphasize caring

and the husbands emphasize rules and logic. In parent-child conflicts the same women emphasize rules and the children advocate for sympathy and understanding. This observation supports their assertion that the differences between men and women seen in Gilligan's research could be related to social structure and the individual's position in this structure. While in a dominant position most persons tend to support rules, discipline, control and rationality, similar to the justice approach described by Kohlberg. The rules were developed to support the maintenance of the status quo and are therefore supported by the dominant social group. When someone is in a subordinate position, they often appeal to mercy, sympathy, and understanding, as in the ethic of care (Hare-Mustin & Marecek, 1988). Similar behavior has also been documented in other groups that are in fewer powerful positions in their social networks. Harding (1987) and Stack (1986) describe this experience for Black males, who experience financial disfranchisement. These men develop a perspective that emphasizes interpersonal connection that resembles the ethic of care presented by Gilligan (1984).

Clopton and Sorell (1993) found no indication that gender differences in the use of care and justice perspectives in moral reasoning were significant for their sample of husbands and wives. They indicated that this similarity resulted from restricting the domain of decision to areas of parenting. Clopton and Sorell argued that past differences seen in the moral reasoning of men and women may result more from the types of dilemmas they encounter than stable intrapsychic characteristics.

Additionally, Nails (1983) criticized both Kohlberg (1982) and Gilligan (1982) for developing causal links in their theories without providing support from other

resources or from outside the immediate situation. This criticism included the development by both Kohlberg and Gilligan of stages of moral development. Nails asserted that the assumption that stages can exist in this area is based in a highly controversial and nebulous realm of criteria for ethical development. It was Nail's belief that the generalizations about the sexes made by Gilligan from questionable data could establish boundaries that would limit expectations for both males and females. It was also important to Nails that generalizations about groups not be confused with the response of any particular individual. Nails concludes her critique with a plea to perceive moral development as a complex process that might best be viewed as an interaction among multiple variables.

Flanagan and Jackson (1987) reviewed claims made by Kohlberg (1984) and Gilligan (1982) in an attempt to gain perspective on the moral psychology debate. Flanagan and Jackson (1987) proposed a moral psychology that is virtue-theoretical in the Aristotelian tradition. They desired to move away from the cognitive-developmental tradition of Piaget (1962) which they saw as Kohlberg's position. The basis for this perspective is threefold. First, Flanagan and Jackson argued that there is no clear taxonomy of the elements of both the justice and care orientations. The lack of careful analysis of the differences between good and "bad" kinds of care provided the second area of concern addressed in this article. Finally, the authors presented the variety of perspectives that can be used as foundations for moral outlooks and reflected on the inaccuracy of self-report as a tool for discerning an individual's psychology. The position proposed by Flanagan and Jackson advocated for a diversity of moral positions and supported the conclusions

proposed by Nails (1983). All of these authors found little to support the claim that the care or justice perspectives should be considered central.

Dilemma Characteristics and Response

Support for Gilligan's (1986) assertions that gender influences moral orientation were found by Langdale (1986). In her study, Langdale presented 144 subjects, ages 24-60+, four dilemmas. All of the subjects were presented the Heinz dilemma, seventy-six of the respondents were given one of two versions of an abortion dilemma generated Langdale, and thirty of the participants generated a real-life dilemma. Results of this study demonstrated consistency in orientation, justice or care across dilemmas. Males demonstrated a consistent preference for justice reasoning across dilemmas and care was predominately used by females.

Recent research on the effects of gender on decision making have suggested that characteristics other than gender may have influence on this process (Clopton, 1989; Friedman, Robinson, & Friedman, 1987; Pratt, Golding, Hunter, & Sampson, 1988; Walker, de Vries & Trevethan, 1987; Walker, 1989). Each of these studies suggested that men and women use a mix of care and justice in moral reasoning and that dilemma characteristics influence the decision making style.

Freidman, Robinson, and Friedman (1987) found, in their study of 101 psychology students, no significant gender differences in responses to questions about four traditional hypothetical dilemmas (Heinz, Doctor, Prisoner, & Newspaper). Students were presented with a list of Gilligan (G) items and Kohlberg (K) items that had been developed from the respective theoretical frameworks. Both sets of items were presented after each dilemma and the students

were asked to check all the items that applied to the dilemma. None of the individual dilemmas produced significant differences in either the K or G scales.

Walker, de Vries, and Trevethan (1987) assessed reasoning on hypothetical dilemmas and a real-life dilemma using 80 family triads (mother, father, and child). Gender did not significantly contribute to the differences in reasoning on either dilemma. Consistently age did demonstrate significant differences for decision making when children and adults were assessed. When the content of the real-life dilemma for adults was assessed differences were found in the content of the dilemmas generated by men and women. Men generated more impersonal dilemmas and women produced more personal themes. Analysis of response type and hypothetical dilemma type indicated that personal relationship focused dilemmas produced more care as opposed to rights responses regardless of subject's gender.

In their test for gender differences in moral orientations, Pratt, Golding, Hunter, and Sampson (1988) contributed more to the growing evidence that factors other than gender influence moral choice. Twenty-four (12 men, 12 women) subjects were presented with two of Kohlberg's hypothetical dilemmas and a Gilligan personal dilemma task. No gender differences were found in responses to hypothetical dilemmas when they were measured by Kohlberg's element categories. Assessment of the real-life dilemmas found that men were significantly more likely to demonstrate justice responses than were women. When the content of the real-life dilemmas was assessed women provided more personal relationship problems. Gender differences for the real-life dilemmas were not significant for relational dilemmas. This

finding would suggest that dilemma content may indeed have an influence on moral reasoning.

Walker (1989) conducted a longitudinal study of moral reasoning using 233 subjects, 5 to 63 years old. Two identical interviews were conducted with a two-year interval. Each of the subjects responded to hypothetical and a real-life dilemmas which were scored utilizing both Gilligan and Kohlberg criteria. Gender did not demonstrate a significant interaction. After assessing the content of the real-life dilemmas, Walker concluded that the nature of the dilemma is a better predictor of moral orientation than gender.

A need to consider an integrated moral theory and to conceptualize the ethic of care more broadly than a gender specific perspective is also supported by research (Clopton, 1989). Clopton (1989) explored the ethical decision making of informants on real and hypothetical ethical dilemmas. The results of this study suggest that the characteristics of the dilemma rather than the gender of the respondent are more important in determining the type of reasoning used.

Clopton (1989) developed a study to test the differences in ethical decision making between men and women in hypothetical and real-life dilemmas. The respondents were forty married couples. Half the couples were the biological parents of handicapped children and half were the biological parents of non-handicapped children. Each respondent was asked to respond to four dilemmas: (a) a structured, hypothetical dilemma designed to have equal relevance and emotional appeal to both parent groups; (b) a structured, hypothetical dilemma that had equal emotional appeal but unequal relevance to the parent groups; (c) the parents of handicapped children were asked to describe a real-life

dilemma they experienced in their parenting and parents of nonhandicapped children were asked to imagine they were parents of a mentally retarded, physically handicapped child and describe a dilemma they encountered parenting this child; (d) parents of the nonhandicapped children were asked to discuss a dilemma they encountered raising their own children.

The results of Clopton's (1989) study indicated that there were more care responses on the dilemmas that were rated higher in emotional appeal, personal involvement, difficulty, and importance. The author indicated that the most surprising result of the study was the lack of gender differences in any of the scores on the dilemmas. The results of Clopton's work add to the data that suggests characteristics of the dilemma rather than gender of the respondent influence the type of moral reasoning utilized.

This literature (Clopton, 1989; Friedman, Robinson, & Friedman, 1987; Pratt, Golding, Hunter, & Sampson, 1988; Walker, de Vries & Trevethan, 1987; Walker, 1989) would suggest that it is time to remove theories about moral reasoning from the social political battle ground and begin a search for a theory of ethical decision making that integrates the perspectives of care and justice. As is suggested by Flanagan and Jackson (1987), it is important to consider a rich diversity in ethical decision making and to utilize research methods that provide opportunities to consider a complex moral system. Research methodologies that provide the subjects with the opportunity to self-select a moral dilemma and describe their reasoning in these situations were shown to provide an initial framework to address the need for a model that allows the integration of the justice and care perspectives (Clopton, 1989).

Moral Reasoning and Professional Orientation

As discussed previously, the traditional focus of health care ethics parallel the justice model of decision making (Fry, 1989). The goal of the justice perspective is to treat all individuals equally, regardless of the context. Decisions are based on the logical, impartial application of ethical principles to achieve justice for all. When the ethical principles for the professional associations of family therapists and individual therapists, are reviewed they reflect this focus on individual rights and justice. The focus of these codes is concern about assuring the rights of individual clients (AAMFT, 1991; Corey, Corey, & Callanan, 1984).

The COAMFTE(1988) indicates the course that provides information about the theoretical foundations of marital and family therapy must enable the students to conceptualize about human problems from a systems paradigm. To accomplish this goal the commission indicates that the students should be taught systems and cybernetics theory. When the assumptions of both justice and care perspectives of ethical decision making are reviewed, the assumptions of the care perspective provide the best fit with systems/cybernetic theory.

The ethic of care has as its primary concern the complexities of attachment within relationships and has as its goal to achieve a balance in these relationships to meet the needs of all concerned. The primary metaphor is one of a web or connections (Lyons, 1990). The justice perspective has as its primary concern individual rights and fairness with a focus on adherence to standards or principles that evolve from an objective, rational perspective.

Systems/cybernetic theory, the theoretical framework for family therapists, values the understanding of the relationships that connect individual parts into a whole and the understanding of the patterns that connect these parts (Keeney, 1983). This focus of systems/cybernetic theory aligns it with the ethical concerns of the care perspective. It could therefore be predicted that family therapists would make ethical decisions using a care perspective.

The code of ethics developed by the American Psychological Association (APA) addresses a variety of issues that reflect the diversity of practice sites for psychologists. These practice sites vary from positions that focus on research, to industrial psychology, to individual, private therapy practices. Ethical concerns of psychologists, as described in the research of Pope and Vetter (1992), reflect this diversity. The issues most frequently identified by the 679 respondents to Pope and Vetter's questionnaire identified issues related to confidentiality as the most frequently encountered problem, followed by dual relationship issues and concerns related to reimbursement for services.

To assist those psychologists in counseling roles the APA provides speciality guidelines for their practice (Corey, Corey, & Callanan, 1984). These guidelines reflect the theoretical assumptions of the models of helping. Corey, Corey and Callanan (1984) place all therapeutic models into four categories: the moral model, the compensatory model, the medical model, and the enlightenment model. The differences in these categories are based on the distinction about where the responsibility for discovering solutions to problems resides. The moral model sees the individual as responsible for the problems in their life, as well as for

discovering the solutions. The compensatory model does not make the individual responsible for their problems but does make them responsible for the solutions. Individuals are perceived as responsible for neither their problems nor the solutions to these problems and are thought to need treatment from the outside expert in the medical model. In the enlightenment model, individuals are responsible for their problems but require the direction of others because they are unwilling or unable to develop solutions. Each of these models focuses attention on the individual rights and responsibility.

With this focus on individual rights and responsibility, it would appear that the ethical decision making model that provides the best fit with the theoretical framework of psychology would be the justice model. When the psychologists identified the issues they most often confront, the areas that were identified related to concerns about relationships with clients. Issues such as reporting of child abuse, the development of friendships with clients, and seeing clients who are friends with a personal friend of the therapist are a small sample of the general types of ethical dilemmas identified in the research done by Pope and Vetter (1992). When the psychologists were asked what would help them with these dilemmas, they requested principles that clearly and realistically address the situations (Pope & Vetter, 1992). There is no indication that the respondents found the justice model inadequate for making the decisions related to the identified situations.

Contribution to the Literature

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Family therapy is currently involved in the process of developing an ethical perspective that is consistent with the framework from which interventions evolve (Green, 1986; O'Shea & Jessee, 1982; Solovey & Duncan, 1982; Wendorf & Wendorf, 1985). This process has gone in two directions. The work initiated by Hare-Mustin and her colleagues (Hare-Mustin et al., 1979; Hare-Mustin & Hines & Hare-Mustin, 1978) placed into question the process of ethical decision making that requires the sacrifice of the rights of individuals for the good of the family system. This criticism initiated a movement among family therapists who attempted to develop an ethical perspective that was theoretically consistent with family therapy. This process was initiated because of a belief that the rules being used by Hare-Mustin and her colleagues to evaluate the ethical decisions made by family therapists were not consistent with the systems/cybernetics theoretical framework of family therapy (Green & Hansen, 1986; O'Shea & Jessee, 1982; Solovey & Duncan, 1992; Taggart, 1982; Wendorf & Wendorf, 1985).

T. C. Schneirla (Tobach, 1970) and Ludwig von Bertalanffy (1952, 1967) provided a theoretical perspective supporting the hypothesis that ethical decisions made from a systems/cybernetics epistemology need to be evaluated using a set of rules that are different from those applied to the traditional individual therapies. Both Schneirla and von Bertalanffy asserted, based on their research of systems, that the laws and principles that apply at one level of system organization do not necessarily hold true at another

level of organization. Each level contains different processes. Therefore, social entities would have different rules than individual systems (Von Bertalanffy, 1952, 1967).

The primary concerns in systems theory are related to interactional patterns at various system levels. The focus of family therapy, guided by systems theory, then becomes assisting the system in evolving alternate patterns of interaction that facilitate functioning (Keeney, 1983). This perspective appears problematic when evaluated utilizing traditional ethical criteria that evolve from the individually focused traditional justice perspective (Fry, 1989).

The majority of the work on ethical decision making in family therapy has been in the area of proposing alternative ethical theoretical perspectives the authors felt were more consistent with systems/cybernetics theory (Wendorf & Wendorf, 1985). Little attention has been given to understanding the process utilized by family therapists in making ethical decisions within a systems/cybernetics theoretical framework.

Green and Hansen (1986), Ratliff (1988) and Brock and Coufal (1989) attempted to assess the ethical decision making of family therapists. This research focused on the therapist's application of moral principles to hypothetical dilemmas. If moral decision making is a complex process that involves the characteristics of the dilemma, as was suggested by Clopton and Sorell (1993) and Flanagan and Jackson (1967), then methods to assess the decision making done by therapists should accommodate this complexity. It appears that if a true picture of the process used by family therapists in making moral choices is to be discerned, a

research methodology that elicits real-life moral dilemmas would be most useful.

Current research and theory suggest that there are at least two perspectives from which ethical decisions are made, justice and care. The type of moral reasoning used may be context dependent which is suggested by the differences seen in those decisions made in real-life as opposed to hypothetical dilemmas (Clopton, 1989; Friedman, Robinson, & Friedman, 1987; Pratt, Golding, Hunter, & Sampson, 1988; Walker, de Vries & Trevethan, 1987; Walker, 1989). The work of Kohlberg (1981) and Piaget (1965) also suggests that the individual's moral decisions are influenced by personal perceptions that provide a filter for viewing these issues. The need to understand that personal perspective can influence moral decision making is supported theoretically by cybernetics of cybernetics that proposed the viewer cannot be separated from the observed (Keeney, 1983). Understanding that context and type of dilemma used influence the decision making process would support research questions that explore how family therapists make ethical decisions for real-life situations.

Empirical studies to describe moral reasoning have focused on two models. The justice model as described by Kohlberg (1969, 1981, 1984) and the ethic of care as presented by Gilligan (1982). Ethical decision making that evolves from the justice model focuses on issues of fairness, individual rights and maintaining standards or principles. The care perspective is concerned with the complexities of attachment in relationships and finding a balance that meets everyone's needs (Clopton, 1989). It would appear, based on the theoretical perspective, that the ethic of care would be more congruent with a systems/

cybernetic theoretical framework and that therapists that are making decisions in this context would use this perspective. However, this issue has not been examined in a manner that would reduce the bias toward making decisions from the justice perspective. All of the research on the ethical decision making of family therapists has depended on hypothetical dilemmas and not assessed their decision making in real-life situations.

The purpose of this study was to facilitate the development of an ethical decision making perspective for family therapists that is theoretically consistent with systems/cybernetic theory. To provide a base for this development, this study was designed to elicit the type of decision making therapists are using with real-life dilemmas. The content of the dilemmas and the decision making utilized to resolve them was analyzed to determine the perspective used to make the decision. This data can provide a data base from which to develop theoretically congruent ethical guidelines for family therapists utilizing a design demonstrated to enhance understanding of the individual's ethical decision making process.

The guiding questions for this study were as follows.

1. How are practicing family and individual therapists making decisions about the ethical issues they face in their practice?

Previous research on the ethical decision making of family therapists has utilized hypothetical dilemmas to elicit information about family therapists' ethical decision making (Brock & Coufaul, 1989; Green & Hansen, 1986, 1989; Ratliff, 1988). This research did not demonstrate how family therapists are making ethical decisions in their practice, but the therapists did indicate that the models of ethical

decision making currently presented by the AAMFT are not useful in making these decisions. Gilligan (1982) and Kerber (1986) have suggested that informants reason differently on hypothetical and real-life dilemmas. In their work on ethical decision making, these authors have hypothesized that the abstraction of hypothetical dilemmas separates the moral problem from social contingencies and predisposes a preference for justice reasoning on the hypothetical dilemmas and for care reasoning on the real-life dilemmas (Gilligan, 1982; Kerber, 1986). This suggests that family therapists and individual therapists will demonstrate a preference for care reasoning on the real-life dilemmas that will be elicited by this research. This preference would be increased by the theoretical orientation of family therapy that emphasizes relationship (COAMFTE, 1988), as does the care perspective.

As previously discussed, past research on ethical decision making of individual therapists has also utilized the hypothetical dilemma design to elicit information or has asked psychologists to identify areas that were ethically troubling (Borys & Pope, 1989; Holroyd & Brodsky, 1977; Pope & Vetter, 1992; Stake & Oliver, 1991). Based on the information about ethical decision making cited above, it could be predicted that individual therapists who practice individual therapy would prefer care reasoning, as opposed to justice reasoning, in real-life dilemmas (Gilligan, 1982). This effect would be diminished compared to the one seen for family therapists because of the emphasis on individual rights and responsibilities found in the theoretical focus of psychology (Casas & Thompson, 1991).

The following statistical hypotheses were tested:

H1: Both family therapists and individual therapists

will score higher in care on the real-life dilemma than the hypothetical dilemmas.

H2: The care scores of family therapists will be significantly higher than the care scores of the individual therapists for care on the real-life dilemma.

2. Does the theoretical orientation of family therapists or individual therapists, affect the frequency of justice and care responses in real life dilemmas?

Although past research has suggested that real-life dilemmas produce a greater proportion of care responses than hypothetical dilemmas (Gilligan, 1982), the potential effects of the basic theoretical assumptions of therapeutic orientations cannot be ignored. The theory that supports family therapy emphasizes relationship and attachment (COAMFTE, 1988), and the theory that supports individual therapy focuses on individual rights and responsibilities (Casas & Thompson, 1991). The individual rights' focus is more congruent with the justice model of ethical decision making. The care model, with its focus on relationship, is more congruent with the theoretical framework of family therapy than is the justice model with its focus on context-free rules and individual rights.

As discussed previously, the work of Gilligan (1982) suggests that informants reason differently on hypothetical and real-life dilemmas. In Gilligan's research, justice reasoning has been the predominant response to hypothetical dilemmas. It was therefore predicted that both family and individual therapists would demonstrate similar scores on the hypothetical individual dilemma. It was further predicted that family therapists would have a higher

percentage of care responses than the individual therapists to the family hypothetical dilemma. Although the family dilemma is a hypothetical dilemma, it would elicit a theoretically congruent response from both therapist types which, for family therapists would be more congruent with care reasoning.

The statistical hypotheses tested were:

H3: Scores for family therapists and individual therapists will not differ on the individual therapy hypothetical dilemma.

H4: Family therapists will score significantly higher in care than individual therapists on the family hypothetical dilemma.

CHAPTER III

RESEARCH DESIGN

As discussed in Chapter I, previous research on the ethical decision making of family therapists has utilized hypothetical dilemmas to determine the types of decisions the therapists are making. Kerber (1986) suggested that the impersonal character of the hypothetical dilemmas presented to subjects by researchers might elicit a justice response. These responses tend to be detached, logical and impartial or more objective in their nature because the decision maker is distanced from the details for the problem (Gilligan, 1982). Gilligan (1982) suggested that research designs that utilize a personal dilemma more frequently elicit a care response. The writings of Kerber (1986) and Gilligan (1982) would suggest that family therapists may be using a moral decision making process in their daily practice that is not reflected in their responses to the hypothetical dilemmas that are currently being used in family therapy research on ethical decision making.

The proposals of Gilligan and Kerber have been addressed by several projects that reviewed responses to real-life and hypothetical dilemmas. Research by Pratt, Golding, Hunter, and Sampson (1988), Walker, de Vries and Trevethan (1987), Walker (1989) and Peter and Gallop (1994) has demonstrated that the nature, or type of dilemma impacts the type of moral orientation. These authors found that real-life dilemmas could be further categorized as personal or impersonal and that personal dilemmas generate a care

orientation and impersonal dilemmas generate a justice orientation. A personal dilemma is one involving a person, or group of people, with whom a participant has a significant, generally continuing relationship. An impersonal dilemma involves a person or group of people with whom a participant does not have a significant relationship (Walker et al., 1987).

When this understanding is placed in the context of the current debate in family therapy about the development of ethical guidelines to assist with decision making in complex circumstances, the need for research that provides better understanding of these processes becomes apparent. The research model developed by Gilligan that utilizes open-ended clinical interviewing techniques and content analysis can provide information that will facilitate the development of ethical guidelines that integrate theory and practice in family therapy and provide information on how this process may be different for individually oriented therapists.

This chapter will begin with a presentation of content analysis. Content analysis is a method of observation and measurement that can be applied to any form of communication. It is used to determine emphasis or frequency of communication phenomena (Babbie, 1992; Kerlinger, 1986; Stempel, 1990).

The second portion of this chapter will describe the methods utilized in this study. Information related to selection of informants, procedures for the interviews, development of the interview schedule, coding of data, and strategies for data analysis will be included.

Content Analysis

Content analysis is a technique that facilitates the systematic analysis of the content of communication (Stempel & Westley, 1990). It is appropriate to apply content analysis to any form of communication (Babbie, 1992). Leininger (1985) identified content analysis as an appropriate method for analyzing value data. She identified value analysis as focused on the abstraction of "preferences, choices, any thing or idea that is viewed as desirable, and implicit or explicit forces that tend to guide human thoughts and actions" (Leininger, 1985, p. 61). Since the purpose of this study was to understand the ethical decision making of family and individual therapists, this study would be defined as value analysis and the use of content analysis would be appropriate.

Gilligan and her colleagues have established a precedent for utilizing content analysis as a method for the analysis of data on ethical decision making. This method is outlined in A Guide to Reading Narratives of conflict and Choice for Self and Moral Voice (Brown et al., 1988). Brown et al. (1988) constructed categories that meet the objectives and conceptual framework of this study. The method described by Brown and her colleagues guides the reader to code latent and manifest content in a process that places content in proper context. This method for reading narratives was refined by Clopton (1989) to more clearly define care and justice and to streamline the evaluation process in a manner that facilitates the use of data in statistical analysis. This study used the method that was

first described by Brown et al. (1988), as it was refined by Clopton (1989). The test for category appropriateness described by Babbie (1992) and Stempel and Westley (1990) was met because the defined categories have been demonstrated as useful in similar research (Clopton, 1989; Friedman, Robinson, & Friedman, 1987).

Reliability and validity of the information obtained from content analysis are evaluated through intercoder reliability and verification with a panel of experts (Brink, 1989; Kerlinger, 1986; Weber, 1990). Intercoder reliability is established when coders, unaware of the study purpose, analyze the same text and produce comparable results. These results are then confirmed by the panel of experts (Brink, 1989; Weber, 1990).

Informants

The ability of the sample selection to enhance the validity of the information obtained is an important consideration. When the sample is theoretically representative of the role being studied, the validity of the information obtained is enhanced (Brink, 1989; Leininger, 1985). The informants for this study were selected utilizing criteria that ensured that they represented the approach to ethical decision making of family therapists and individual therapists in a manner that fulfilled the theoretical demands of the research questions.

Both the individual and family therapists were selected based on purposive sampling methods. Purposive sampling assures that all informants are deliberately selected

according to the theoretical needs of the research (Glaser & Strauss, 1967; Morse, 1986, 1988). The researcher can choose to interview those informants whose experience is considered typical or those who have particular expertise. Glaser and Strauss (1967) and Morse (1986, 1988) suggest that evaluation of samples be based on appropriateness and adequacy of the sample to provide the information necessary to meet the theoretical demands of the study. This study utilized experts representing strategic family therapy and individual therapy and professional standards established by the recognized professional organizations to determine the appropriateness of informants for the theoretical purposes of this study.

Names of potential informants were obtained by contacting regional faculty of the Family Therapy Institute of Washington, D.C., talking with individual therapists representing professional organizations, and referrals from potential informants and interviewers. Initial contact with each informant occurred by telephone. Sixty-two informants were contacted by the three interviewers, 31 individual therapists and 31 family therapists. During this interaction an initial assessment was conducted to determine the ability of the therapist to meet the theoretical demands of the study. If the informant met the criteria a subsequent interview was scheduled (refer to Appendix A for Phone Contact Data sheet). All of the potential informants contacted agreed to an interview. Two potential informants, one family therapist and one individual therapist, were

dropped from the interview list because of difficulties in scheduling the two-hour interview.

Informants were family therapists who defined themselves as utilizing the methods identified with family systems theory and strategic therapy and individual therapists who identified themselves as utilizing methods that are not identified with family systems/cybernetic or strategic focused family therapy. Final assessment of the therapist's theoretical compatibility with the study was done with a demographic data form (refer to Appendix A, for Demographic Data for Therapists form) that required the potential informants to identify their primary professional and theoretical identification and the therapeutic techniques they utilized.

The methods that define strategic family therapists include paradox, the "benevolent lie," reframes, and other strategic therapy interventions (Haley, 1976; Lindley, 1987). The faculty and staff of the Family Therapy Institute of Washington, D.C., a nationally recognized training institute for strategic family therapy, assisted in identifying potential family therapist informants. This provided an expert panel to certify the expertise of the informants since they are recognized as the primary trainers for this family therapy model. Additionally, the family therapist informants were involved in providing direct client services at least ten hours per week on the average.

Individual therapists were currently involved in clinical practice an average of 10 hours a week and did not apply techniques related to strategic or family therapy

within the theoretical framework of these systemic models. Therapists who identified themselves as individual therapists and identified that they used a theory that is individual in perspective were placed in this group. The individual therapist group excluded persons who identified themselves as utilizing theory and techniques identified with strategic family therapy.

Thirty individual therapists and thirty family therapists were interviewed. This resulted in 60 interviews. Demographic data was obtained on the therapists from both groups to assess for differences other than theoretical perspective (refer to Appendix A, for Demographic Data for Therapists form). Items considered here were gender, age, educational preparation, years of experience, professional certifications, primary professional identification, theoretical identification, therapeutic techniques used, licensure, time spent doing therapy, and involvement with ethics education. Each informant was told that the purpose of the study was to increase understanding of professional ethical decision making which could then facilitate the development of professional standards that would better serve the practitioner. This information encouraged participation by demonstrating how the informant could personally benefit from the data. Each participant was offered a summary of the research results at the conclusion of the study.

Analysis of Demographics

The sample consisted of 30 family therapists and 30 individual therapists. The family therapy group included 16 men and 14 women, whereas the individual therapy sample included 14 men and 16 women. A chi-square analysis indicated there was no difference between the groups in gender representation, $\chi^2 (1; N = 60) = p > .60$.

Analysis of therapist characteristics indicated the sampling methods were successful in identifying two groups with similar professional qualifications, but theoretically distinct orientations toward therapy (see Table 3.5). The mean age for therapists was 41.48 ($N = 60$, $SD = 7.61$) years. There was no significant difference between individual and family therapists on age, $F (1,59) = .58$, $p > .45$. The mean for years of doing therapy was 12.88 ($N = 60$, $SD = 6.79$). There was no significant difference between the two groups on this variable, $F (1,59) = 1.85$, $p > .17$. The mean number of hours per week spent doing therapy was 17.47 ($N = 60$, $SD = 6.23$), with no significant difference between the family and individual therapists, $F (1,59) = 2.15$, $p > .14$. Equivalent numbers of family and individual therapists were licensed, $n = 25$ and $n = 26$, respectively. The informants did not differ significantly in the degree to which they were licensed, $\chi^2 (1, N = 60) = .0000 = p = 1$. Both the family and individual therapists reported a high degree of professional certification, with frequencies of 30 and 27, respectively. There was no statistical difference between the groups regarding certification, $\chi^2 (1, N = 60) = 3.16$, $p > .07$.

Significantly more of the family therapists ($n = 27$) than the individual therapists ($n = 17$) indicated that they supervised other therapists, $\chi^2 (1, N = 60) = 8.52, p = .0035$. Post hoc difference in two proportion analysis indicated there was a significant difference in the two groups for those reporting that they did not supervise (difference = .03) with more individual therapists reporting that they did not supervise. There was not a significant difference between those saying they did supervision. A 2×3 , supervision by dilemma type repeated measures analysis of variance of care scores of the therapists on the personal, individual and family dilemmas did not demonstrate a significant effect for supervision status, $F = (1, 58) = .66, p = .418$ (refer to Table 3.1, p.105, for source table). There was a significant within-subject effect for dilemma type, $F = (116, 2) = 6.60, p = .002$. This would indicate that there is greater difference in each therapist's scores than there is between the supervision versus nonsupervision therapists (refer to Table 3.1, for source table).

Family therapists reported a higher frequency of the master's degree ($n = 16$) as their highest professional degree than did the individual therapists ($n = 11$), whereas the individual therapists reported more frequently than family therapists that the doctorate was their highest degree ($n = 19$; family therapists $n = 14$) was their highest professional degree. This difference was not statistically significant, $\chi^2 (1, N = 60) = 1.68, p = .194$. Difference of two proportions post hoc analysis indicated that the difference between the therapist groups with a master's

degree was significant at the .05 level ($p = .05$), while the difference for the Ph.D. degree between the two groups was not significant ($p = .06$).

As shown in Table 3.2, most of the family therapists identified family therapy ($n = 14$) or social work ($n = 10$) as their primary professional discipline. Four family therapists identified psychology, one identified medicine and one identified other as their primary disciplines. Individual therapists identified psychology ($n = 15$) as their primary professional organization. Additionally, seven individual therapists identified social work, three identified nursing, two identified medicine, and three identified other (counseling) as their primary professional identifications. As would be expected there was a significant difference between the family and individual therapists with respect to their primary professional identification, $\chi^2 (5, N = 60) = 25.23, p < .0001$. Difference of two proportions tests were conducted to assess for the location of significant differences in professional identification (Hoel, 1960). Post-hoc analysis indicated that significant differences occurred with family therapy, nursing, psychology, medicine, and other. More family therapists indicated identification with family therapy, whereas more individual therapists indicated identification with nursing, psychology, medicine, and other.

Reflecting the selection criteria, the theoretical frameworks most frequently used by family therapists were strategic and structural therapy ($n = 28$ and 25 , respectively). Among individual therapists, individual

behavioral and brief therapy ($n = 18$ and 18 , respectively) were most frequently selected as the theoretical frameworks (see Table 3.3, p. 107).

Therapist use of theoretical frameworks was examined in separate chi-square analyses for each theory because each informant could select multiple theories. Examination of the theoretical frameworks found that individual and family therapists do differ in their identification with several models (see Table 3.3). The family therapists indicated that they were more likely than the individual therapists to use MRI, strategic, structural, solution focused, systems and brief therapy models.

Overall, family and individual therapists were significantly different in the therapy techniques they used. On six of the eight techniques the two groups were distinguished from one another (see Table 3.4, p. 108). There was a significant difference between the groups in the use of directives, prescribed rituals, positive connotation, ambiguous task assignment, paradox, and metaphoric task assignment. For each of these techniques, family therapists indicated that they used them more frequently than did the individual therapists.

The two techniques on which family therapists and individual therapists did not demonstrate significant difference were invariant prescription and reframe. Most of both the individual ($n = 27$) and family ($n = 24$) therapists indicated that they did not use invariant prescription, whereas reframe was indicated by all but two of the informants as a technique that they used.

Prior professional experience with ethics committees and ethics education was the same for both the individual and family therapists. The majority of both the individual ($n = 23$) and family ($n = 21$) therapists indicated that they had been exposed to ethics education, $\chi^2 (1, N = 60) = .341$, $p > .559$. Difference in two proportions post hoc analysis indicated that there was no significant difference at the .05 level between the groups for those who indicated they had ethics education while the groups that did not have ethics education were significantly different. More family therapists than individual therapists had not had ethics education.

Few of the informants from either group had experience with ethics committees. Of the family therapists, only two indicated that they had experience with ethics committees, whereas among the individual therapists only seven had this experience, $\chi^2 (1, N = 60) = 3.26$, $p > .07$. Post hoc difference in two proportions tests show that there was no significant difference between the two groups on this measure.

Evaluation of all characteristics associated with the informant groups demonstrated that the family and individual therapists differed as expected. The individual and family therapy groups met the theoretical demands of the study (refer to Table 3.5, pages 109-110 for a summary of the characteristics of therapists and therapy practice).

Procedures

The need for the interviewer to have skills in developing rapport while obtaining the desired information is especially important when the area of inquiry is of intimate or secretive knowledge (Leininger, 1985). Since the goals of this study were to increase understanding of the moral decision making of the therapists, the development of rapport by the interviewer was crucial. The interviewers were selected by the investigator, in part, because of an ability to develop rapport with the informant population and were persons who could easily be perceived by the informants as trustworthy. The interviewer's ability was evaluated by experience with similar research, professional experience with potential informant groups, and review of the first interview taped by the interviewer.

Two Ph.D. prepared faculty from West Virginia University Health Sciences Center Department of Behavioral Medicine and Psychiatry and one Ph.D. prepared faculty from Florida State University School of Social Work were trained to administer the interviews. Two of the interviewers were doctorally prepared family therapists with backgrounds in social work and content analysis research methods. One interviewer was a doctorally prepared psychologist who had extensive experience in administering semi-structured and open-ended clinical interviews.

The interviewers were required to review the interviewer's guide developed for this study before conducting any interviews. After the interviewers had reviewed the guide, the investigator discussed the

information to assure mutual understanding of the purposes and processes of the interviews. The investigator maintained contact with the interviewers throughout the interviewing process to discuss concerns and problems as they arose. These discussions occurred at regularly scheduled meetings along with periodic review of the taped interviews to assess for interviewing consistency. The interviewer's guide can be found in Appendix B. This guide was developed from the suggestions made by Spradley (1979), Clopton (1991), and Gilligan and her colleagues (Brown et al., 1988).

Each informant was interviewed at a mutually agreed-upon location by the trained interviewers. Informant's confidentiality was maintained at all times. Each informant was given a number code by the interviewer. The informants were told of this process and of the fact that there was no master list kept that could be used to identify them by their code number. All interviews were taped for later transcription. All therapists completed a survey of the demographic data before the interview began and signed a consent to participate in the research (see Appendix A, p.161). The consent gave the informants an opportunity to request a summary of the research findings. The consent for participation was filed separate from the coded interview to maintain the confidentiality of the informants.

Both the family therapists and the individual therapists were asked similar questions based on structured interviewing principles. The initial question requested that the informants talk about a clinical decision they actually faced that required a difficult choice. Follow-up

questions asked by the interviewer facilitated the informant's description of the decision making process related to this situation. These questions were adapted from the "Real-Life Moral Conflict and Choice Interview" developed by Gilligan and her colleagues (Brown et al., 1988; Gilligan, 1982), as it was revised by Clopton (1991).

Besides describing a real-life dilemma, the informants were asked to respond to two hypothetical dilemmas that were read to them. The hypothetical dilemmas were designed to assess the effects of type of client system (individual or family) on the informant's decision making, whatever the therapist's theoretical or professional orientation. The first dilemma described a situation that occurs when a therapist works with an individual client. The gender of neither the client nor the therapist was identified to avoid potential biasing effects related to the gender of the protagonists. The second dilemma addressed a situation that evolves from working with a family and was related to the relationships within the family. The gender of the therapist was not identified to avoid gender biases. The gender of the clients was identified because of the nature of the roles in a family system, i.e., husband-wife. To provide equal emotional appeal for both hypothetical dilemmas, the dilemma was a client situation and did not involve the relationship between the client and the therapist as might occur when decisions are being made about dual relationships.

The hypothetical dilemmas typified the issues not involving dual relationship concerns identified in previous research as most difficult for both family therapists and

psychologists (Green & Hansen, 1986, 1989; Pope & Vetter, 1992; Ratliff, 1988). They were adapted from a workbook on ethical decision making developed by N. Ratliff (1988) (see Appendix A).

The first dilemma focused on an individual therapy situation related to issues of confidentiality. The client was involved in behaviors that placed others at risk and did not demonstrate a willingness to discontinue the activities. This dilemma was selected because issues of confidentiality have been identified as either one of the most frequently encountered or most troubling by the therapists in previous family therapy and psychology research (Green & Hansen, 1989, Pope & Vetter, 1992; Ratliff, 1988).

Hypothetical dilemma number two presented a family situation involving child abuse. The family referred themselves for treatment and revealed a recent history of sexual abuse between the father and the daughter. Again this situation was selected because family therapists have identified issues related to child abuse as problematic. The subjects in a study conducted by Green and Hansen (1989) rank ordered it number one for ethical significance, and Ratliff (1988) found that the family therapists in her sample rated this issue as number one in need of attention by professional organizations.

As with the real-life dilemma, following presentation of each hypothetical dilemma the informants were asked the same questions to facilitate description of the decision making process related to the situation presented (see Appendix A, pp.170-174). The follow-up questions about the

hypothetical dilemmas were open-ended and as similar as possible to those asked about the real-life dilemma to maintain consistency.

After describing the real-life dilemma, and following responses to each hypothetical dilemma, the informants were asked to rate the dilemma on a scale from 1, very low, to 5, very high, according to the importance, difficulty, and degree of interpersonal relationship perceived in the dilemma (see Appendix A, p.161 for dilemma rating form). The informants were provided with the rating forms to complete if the interview was conducted in person. If the interview was conducted over the telephone, the questions were read to the informant by the interviewer.

Interviewer 1 conducted 42 of the interviews, 15 with individual therapists and 27 with family therapists. Interviewer 2 conducted 15 of the interviews, 14 with individual therapists and one with a family therapist. Interviewer 3 conducted three interviews with family therapists. To obtain a sample of family therapists who met the theoretical criteria for informants, Interviewer 1 conducted 24 interviews by long distance phone calls. The remaining interviews were done in face-to-face interactions with the informants. After review of sample tapes from each interviewer and all transcripts, it was determined that all of the interviews were of good audio quality, followed the appropriate format and were used in the data set.

Among family therapists 20 were interviewed over the phone whereas 10 were interviewed in person. Twenty-six of the individual therapists were interviewed in person and

four were interviewed on the phone. Chi-square analysis of the interview location indicated that there was a significant difference between the two groups in location, $\chi^2 (1; N = 60) = 17.77 = p < .001$. More family therapists were interviewed over the phone than in person and more individual therapists were interviewed in person than over the phone. One-way analysis of variance for the effects of location of the interview on the type of ethical decision making used demonstrated that there was no significant effect for location on care scores for each of the three dilemmas, $F (1,58) = .79, p = .37$. This disparity between in-person and phone interviews found when comparing individual and family therapists was due to the difficulty in obtaining a local sample of family therapists that met the sampling criteria of the study.

The primary investigator did not conduct any of the interviews and, after reviewing the first two interviews of each interviewer, did not listen to the tapes. This procedure allowed the investigator to remain blind to the professional orientation and gender of the therapist for most of the tapes. This procedure placed the investigator in a position to code the interviews blind to the informant's gender and professional identity.

Verbatim transcriptions of the interviews were typed into the computer software program, Qualpro (Blackman, 1992) by one of four typists. References that would identify the informant's professional identity, geographic location, agency identification, personal identity, and client's identity were concealed before the interviews were coded.

Transcription of each interview averaged four hours of typing time.

Qualpro is a text database manager that expedites the location, coding, and labeling of text. The codes are attached to the text without altering the document, and codes and code frequencies can be compiled. This program differs from other data management programs such as Ethnograph, Tap, Textbase, and Alpha because it provides the opportunity to compute intercoder reliability. Beyond reporting reliabilities between coders, Qualpro provides a Table of Agreements and a Confusion Matrix that assist with the identification of exactly where sources of confusion between coders exist. This program also provides quantitative frequency counts of the categories and qualitative narrative data from the text. This information was utilized in the development of intercoder reliability.

The transcripts were coded utilizing the manual found in Appendix C. This manual was developed by Gilligan and her associates (Brown et al., 1988) and revised by Clopton (1991). This guide directs the coders on how to classify responses in the interviews according to care or justice. The coders were blind as to the professional identity and gender of the informant. The coders were provided with printed transcripts of the interviews to code. It required approximately two hours to code one interview. After the coders marked the interview transcripts, this information was added to the interviews in the Qualpro program. The Table of Agreements and Confusion Matrix for the Qualpro

printouts was utilized to identify specific areas that needed refinement in the coding process.

The primary investigator and a graduate student in women's studies divided the interviews for coding. The primary investigator was the primary coder for 20 of the interviews and the graduate student was primary coder for 40 of the interviews. Because of her familiarity with the theoretical foundation for this project that evolved from her work in women's studies, the graduate student quickly demonstrated the level of understanding of the concepts of care and justice necessary to code the interviews.

The transcripts were coded by the primary investigator or coder in groups of three or four. The codes for each interview were marked in the margins of the text and then entered into the Qualpro program. A printout of the codes with the lines of text that received that code was then obtained from the computer program. After the coding of each group of interviews, a meeting was held to discuss the coding process and clarify areas of discrepancy. The codes that were developed after the discrepancies were resolved were used for data analysis. Each informant's responses resulted in one set of codes that were utilized in data analysis. The coding process took approximately two hours per interview.

After the coders reviewed the coding manual, intercoder reliability was assessed utilizing a sampling of text that had been previously coded by the researcher. The training process for coders continued until an intercoder reliability of at least .80 was achieved. The .80 reliability level is

based on the recommendations made by Krippendorff (1980) for inferences based on category coding. Topf's (1986) review of the literature on intercoder reliability indicated that she found a consensus among behavioral scientists that a percentage agreement of 70% was necessary, 80% was adequate, and 90% is good. Topf's standard for adequate differs from intercoder reliabilities achieved by researchers utilizing the category definitions established for care and justice by Gilligan and her colleagues (Clopton, 1991). Clopton (1991) indicated that the intercoder reliability for the categories of care and justice has been .74 to .72. Clopton (1991) achieved .75 and .73 for her study utilizing the care scores for the dilemmas for correlation. Clopton's intercoder reliability was consistent with the data from previous studies utilizing this coding process (Donenberg & Hoffman, 1988; Gilligan & Attanucci, 1988; Lyons, 1983; Walker, 1989). Krippendorff (1980) and Weber (1990) indicate that lower percentage agreements result from ambiguous definitions or coders' inability to understand the meaning of the category. Topf (1986) and Washington and Moss (1988) recommend a process that allows ample time for debriefing of the coders to refine the tool and increase understanding of the theoretical constructs.

Topf (1986) and Washington and Moss (1988) argue that measures of interrater reliability should give researchers a methodology that assesses agreement about the occurrence and nonoccurrence of the measurable event. Topf presents three methods for estimating interrater reliability. The methods she discusses are percentage agreement (T%), kappa (κ) and

phi (Φ). The use of percentage agreement increases the risk for inflated estimates because it does not correct for chance agreement. Kappa and phi control for chance agreement using correlation-like measures of agreement. These measures devalue high or low frequency agreement and favor moderate frequencies. Additionally, significance levels are available for the lower levels of agreement for both kappa and phi. These two measures will equal one another within .20 of a point. The correlation-like measures reflect formal reliability theory.

Baer (1977) argued that having the estimate of interrater agreement to be part of formal reliability theory is not appropriate. This argument is based on the understanding that formal reliability theory is concerned with item homogeneity on psychometric tests and homogeneity across raters is different. The process of increasing interrater agreement does not usually involve dropping or adding raters as is done with items on the psychometric test. The same raters are retained and refinement and revision of the category is used to improve the quality of agreement. Because of this debate, Topf recommends that the researcher provide documentation of the methods used in obtaining the reliability measures reported and suggests that multiple estimates of reliability could be reported to provide accurate measures of validity.

With the assistance of the table of coder agreements from Qualpro to identify areas of greatest confusion between coders, the investigator worked with the coders to achieve at least a .80 level of agreement suggested by Krippendorff

as acceptable for content analysis. Three sets of interviews were coded. The first trial produced agreement of 44% total agreement, 30% occurrence agreement, and 70% nonoccurrence agreement. The second trial produced 84% total agreement, 57% occurrence agreement, and 78% nonoccurrence agreement. This resulted in a kappa of .60. The final trial produced 90% total agreement, 66% occurrence agreement, and 79% nonoccurrence agreement. This resulted in a kappa of .62. Since other authors did not indicate that they used kappa it is assumed that they were reporting total agreement, therefore the .90 total agreement achieved by this study is above the .80 level of agreement suggested by Krippendorff and the .72 to .75 achieved by previous researchers using the care and justice categories as defined by Gilligan.

During the training sessions it became evident that agreement on what not to code was easy to achieve. The difficulty became defining the unit of care and justice to code. Initially there was some disagreement related to the distinctions between care and justice. This issue was greatest when the distinctions were attempted without attending to context cues or the discussion around the coded entity. Once agreement was achieved between the coders about the appropriate context cues to consider, the agreement about care and justice responses became much more consistent.

This issue is best exemplified by review of lines 102 to 118 in the interview of Informant 3 (see Table 3.6, p. 111). Line 102 is coded care by both coders. Lines 103 to

111 are uncoded by both coders. Coders agreed that lines 112-115 should be coded justice, however, Coder A also coded lines 116-118 as justice while Coder B left them uncoded. Thus, the coders agreed on the type of decision making taking place in a particular sequence of text but were not in agreement on how much of the text should be included in the sequence.

Data Analysis

Content analysis, in more recent years has been utilized to preserve the meaning of qualitative data that focuses on inductive analysis of the phenomenon studied (Lenninger, 1985; Sells, 1993). The inductive process of content analysis requires that hypotheses or questions be systematically derived from a theory related to context before hypotheses or causal propositions in quantitative research are presented (Smith, Sells, & Newfield, in press). Marshall and Rossman (1989) refer to these questions as guiding hypotheses and caution the researcher to use these only as tools to generate questions and to search for patterns. Content analysis was utilized to identify care and justice type moral reasoning in the informant interviews.

Coders read the transcripts for clear moral statements, and each statement was coded as either care or justice. Each informant was given a separate score for the individual, family, and personal dilemmas. These scores were based on the percentage of the responses that represented care responses. The number of care responses was divided by the total number of coded responses for each dilemma and for the

complete interview. After the interviews were coded, the care scores were assigned to the overall response of each informant, as well as, the personal dilemma, the family therapy dilemma and the individual therapy dilemmas separately. These scores were then used in planned comparisons to test the differences between the individual and family therapists.

Table 3.1
Source Table for Supervision by Dilemma ANOVA

Source	D.F.	SS	MS	F	<u>P</u>
<u>Between Groups</u>					
Within+Residual	58	42492.86	732.64		
Supervision	1	486.54	486.54	.66	.418
<u>Within Groups</u>					
Within+Residual	116	376.22			
Dilemma Type	2	4964.15	2482.08	6.60	.002
Supervision x					
Dilemma Type	2	1733.57	866.79	2.30	.104

N = 60

Note. Supervision refers to whether or not the therapist was a supervisor.

Table 3.2
Primary Professional Identification of Therapists

Professional Identifications							
	Family Therapy	Social Work	Nursing	Psychology	Medicine	Other	Totals (n)
Family (n)	14	10	0	4	1	1	30
	46.66%	33.33%		13.33%	3.33%	3.33%	
Indiv- idual (n)	0	7	3	15	2	3	30
		23.33%	10%	50%	6.66%	10%	
Totals (n)	14	17	3	19	3	4	60
Percent	23.30	28.3	5.0	31.7	5.0	5.0	100

Table 3.3
Theoretical Orientations of Therapist Types

Theory Types	Family Therapists	Individual Therapists	χ^2	D.F.
Strategic	28	2	45.07***	1
Structural	25	5	26.67***	1
Brief Therapy	29	18	11.88**	1
Individual Psychodynamic	9	10	.077	1
Family Psychodynamic	9	7	.340	1
Individual Behavioral	14	18	1.07	1
Family Behavioral	15	7	4.59	1
MRI	20	2	23.25***	1
Experiential	8	2	4.32	1
Solution Focused	22	12	6.79*	1
Systems	22	7	15.02***	1
Other (counseling)	12	12	00.00	1

* $p < .01$

** $p < .001$

*** $p < .0001$

$N = 60$

Table 3.4
Therapists Using Various Techniques

Technique	Family Therapists	Individual Therapists	χ^2	D. F.
Paradox	26	10	17.78***	1
Reframing	30	28	2.07	1
Metaphoric Task Assignment	23	5	21.69***	1
Invariant Prescription	6	3	1.18	1
Prescribed Rituals	26	7	24.31***	1
Positive connotation	30	8	34.74***	1
Ambiguous Task Assignment	21	4	19.82***	1
Directives	30	19	13.47**	1

* $p < .01$

** $p < .001$

*** $p < .0001$

Table 3.5
Characteristics of Therapy Practice

General Description	Family Therapists (n = 30) M ± SD	Individual Therapists (n = 30) M ± SD
Age (Years)	42.33 ± 8	40.73 ± 7
Years of Therapy Experience	14.06 ± 8	11.70 ± 5
Hours per week of Therapy	18.63 ± 6	16.30 ± 6
Percent of time doing individual therapy	29.44 ± 22	61.23 ± 30
Percent of time doing family therapy	50.67 ± 25	7.30 ± 11
Percent of time doing conjoint therapy	8.61 ± 18	.80 ± 2
Percent of time doing group therapy	2.33 ± 5	22.83 ± 29
Percent of time doing other therapy	1.60 ± 4	3.83 ± 13

Table 3.5
(Cont.)

General Description	Family n	Individual n
<u>Gender of Informant</u>		
Female	14	16
Male	16	14
<u>Highest Professional Degree</u>		
Masters	16	11
Doctorate	14	19
<u>Professional Certification</u>		
Yes	30	27
No	00	03
<u>Supervise Other Therapists</u>		
Yes	27	17
No	03	13
<u>Primary Professional Identification</u>		
	14	00
Family Therapy	10	07
Social Work	00	03
Nursing	04	15
Psychology	01	02
Medicine	01	03
Other (counseling)		
<u>Licensed</u>		
Yes	26	26
No	04	04
<u>Served on Ethics Committee</u>		
Yes	02	07
No	28	23
<u>Experienced Ethics Education</u>		
Yes	21	23
No	09	07

Table 3.6
Coding Samples Table of Agreements
Informant 003

Code No.	Line No.	Coder A	Coder B	Match
95	102	Care	Care	Agree
96	103	Uncoded	Uncoded	Agree
97	104	Uncoded	Uncoded	Agree
98	105	Uncoded	Uncoded	Agree
99	106	Uncoded	Uncoded	Agree
100	107	Uncoded	Uncoded	Agree
101	108	Uncoded	Uncoded	Agree
102	110	Uncoded	Uncoded	Agree
103	111	Uncoded	Uncoded	Agree
104	112	Justice	Justice	Agree
105	113	Justice	Justice	Agree
106	114	Justice	Justice	Agree
107	115	Justice	Justice	Agree
108	116	Justice	Uncoded	Disagree
109	117	Justice	Uncoded	Disagree
110	118	Justice	Uncoded	Disagree

CHAPTER IV

RESULTS

Hypotheses Testing

The following statistical hypotheses were tested:

1. Both family therapists and individual therapists will score higher in care on the real-life dilemma than on the hypothetical dilemmas.

2. The scores of family therapists will be significantly higher than the scores of the individual therapists for care on the personal (real-life) dilemma.

3. Scores for family therapists and individual therapists will not differ on the individual therapy hypothetical dilemma.

4. Family therapists will score significantly higher in care than individual therapists on the family hypothetical dilemma.

To test the hypotheses, each subject's care scores were entered in a $2 \times 2 \times 3$ (Type of therapist [family or individual] by gender by dilemma [individual dilemma, family dilemma, personal dilemma]) repeated measures analysis of variance with dilemma the repeated measure (see Table 4.1, p. 118, for mean dilemma scores; see Table 4.2, p.120 for source table). The individual therapy dilemma was hypothetical and involved an HIV positive client who refused to discontinue sexual relationships. In the family therapy hypothetical dilemma, the family presented requesting the therapist not report the father had sexual relationships with one of the daughters. The personal dilemma was a situation from the informant's own practice that they identified as having involved difficult decision-making. The results of this analysis demonstrated no significant

interaction between therapist type and dilemma type, $F(2, 112) = 1.18$, $p = .310$, indicating that the individual therapists and family therapists did not differ in their care scores within each dilemma. There was also no significant interaction between gender and dilemma type, $F(2, 112) = .74$, $p = .479$. There was however, a within-subject effect for dilemma, $F(2, 112) = 8.67$, $p < .001$. These results indicated that there was a significant difference across the care scores of each dilemma regardless of therapist type or gender. The mean scores for the individual, family and personal dilemmas were 59.28 ($SD = 21.95$), 62.95 ($SD = 22.10$), 73.65 ($SD = 22.96$), respectively. These scores indicated that the therapists were making care-based decisions more than 50% of the time on all of the dilemmas, with the personal dilemma demonstrating the greatest percentage of care-based decisions.

To test the specific hypotheses, planned comparisons were performed to evaluate differences between: (H1) family and individual therapists' care scores on the personal (real-life) versus the hypothetical dilemmas; (H2) care scores of the individual versus the family therapists on the personal (real-life) dilemma; (H3) care scores of the individual versus family therapists on the individual hypothetical dilemma; and (H4) care scores of the individual versus the family therapists on the family hypothetical dilemma (see Figure 4.1).

In the analysis of Hypothesis 1, care scores of the family and individual therapists were pooled because the hypothesis indicated that together, the therapist types would score higher on the personal dilemma than on the hypothetical dilemmas and the repeated measures showed no

interaction effect of therapist type with dilemma. A significant difference was found between the mean care scores for the personal dilemma and the two hypothetical dilemmas, $F = (2, 179) = 6.70$, $p = .0016$, T probability of the contrast of personal versus family and individual dilemmas $< .0001$. The results of post-hoc Tukey-HSD tests were consistent with the findings of the planned comparisons indicating that there was a significant difference between the mean personal dilemma scores and both the individual and family dilemma scores. The difference between the individual and family dilemma scores was not significant. Hypothesis 1 was supported.

Hypotheses 2, 3, and 4 were tested with 2×1 (Therapist type by Type of Dilemma) planned comparisons because the hypotheses addressed therapist type differences within the same dilemma (see Figure 4.1, page 117 for Planned Comparison Weights). There was not a significant effect for type of therapist when the individual therapy, family therapy, and personal real-life dilemmas were assessed separately, $F_{s(1,59)} = .81$, $p = .37$, $.91$, $p = .35$, $.57$, $p = .45$, respectively. Thus, Hypotheses 2 and 4 that predicted significant differences between the individual and family therapists on the personal and family dilemmas were not supported. However, Hypothesis 3 which predicted that scores for family and individual therapists would not differ on the individual dilemma was supported.

Supplementary Analysis of the Dilemma Characteristics

Previous research has suggested that the characteristics of the dilemma more than informant characteristics may influence the type of moral reasoning

utilized (Clopton, 1989; Kerber, 1986). Therefore, supplementary analyses of the dilemma characteristics for which respondent ratings were obtained were calculated.

The means of the ratings of the three dilemmas on degree of perceived interpersonal relationship in the problem, respondent's personal involvement with the problem, perceived importance of the problem, and perceived difficulty of the problem, by therapist type and gender were all inter-correlated (see Table 4.3, p. 121). Correlations for the ratings with gender and therapist type were low and not significant.

According to the results in Table 4.3, respondent ratings of difficulty and importance were significantly correlated within each dilemma type (i.e., difficulty ratings for the hypothetical personal dilemma were significantly correlated with importance ratings for the same dilemma). Personal involvement and importance ratings were also correlated significantly within each dilemma type. Personal involvement and difficulty ratings were significantly correlated within the individual and personal dilemmas. Personal involvement and degree of interpersonal relationship ratings were significantly correlated within the individual dilemma. Personal involvement ratings for the individual dilemma and interpersonal relationship ratings for the family dilemma were also correlated.

Difficulty ratings were significantly correlated with one another across all of the dilemmas. Ratings of interpersonal relationship were also significantly correlated between the personal, individual and family dilemmas.

Ratings means were compared among dilemma types in a series of one-way ANOVAs followed by post-hoc tests with

familywise error rate set at $p < .05$ to assess for significant differences in ratings between the dilemmas. The ratings of importance of the dilemma and degree of difficulty were the only two ratings that demonstrated significant differences between the dilemmas, $F(2, 177) = 23.58$, $p < .0001$, & 6.46 , $p < .01$, respectively. The post-hoc tests indicated that the greatest difference on the ratings of importance was between the personal dilemma and the family and individual dilemmas as shown in Tables 4.4 - 4.7. The mean importance rating for the personal dilemma was significantly lower than the mean importance ratings for both the family and individual dilemmas. Degree of difficulty ratings were found by the Tukey HSD test to be significantly different between the individual dilemma and the family and personal dilemma. The individual dilemma mean rating was significantly higher than the mean ratings for both the personal and family dilemmas.

Regression analysis of ratings by care scores within each dilemma was conducted to further assess the correlations of dilemma ratings. Overall care scores for each dilemma type the dependent variable for each of the three dilemma types. The ratings of difficulty, interpersonal relationship, importance, and personal involvement for the dilemma were entered. The overall F was not significant. The only significant R^2 was degree of interpersonal relationship for the personal dilemma ($R^2 = .117$; $B = 7.53$; $\beta = .35$; $\text{Sig. } T = .01$). The results of this analysis for the personal dilemma can be found in Table 4.8, p.127. Given the overall nonsignificant F and the lack of significant predictors of care scores, it would appear that care scores are not predicted by difficulty, interpersonal

relationship, importance, and personal involvement
assessments by the informants.

Table 4.1.
Mean for Moral Orientation
Scores for Dilemmas 1-3

	Individual Dilemma	Family Dilemma	Personal Dilemma
Family Therapists (N=30)	<u>M</u> 56.73 <u>SD</u> 22.90	<u>M</u> 65.67 <u>SD</u> 22.59	<u>M</u> 75.90 <u>SD</u> 23.70
Individual Therapists (N=30)	<u>M</u> 61.83 <u>SD</u> 21.02	<u>M</u> 60.23 <u>SD</u> 21.64	<u>M</u> 71.40 <u>SD</u> 22.37

	Individual Dilemma		Family Dilemma		Personal Dilemma	
Hypothesis 1	-1		-1		+2	
	IT	FT	IT	FT	IT	FT
Hypothesis 2	0	0	0	0	-1	+1
Hypothesis 3	+1	-1	0	0	0	0
Hypothesis 4	0	0	-1	+1	0	0

FT= Family Therapists
IT= Individual Therapists

Figure 4.1. Planned Comparison Weights

Table 4.2
Source Table for 2 x 2 x 3 Repeated Measure ANOVA
Dilemma is Repeated Measure
(N = 60)

Source	D.F.	SS	MS	F	p
<u>Between Groups</u>					
Within + Residual	56	41705.72	744.75		
Type	1	163.56	163.56	.22	.641
Gender	1	904.80	904.80	1.21	.275
Type x Gender	1	252.07	252.07	.34	.563
<u>Within Groups</u>					
Within + Residual	112	43366.58	387.20		
Dilemma	2	6711.19	3355.59	8.67	.000
<u>Between x Within Groups</u>					
Type x Dilemma	2	916.72	458.36	1.18	.310
Gender x Dilemma	2	573.74	286.87	.74	.479
Type x Gender x Dilemma	2	415.05	207.53	.54	.587

Key: Dilemma = Dilemma Type (Family, Personal, Individual)
Type = Therapist Type (Family or Individual)
Gender = Gender of Therapist (Male or Female)

Table 4.3
Correlations of Ratings for Family and Individual Dilemmas
(N=60)

	IPR Ind	IPR Fam	PI Ind	PI Fam	IMP Ind	IMP Fam	DIF Ind	DIF Fam
IPR Ind								
IPR Fam	.70***							
PI Ind	.47***	.43**						
PI Fam	.20	.24	.75***					
IMP Ind	.13	.10	.33*	.19				
IMP Fam	.13	.10	.30	.30*	.57***			
DIF Ind	.31*	.20	.38*	.25	.35*	.17		
DIF Fam	-.02	.07	.02	.08	.21	.31*	.39*	
Gen- der	-.24	-.11	.00	.18	.06	-.03	.08	-.17
Type	-.13	-.08	-.28	-.24	-.12	-.20	.02	-.09
FAM Care	-.07	-.10	.03	.01	.23	.11	.15	-.02
Ind Care	.06	.11	.04	.09	.08	-.02	.14	.12
Per Care	.03	.04	.07	-.05	.08	.06	.05	-.07

KEY

Per = Personnel Dilemma
Fam = Family Dilemma
Ind = Individual Dilemma
* $p < .01$
** $p < .001$
*** $p < .0001$

IPR = Degree of Interpersonal Relationship
PI = Degree of Personal Involvement
IMP = Importance of the Dilemma
DIF = Difficulty of the Dilemma
Care = Dilemma Scores

Table 4.3 (cont)

	IPR Per	PI Per	IMP Per	DIF Per	Gender	Type	Fam Care	Ind Care	Per Care
IPR Per									
PI Per	.35*								
IMP Per	.34*	.33*							
DIF Per	.21	.52***	.51***						
Gender	.06	.08	-.02	-.05					
Type	.81	-.26	-.02	.05	-.13				
Fam Care	-.004	.14	.08	.03	-.02	-.12			
Ind Care	.15	.04	.24	.20	-.22	.12	.26		
Per Care	.32*	.13	.03	.10	-.06	-.10	.10	.33*	

KEY

Per = Personnel Dilemma
 Fam = Family Dilemma
 Ind = Individual Dilemma

* $p < .01$
 ** $p < .001$
 *** $p < .0001$

IPR = Degree of Interpersonal Relationship
 PI = Degree of Personal Involvement
 IMP = Importance of the Dilemma
 DIF = Difficulty of the Dilemma
 Care = Dilemma Scores

Table 4.4

Source Table for Ratings of Personal Involvement
for All Dilemmas
(N=60)

Source	D.F.	SS	MS	F	p
Dilemma	2	5.03	2.52	1.92	.1495
Error	177	231.92	1.31		
Total	179	236.95			

Tukey HSD

<u>Dilemma</u>	<u>Mean</u>
Individual	3.67
Family	3.73
Personal	4.05

Note: No two groups are significantly different at the .05 level.

Table 4.5
Source Table for Rating of Degree of Interpersonal
Relationship Comparing All Dilemmas
(N=60)

Source	D.F.	SS	MS	F	p
Dilemma	1	1.23	.62	.5054	.6041
Error	177	215.97	1.22		
Total	179	217.20			

Tukey HSD

<u>Dilemma</u>	<u>Mean</u>
Individual	4.02
Personal	4.00
Family	4.18

Note: No two groups are significantly different at the .05 level.

Table 4.6
Source Table for Importance of Dilemma Ratings
Comparing All Dilemmas
(N=60)

Source	D.F.	SS	MS	F	p
Dilemma	2	24.23	12.12	23.58	.0001
Error	177	90.97	.51		
Total	179	115.20			

Tukey HSD

<u>Dilemma</u>	<u>Mean</u>	<u>Sig. Differences</u>
Personal	3.88	Individual & Family
Family	4.62	
Individual	4.70	

Table 4.7
Source Table for Degree of Difficulty
Comparing All Dilemmas
(N=60)

Source	D.F.	SS	MS	F	p
Dilemma	2	14.81	7.41	6.46	.002
Error	177	202.83	1.15		
Total	179	217.64			

Tukey HSD

<u>Dilemma</u>	<u>Mean</u>	<u>Sig. Differences</u>
Individual	4.25	Personal & Family
Personal	3.65	
Family	3.63	

Table 4.8
Summary of Simultaneous Regression Analysis for Variables
Predicting Care Scores with Care Score for Personal Dilemma
as Dependent Variable

Variables	<u>B</u>	<u>SE B</u>	β
Interpersonal			
Relationship	7.530	3.042	.347*
Involvement	.021	3.189	.001
Importance	-3.403	3.749	-.139
Difficuly	2.350	3.739	.103

Note: $R^2 = .118$; $F(4, 55) = 1.84$, Sig. = .14

* $p < .01$

CHAPTER V

DISCUSSION

This project has brought content analysis to the study of ethical decision making of therapists in an effort to inform the development of guidelines for ethical decision making congruent with the theoretical foundation of family therapy. Family and individual therapists were asked to discuss their ethical decision making processes around three dilemmas. The dilemmas were: an individual therapy dilemma that involved an HIV positive client; a family therapy dilemma related to sexual abuse, and a dilemma from the therapist's own practice.

Limitations

The findings of this study were limited by several factors.

1. The sample was limited by its size and its representativeness. It only represents those family therapists who identify themselves as utilizing the therapeutic techniques of paradox, reframing, metaphoric task assignment, invariant prescription, prescribed rituals, positive connotation, ambiguous task assignment and directives and individual therapists who identify themselves as individually oriented therapists.

2. The findings are limited in generalizability to those therapists who do family therapy and utilize the specified therapeutic techniques and to those individual therapists that identify themselves as individual therapists and do not utilize theoretical frameworks consistent with systems/cybernetic theory.

3. The structured interview technique may yield biased results since all informants were volunteers who consented to an interview.

Delimitations

Specific delimitations included in the study were:

1. Each informant was interviewed with the same interview schedule.

2. The research design that elicits real-life narratives of moral conflict and choice from the informants may limit the bias toward ethical decision making from the justice model (Clopton & Sorell, 1993; Walker et al., 1987).

3. Each interview was conducted a trained interviewer.

4. Each interview rater was trained according to the format presented by Argyis et al. (1987) and revised by Clopton (1989). Each interview rater was evaluated on sample interviews and an interrater reliability of 90% was established.

5. Ethical decision making may be affected by the informant's gender. Gilligan (1982) asserted that women are rated lower than men on Kohlberg's scales of moral reasoning because of early developmental experiences. Based on her research with women, Gilligan developed an alternate model for women's moral reasoning. Review of research based on Kohlberg's model of moral reasoning (Walker, 1989; Rest, 1983) has not discovered a clear-cut gender bias in this research. Meyers and Kittay (1987) argue that the differences between male and female responses on moral dilemmas can be attributed more to significance of the dilemma to the individual than to the gender of the decision maker. Clopton and Sorell (1993) found no support for the argument that differences in the use of care and justice

moral reasoning are related to gender in their sample of parents.

Major Findings

The major premise of this study was that there would be a significant difference between individual and family therapists in their process of ethical decision making which evolved from their theoretical orientations. Individual therapists were predicted to favor a justice model because of the emphasis on the rights of the individual in the theoretical models used to direct their practice. Family therapists were predicted to favor a care orientation to ethical decision making derived from family therapy's theoretical focus on understanding relationships within a particular family system. Analysis of the data clearly did not support these predictions.

Both the individual and family therapists demonstrated a preference for a care approach to ethical decision making in both the real-life and hypothetical dilemmas. There was no significant difference between the two therapist types in their preferred decision making style. This preference for care decisions was evident even in situations where the therapist recognized clear legal guidelines that mandated certain behaviors as in the family therapy sexual abuse situation.

Consistently, in all of the dilemmas the therapists would place emphasis on meeting the client's/family's needs and maintaining the relationship with the client. This would indicate practicing therapists have, in their practice, adopted a model of decision making that focuses on values identified with an ethic of care. This was most strongly demonstrated with the care scores for the personal dilemma

selected from the therapists' own practice. The mean care score for this dilemma was 73.65, indicating that the informants utilized care reasoning more than 73 percent of the time on this dilemma. Therapists, regardless of theoretical orientation, appear to share a common ethical foundation which values relationship. It appears that these therapists practice the interpersonal focused care model of ethical decision making that Casas and Thompson (1991) and Stake and Oliver (1991) recommended as providing a more appropriate model for resolving the complex interpersonal relationship issues confronted by individual therapists. This study would suggest that a therapist's ethical perspective supersedes their theoretical orientation when making ethical decisions.

Informant Characteristics

Differences in the use of care and justice reasoning could not be explained by any of the factors related to informant characteristics. The traditional explanation of reasoning differences in decision making, gender of informant, was not found in this study to be related to the increased frequency of care responses. Gender was not related to the increased frequency of care responses. This finding was congruent with the findings of Friedman, Robinson, and Friedman (1987), Walker (1989), and Clopton and Sorell (1993).

The research of Dreyfus and Dreyfus (Benner, 1984) suggested that proficiency at a task influences the decision making process. Those persons with limited experience may rely more on context-free rules for making decisions. Utilizing context free rules for ethical decision making parallels the justice approach for making ethical decisions.

Measures for experience used in this study were supervision and years of therapist experience. It was assumed that those who supervise other therapists had more clinical experience and expertise than those that were not. Again, the difference in decision making seen in this study was not explained by therapist characteristics. Level of expertise did not significantly affect the number of care and justice responses for the therapists in this study. It would appear that dilemma characteristics more than those factors related to informants' gender, experience, theoretical perspectives or training explain the differences found in ethical decision making.

Assessment of the ratings of dilemma characteristics did not provide information that explains the significant differences in the care scores on the personal dilemma and the individual and family dilemmas. The only dilemma characteristic rating that paralleled the pattern found in the care scores of the dilemmas was importance where the family and individual dilemma ratings were significantly different from the ratings for the personal dilemma. This difference did not, however, directly parallel the differences found between the care scores of the dilemmas. When the care scores for each dilemma were assessed, the personal dilemma had the highest rating. When the means for the importance rating were reviewed, the mean ratings for the family and individual dilemmas were higher than the mean rating for the personal dilemma. Thus, although the informants made the most care responses to the personal dilemma, they rated the individual and family dilemmas as more important than the personal dilemma.

Personal Dilemma

The therapists' scores on the personal dilemma supported the first hypothesis suggesting that both groups of therapists would have higher care scores on this dilemma than on the two hypothetical dilemmas. Clearly, informants had greater concern for relationship issues in making a decision about a real-life situation that they selected than in making decisions about hypothetical dilemmas.

Peter and Gallop (1994), Pratt, Golding, Hunter and Sampson (1988), Walker et al. (1987), and Walker (1989) have found that when relationships are perceived as more personal, care reasoning is used more frequently. The only dilemma characteristic that was rated higher for the personal dilemma than the individual or family dilemmas was personal involvement. The present study provides support for the nature of the relationship having an impact on moral reasoning. Personal involvement, however, did not contribute significantly to any of the dilemma care scores in the regression analysis. This would suggest that the relationship between personal involvement and care scores in the present study, although present, is not strong.

Personal involvement as a characteristic that increases the use of care decision making was not supported by the findings of Clopton (1989). Clopton concluded that her findings made "the general proposal that higher levels of personal involvement in a dilemma will cause an increase in the level of care responses even more difficult to defend" (p. 92). The findings of this study, which suggest that personal involvement may contribute to the type of decision making used, support the need to further investigate dilemma characteristics as factors that influence moral choice.

The personal dilemma was rated second for degree of difficulty. This rating does not assist in understanding the high percentage of care responses provided by the informants because its rank as number two for difficulty does not correspond with its rank as number one for percentage of care responses.

In the present study, the preference for care decisions was not strongly statistically associated with the dilemma characteristics assessed after each interview. Continued lack of agreement on the impact of dilemma characteristics on moral reasoning suggests there may be other factors not investigated in this study that may influence informant responses. This supports the recommendation of Clopton (1989) for continued investigation of dilemma characteristics that contribute to decision making preferences.

Individual Dilemma

The lowest scores for care were found on the individual hypothetical dilemma. The individual dilemma addressed an HIV-positive client who indicated that he or she continued to have sexual relationships despite an adequate understanding of the disease process. Lack of difference between the two therapist groups on their decision making approach to this dilemma supported the third hypothesis of the study. This would suggest that theoretical and professional characteristic differences between the therapist groups did not influence their reasoning on this individual therapy based hypothetical dilemma.

When reviewing the dilemma characteristics, this dilemma received the highest scores for importance and degree of difficulty and the lowest scores for personal

involvement. These ratings of dilemma characteristics suggest that of the hypothetical dilemmas, this one was perceived as the most difficult and important, however, this dilemma received the lowest personal involvement score of all of the dilemmas. The low score on the personal involvement does, however, parallel the findings of Pratt et al. (1988), and Walker et al. (1987) that suggest personal involvement or relevance may contribute to an increase in care responses. Clopton and Sorell (1993), however, reported mixed support for the interaction between care scores and personal involvement or relevance. It must be remembered that the relationship between care scores and dilemma characteristics for this study did not produce statistically significant results and, therefore, cannot be considered to provide strong support for the link between dilemma characteristics and care scores. The lack of consistent patterns linking ratings of dilemma characteristics and the care score of dilemma continues to suggest that additional factors not evaluated in this project contributed to the informant's method of ethical decision making.

The low care score for this dilemma could possibly be related to the lack of familiarity therapists had with this issue. Lack of therapist experience with this issue is supported by the characteristics of difficulty and importance being rated the highest for this dilemma. If therapists have had no experience with the situation, they may find it more difficult to resolve the issues and may perceive that it would be an important issue. A lack of familiarity could encourage therapists to appeal more to authority or legal remedies in decision making which would be reflected in a lower care score.

Family Dilemma

This dilemma involving sexual abuse in the family received the second highest care score. Dilemma characteristic scores rated this situation as number one for degree of interpersonal involvement and the lowest for difficulty. It received the number two rating for degree of personal involvement. Again, the dilemma characteristic scores provide little information about the care scores for this dilemma since they are not consistent with the dilemma's care score. The degree of personal involvement rating parallels the second position care score ranking. Again, however, this characteristic did not enter the regression analysis as a significant predictor of care scores. Since the relationship between degree of personal involvement and care score was not statistically significant, this provides additional support for Clopton's (1989) conclusion that defending this characteristic as a contributor to increased care responses is difficult.

The low difficulty rating could possibly be related to the clear legal guidelines provided for resolving issues related to child abuse. Legally, therapists are required to report abuse to the appropriate agencies of social control. Although there are clear legal guidelines to provide initial direction for therapist decision making, the care score of 62.95 indicates that at some point the informants are integrating decisions that move away from a pure legalistic response and incorporate a response to relationship issues. Tomm (1992, 1995) and Ryder and Hepworth (1990) have argued that the current professional guidelines do not reflect interpersonal complexities and recommend that the professional organization adopt methods of addressing ethical situations in a manner that reflects these concerns.

If the low difficulty rating is linked to the presence of legal guidelines and the care score reflects the informant's need to maintain a relationship with the family while responding to the legal demands of the situation, the results of this study provide some support for the current discussion about AAMFT's guidelines on dual relationships. The present study suggests that therapists are responding to a complex moral/legal situation in a way not currently being considered by the professional organization since the current professional guidelines favor a justice perspective.

Dilemma difficulty ratings could also be influenced by the frequency with which the therapists encounter the problem. If many therapists have encountered this issue in their practice, they may have developed strategies for resolving the issues prior to the presentation of the dilemma in this study, in turn decreasing the perceived difficulty of the dilemma.

Reliability

Caution should be exercised when applying the results of the present study that did not support the hypothesized relationship that family and individual therapists would differ in their decision making style. This finding contradicts the current theories that suggest family therapists make ethical decisions differently than individual therapists because of their theoretical foundation (Becvar & Becvar, 1988; Goldberg, 1993; Hare-Mustin, 1980; Hare-Mustin et al., 1979; Hines & Hare-Mustin, 1978). This was the initial application of this design to the exploration of therapists' ethical decision making using a very select population.

Additionally, the complexity of the coding system is important to consider when reviewing the interview ratings. Ideally, coding systems should clearly define what is to be coded and provide conceptual clarity about the coded labels (Gravin, Kennedy, & Cissna, 1988). Clopton (1989) reported interrater reliability of .75 and .73 for the coding of her interviews. Lyons (1983) reported correlations of .70, .71, and .82, while Walker (1989) reported .88 when using a coding process similar to the one utilized for this study. This study achieved interrater reliability of 90% total agreement after an intensive training period for the coders. This was well within acceptable levels of reliability and congruent with that achieved by similar studies that strengthens findings of this study.

Clopton (1989) also discussed concerns in establishing interrater reliability for her study. She addresses the difficulty of utilizing Gilligan's (1987) conceptualization of care and justice that originates from lack of conceptual clarity. As reported in Clopton, Gilligan suggests that a redefinition of validity and reliability may be necessitated by this design. However, as was found in this study, the difficulties of coding may be addressed, in part, by utilizing highly qualified coders combined with the increased use of context cues when identifying codeable entities. Rather than redefining validity and reliability, this study suggests that addressing issues of conceptual clarity for care and justice coding may be more productive. Support for this approach and for the findings of this study is provided by the .90 total agreement achieved in this study. Certainly this is a challenging aspect of this content analysis design that warrants continued analysis and refinement.

Implications of the Study

The most outstanding result of this study is that family and individual therapists do not differ significantly in the frequency with which they utilize care as a model for making ethical decisions in both real-life and hypothetical situations. Additionally, both types of therapists select a care response greater than 50% of the time when making ethical decisions. This indicates that despite theoretical orientation, therapists are making ethical decisions based on relationship concerns and responses to client's needs, as opposed to a reliance on justice and individual rights. Fry (1989) has suggested that traditional ethics, utilized by professional associations, support equal treatment of all individuals that is congruent with the justice perspective. When this outcome is viewed with an understanding that the ethical codes of professional organizations emphasize justice ethics, it clarifies the concerns expressed by therapists that the professional ethical codes do not address their needs.

Critics of the current ethical perspectives in family therapy (Becvar, Becvar & Bender, 1982; Goldberg, 1993, Hare-Mustin, 1980; Hare-Mustin, Marecek, Kaplan & Less-Levinson, 1979; Hines & Hare-Mustin, 1978; O'Shea & Jessee, 1982; Taggart, 1982) have consistently argued that family therapy is uniquely different from individually focused therapies because of its theoretical foundations in systems theory. Evolving from this perception of difference is concern about ethical decision making utilized by family therapists (Becvar, Becvar & Bender, 1982; Goldberg, 1993, Hare-Mustin, 1980; Hare-Mustin, Marecek, Kaplan & Less-Levinson, 1979; Hines & Hare-Mustin, 1978; O'Shea & Jessee, 1982; Taggart, 1982). As a result of this difference, it

has been suggested that either family therapy needs to develop a unique set of ethical principles to guide this different practice or because of this difference, family therapists violate ethical guidelines that support individual rights. Clearly, the results of the present study do not provide support for emphasizing the difference in ethical decision making between individual and family therapists. Neither family nor individual therapists demonstrated a preference for justice decision making and appear to be more alike than different in their approach to ethical decision making. Their bias is for care-based decisions. This is reflected most strongly in their decisions related to a personal real-life dilemma choosing a care response 73.65% of the time. The results of this study would suggest that it is time for professional organizations to reevaluate their traditional approaches to ethical decision making and incorporate care-based reasoning into their guidelines.

The complexity of developing a professional code of ethics that respects a care perspective presents a unique challenge to therapy professions that have traditionally functioned from justice-based models. The process of applying the nontraditional ethics of care to health care situations is currently being explored by feminist ethicists. Holmes and Purdy (1992) provide examples of this pioneering work in their edited work that includes the articles from two special issues of Hypatia: A Journal of Feminist Philosophy on feminist medical ethics. More recently Rave and Larsen (1995) have also attempted to address the issues related to developing alternative ethical systems for therapists using a feminist perspective. The model of ethical decision making described in this book

attempts to combine the rational-evaluative process with the feeling-intuitive process. The feeling-intuitive process includes contextual information and particular therapist and client characteristics in the decision making.

Professional therapy associations should begin dialogues with their constituents that explore ethics of care and the implications that this orientation has for future decision making. Moving to a care-based ethic would provide family therapists with an ethical model that is more congruent with system/cybernetics theory as discussed earlier. Evidence provided by this study that demonstrates family therapists already favor the ethic of care when faced with ethical decisions should facilitate revision of professional ethical codes. This addresses the concerns expressed by several authors (Goldberg, 1993; Ryder & Hepworth, 1990; Tomm, 1992, 1995; Wylie, 1989) related to the need to address the natural complexity of relationships in decisions. Clearly, the ethics of care recognize the importance of context and relationship and place the ethical decision in the context of the relationship.

Recommendations for Further Research

The present study established that both individual and family therapists interviewed prefer using care-based decisions in their practice of therapy when addressing both real-life and hypothetical dilemmas but more so on real-life. Further research is clearly needed to expand the exploration of this finding to a broader sample of therapists.

Although characteristics of the dilemma appeared to affect the type of decision making utilized, this study did not produce clear information on the relevant

characteristics. The present study continues to add support to the growing body of knowledge that dilemma characteristics contribute to moral reasoning styles (Clopton, 1989; Pratt et al., 1988; Peter & Gallop, 1994; Walker et al., 1987; Walker, 1989). Findings are not consistent in identifying those characteristics that contribute to differences seen in moral reasoning. Continuing efforts to define the dilemma characteristics that affect moral choice are strongly indicated by consistent findings that suggest dilemma type more than any other factor influences moral choice. Factors that could contribute to lack of consistency in identifying dilemma characteristics that influence choice should be examined. Definition of the characteristics and consistency in measuring these variables are possible areas for further development. Those characteristics that have been consistently evaluated are personal involvement and degree of interpersonal relationship. Additional characteristics that have been measured and provided mixed results are degree of difficulty and importance. In this study, evaluation of the care scores on the hypothetical dilemmas demonstrated that the lowest scores were given to the individual dilemma which was rated highest in difficulty and importance. This could indicate that dilemmas perceived as important and that challenge decision making capacities elicit more justice responses. Certainly, this suggests that further investigation of these characteristics is warranted.

The effects of gender on moral choice were again explored. This study added to the growing evidence that gender is not an important variable in determining care and justice responses. Continued investigation of demographic

factors that may have influence on moral choice could include further refinement of professional experience and educational preparation as variables since they have been identified by Benner (1994) as influencing professional decision making. These variables may have influenced the decision making in a manner not identified by this study.

Finally, professional associations could begin to develop alternative guides of ethical decision making. These models could be tested with professional ethics committees in their real-life deliberations and with focus groups utilizing hypothetical dilemmas.

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APPENDIX A
INSTRUMENTS

Phone Contact Data

Name: _____

Address: _____

Phone: _____

1. Family therapist____; Psychologist____ Individual
therapy__ Other____ (please specify)_____.

2. Do you use any of the following techniques in your
therapy (Check all that apply)? paradox__, reframing__,
metaphoric task assignment__, invariant prescription__,
prescribed rituals__, positive connotation__, ambiguous
task assignment__, directives__.

3. **Date, time, and place of scheduled interview:** _____
Informant's home, office or telephone
interview? Describe: _____

4. **Date interview completed:** _____

5. **Do they want summary of study results?** _____

File separately without identifying subject number.

CONSENT FORM

Title

Ethical Decision-making Among Family and Individual Therapists

Introduction

I, _____, have been asked to participate in this research study which has been explained to me by Susan Newfield, R.N., M.S.N., C.S., who is a faculty member of West Virginia University and a Ph.D. candidate at Texas Tech University, or her authorized representative. This study is being conducted in partial fulfillment of the requirements for the Ph.D. in Marriage and Family Therapy degree.

Purpose of the Study

The purpose of this study is to learn more about the decision-making of family and individual therapists when they are faced with difficult choices in their professional practice.

Description of the Procedures

I understand that I will be asked to describe the decisions I would make/made in three situations. Two of the situations will be hypothetical and provided by Ms. Newfield or her representative. The third situation will be a situation that I describe as having been a difficult choice in my own therapy practice. The presentation of each of these situations will be followed by questions from a trained interviewer that will provide more information about my decision-making related to the choice I identify. This interview will be audio-tape recorded. In addition to the interview, I will be asked to complete two forms. The first form provides basic information about my professional preparation and additional professional development experiences. The second form will ask me to rate the three situations on a five point scale.

The study requires that I meet with the trained interviewer for no more than two hours. This meeting will occur at a time and place that is mutually determined by myself and the interviewer and may occur during a telephone conversation. There will be approximately 60 therapists interviewed for this project.

Risks and Discomforts

There are no known or expected risks from participation in this study, except for the risks that occur with personal self-disclosure, however, I understand that the information I give will remain as confidential as legally possible and be used only for the research proposed by Ms. Newfield.

Benefits

I understand that this study is not expected to be of direct benefit to me, but the knowledge gained may contribute a more complete understanding of the processes used by therapists to make decisions when faced with difficult choices. This information could assist educational programs and professional organizations to better meet the needs of practicing therapists. I also understand that I can request a summary of this study from Ms. Newfield to enhance my knowledge of the study topic.

Contact Persons

For more information about this research, I can contact Susan Newfield Monday through Friday during the day at 304-293-2331 or at 304-599-8755 after 6:00 p.m. and on weekends. Ms. Newfield's mailing address is: 3027 HS North, Robert C. Byrd Health Sciences Center, West Virginia University, PO Box 9610, Morgantown, WV 26506-9610. I may contact the dissertation supervisor, Gwendolyn T. Sorell, Ph.D., by phone at 806-742-3000 or by mail to: Texas Tech University, Department of Human Development & Family Studies, PO Box 41162, Lubbock, Texas 79409-1162. If I have questions about my rights as a research participant, I may contact the West Virginia University Institutional Review Board at 304-293-7073 or the Texas Tech University Vice Provost for Research at 806-742-3884, Room 203 Holden Hall, Texas Tech University, Lubbock, Texas 79409-1035.

Confidentiality

I understand that any information about me obtained as a result of my participation in this research will be kept as confidential as legally possible. I will not be identified in any reports made of this study, and all information about me will be coded so that my name will not be on it. All data, including the code number/subject name list, will be kept secure in a locked file cabinet accessible only to the investigator. Tapes from the audio taped interviews will be coded so that no identifying information is on the cassette. They will be kept in a secure locked file cabinet and will only be used to complete the goals of this project. Only code numbers will be used when the tapes are transcribed, no names or personally identifying information will appear on the transcriptions, and tapes will be erased after the transcriptions are made. In any publications that result from this research, neither my name or any information from which I might be identified will be published.

Voluntary Participation

Participation in this study is voluntary. I understand that I am free to withdraw my consent to participate in this study at any time. Refusal to participate or withdrawal will involve no penalty or loss of benefits nor will it affect my current or future relationship with West Virginia University or Texas Tech University. I have been given the opportunity to ask questions about the research, and I have received answers concerning areas I did not understand and by signing this form, willingly give my consent to participate in this study. Upon signing this form, I will receive a copy.

Signature of Participant: _____ Date: _____

Signature of Project Director
or Authorized Representative: _____ Date: _____

Demographic Data for Therapists

Subject Number _____

1. Age _____ 2. Sex _____

2. Family therapist _____ Individual therapist _____

3. Highest Professional Degree

Bachelor's _____ Master's _____ Doctorate _____

4. Professional certifications: i.e., AAMFT Clinical Member, clinical psychology, ACSW, Nurse Clinical Specialist, etc. _____

5. Primary professional identification: i.e., psychology, medicine, social work, nursing, etc.

6. Theoretical identification: (mark all that apply)
strategic _____; structural _____; brief
therapy _____; individual psychodynamic _____;
individual behavioral _____; family behavioral _____;
family psychodynamic _____; MRI/communication _____;
experiential/Whitaker _____; solution-focused _____;
systems/cybernetic _____; other (please
specify) _____.

7. Do you use any of the following techniques in your therapy (check all that apply)? paradox____, reframing____, metaphoric task assignment____, invariant prescription____, prescribed rituals____, positive connotation____, ambiguous task assignment____, directives_____.

8. How often do you use these techniques in your therapy?

Paradox:

Always	Often	Less than once a week	Seldom	Never
5	4	3	2	1

Reframing:

Always	Often	Less than once a week	Seldom	Never
5	4	3	2	1

Metaphoric task assignment:

Always	Often	Less than once a week	Seldom	Never
5	4	3	2	1

Invariant prescription:

Always	Often	Less than once a week	Seldom	Never
5	4	3	2	1

Prescribed rituals:

Always	Often	Less than once a week	Seldom	Never
5	4	3	2	1

Positive connotation:

Always	Often	Less than once a week	Seldom	Never
5	4	3	2	1

Ambiguous task assignment:

Always	Often	Less than once a week	Seldom	Never
5	4	3	2	1

Directives:

Always	Often	Less than once a week	Seldom	Never
5	4	3	2	1

9. If you are a family therapist where did you get your preparation for this? (Check all that apply) family therapy graduate program____ (masters, PhD), other post bachelors graduate program____, workshops____, special training at an institute____, (how long was this program?____), reading books and journals____, other (please specify)_____.

10. If you are an individual therapist, where did you get your preparation for this? post bachelors graduate program____, workshops____, special training at an institute____, (how long was this program?____), reading books and journals____, other (please specify)_____.

11. Are you licensed? Yes____, No____. If yes please describe_____.

12. Professional organization memberships (Please list)_____
_____.

13. Number of years you have been doing therapy?_____.

14. What percentage of your time is spent doing the following types of therapy? individual____; conjoint____; family/marital____; group____; other (please specify)_____.

15. Number of hours per week you do direct therapy._____

16. Do you supervise others doing therapy? Yes__, No__. If yes, please describe_____

17. Have you ever been involved in a professional ethics committee?

Yes____, No_____.

18. Have you ever been involved in an educational program on professional ethics? Yes__, No__. If yes, please describe, briefly._____

_____.

Interview Schedule

NOTE: These questions should follow references to judgements about the situation. Have the informant also elaborate on feelings in a manner that assists in understanding how they relate to the choices involved in the situation. Also ask for elaboration on moral language. Have the informant talk about the shoulds and oughts etc, i.e. What makes this something one should do or that you thought you should do? Your goal is to have the informant paint as complete a picture as possible about the decision they made in the situation.

I am trying to understand how therapists make difficult choices in their professional practice. I would like you to tell me about a difficult choice you have had to make, a decision that involved a situation where you weren't sure what to do.

1. What was the situation? (Be sure to get a full elaboration of the situation. Remind informants not to use names or provide other information that could be used to identify the client).
2. What was the conflict for you in that situation? What made it a conflict?
3. In thinking about what to do, what did you consider? What made these important considerations? Was there anything else you considered?
4. What did you decide to do? What happened as a result of this decision?
5. Do you think this was the right thing to do? Why/why not?

6. What was at stake for you in this situation? What was at stake for others? In general what was at stake?
7. How did you feel about the decision? How did you feel about it for the other(s)?
8. Is there another way to see the situation, other than the way you described it?
9. When you think back over the situation, do you think you learned anything from it? What did you learn?
10. Do you consider the situation a moral problem? Why/why not?
11. What does morality mean to you? What makes something a moral problem for you?
12. Do you think that this decision fit the ethical guidelines provided by your professional association (AAMFT or APA)? Describe how it did or did not fit.
13. What made it (difficult or easy) to apply the ethical guidelines from your professional association to this situation?
14. Do you have any recommendations for your professional association about the ethical guidelines they provide for their members?
15. What might you tell a new therapist about the ethical guidelines provided by your professional association and the practice of therapy?

Hypothetical Dilemma Interview Schedule

I'm going to read you a therapy situation, and I'd like to know your answers to some questions about the situation. There aren't any right or wrong answers to the questions I will ask. I just want to know your opinion.

After many sessions a client informs you that they have tested positive for AIDS. When you discuss this with them, they demonstrate an understanding of the disease process and mode of transmission. Although the client has been aware of this condition for several months, they have continued to engage in sexual relationships. The client indicates an unwillingness to discontinue sexual activity or to discuss this information with past and present sexual partners.

What would you do?

Why did you decide to do that?

What was the conflict for you in this situation?

In thinking about what to do, what did you consider?

Was anything else considered?

How did you decide what to do?

What made you decide to do that?

What were your responsibilities or duties in the situation?

Did you make the right decision? Why or Why not?

What was at stake for you in the decision?

What was at stake for others?

How do you feel about it?

Is there another way to see the problem other than the way you described it?

When you think back over the situation, do you think you

learned anything from it?

What did you learn?

Now I will read another situation and I'd like to know your answers to some questions about this story, too.

A family referred themselves to your office to address communication issues. The family consisted of five persons at home; mother, father, two daughters and a son. After several sessions, it was disclosed that sexual abuse had occurred to the oldest daughter by the father. The father had stopped the abuse several months ago, and the family indicated that their primary reason for seeking therapy was to address issues related to the abuse. The family had kept this a secret and confided in you with the request that you not bring others into the situation because they felt the problem was in the process of being resolved. To date this family has worked hard in therapy and all family members, including the father and daughter, seem highly motivated to continue the work in therapy. The father has agreed to a contract with you around the issues of abuse.

What would you do?

Why did you decide to do that?

What was the conflict for you in the situation?

In thinking about what to do, what did you consider?

Anything else you considered?

How did you decide what to do?

What made you decide to do that?

What were your duties or responsibilities in the situation?

What were the duties or responsibilities of others in the situation?

Did you make the right decision?

Why/why not?

What was at stake for you in the decision?

What was at stake for others?

How do you feel about it?

Is there another way to see the problem, other than the way you described it?

When you think back over the situation, did you learn anything from it?

What did you learn?

RATINGS OF THE PROBLEMS CONSIDERED

Please rate each of the problems you considered.

Degree of interpersonal relationship in the problem

Problem about client's sexual activity:

Very High	High	Moderate	Low	Very Low
5	4	3	2	1

Problem about family's concerns:

Very High	High	Moderate	Low	Very Low
5	4	3	2	1

Problem you provided:

Very High	High	Moderate	Low	Very Low
5	4	3	2	1

Your personal involvement

Problem about client's sexual activity:

Very High	High	Moderate	Low	Very Low
5	4	3	2	1

Problem about family's concerns:

Very High	High	Moderate	Low	Very Low
5	4	3	2	1

Problem you provided:

Very High	High	Moderate	Low	Very Low
5	4	3	2	1

Importance of the problem

Problem about client's sexual activity:

Very High	High	Moderate	Low	Very Low
5	4	3	2	1

Problem about family's concerns:

Very High	High	Moderate	Low	Very Low
5	4	3	2	1

Problem you provided:

Very High	High	Moderate	Low	Very Low
5	4	3	2	1

Difficulty of the problem

Problem about client's sexual activity:

Very High	High	Moderate	Low	Very Low
5	4	3	2	1

Problem about family's concerns:

Very High	High	Moderate	Low	Very Low
5	4	3	2	1

Problem you provided:

Very High	High	Moderate	Low	Very Low
5	4	3	2	1

APPENDIX B
GUIDE FOR INTERVIEWERS

GUIDE FOR INTERVIEWERS

Phone Contact to Set Up Interview

1. Have the phone contact form and a pen or pencil.
2. Obtain the individual's name.
3. Verify that the individual is a family therapist or does individual therapy.
4. Verify that the family therapist does strategic therapy or uses the techniques identified on the phone interview form.
5. If the individual does not meet the criteria for the study, explain that they do not fit the criteria for the study and thank them for their interest.
6. If the individual meets the criteria, schedule the interview at a place and time agreeable to both of you.
7. Explain that the interview will take at least an hour of uninterrupted time because of the need to concentrate on the interview questions.
8. Obtain clear directions to the meeting place and obtain a mailing address so the summary can be mailed.
9. The interview will usually be about one hour long, but schedule at least two hours so the interview will not be rushed.

Before the Interview

1. Prepare tape recorder, two extra batteries for the recorder, the proper questionnaire and an extra, 3 hours of tape, labels for the tapes, and two pens or pencils, and directions to the interview location.

2. The questionnaire should be numbered with the informant number. Use consecutive numbers starting with the number 1. Place your interviewer code after the informant number, i.e. 1A would code the first interview for interviewer A.
3. Arrive on time or arrange another time if a problem arises and you cannot keep the appointment.

During the Interview

1. Place the tape recorder as near the informant as possible. Set the recorder on "conference" with the volume on maximum. Be aware of room and outside noise that could interfere with the quality of the tape. Eliminate as much of this noise as possible.
2. Begin the interview schedule. Do not refer to the informant's professional identification in the interview and request that the informant do the same. Also request that the informant not use names of client's in the situation to maintain client confidentiality.
3. Check the tape recorder occasionally to be sure it is running. If you lose part of a response while turning the tape over, ask the informant to repeat the information.
4. Allow the informant all the time he/she needs to consider the response. Silence and patience are often quite effective in drawing out responses. Give the impression that you have all the time in the world.
5. Listen carefully to the responses and show interest in what they think. Phrases which encourage responsiveness should be utilized. These include "Please continue",

"Could you help me to understand a little more about---", "Could you elaborate on----", "Can you give me an example of---", and "What are some other ways you could think about that".

6. Always check to make sure the information in the primary and follow-up questions is addressed. If the informant has addressed the information in the primary question the follow-up questions may not be necessary. If the "why/why not?" choice does not seem appropriate, other probes may be used. Remember to phrase probes neutrally in a manner that does not suggest an answer to the informant. If you follow-up on a particular response, be sure to use the language of the informant. Do not rephrase. You should continue to probe the informant's responses until a reason has been given for the moral choice. Explanations such as "It's just something inside me," or "That's just the way I was raised," or "It seemed like the best thing to do at the time" are not really reasons and should be probed further.
7. If the respondent seems to hesitate, you may reassure him/her that the question is difficult and that there are no right answers, but that you would like to know what they think.
8. Have the informant complete the questionnaire before the interview.
9. Ask the informant whether they would like a summary of the results of the study. If they would, make a note on the piece of paper with their address.

After the Interview

1. Following each interview, immediately label each tape with the informant number.
2. Turn in the informant's name and address, completed questionnaire with informant number, and tapes with informant numbers attached to the primary investigator. The informant's name and address should be on a separate piece of paper so that it may be filed separately to protect confidentiality.
3. After the transcript has been typed, you may be asked to listen to the tape and proof the transcript if there were areas that were difficult to transcribe.

APPENDIX C
RATING MANUAL

RATING MANUAL

To do a rating, you must allow at least two hours time. You should do the ratings in a quiet room where you will not be interrupted. You will need two colored erasable pencils: red and blue. Read and study the entire rating manual before doing any rating. Rating should be done on a copy, not the original transcript. You will be provided with the appropriate copies to do the ratings. You will be provide with sample sections to practice your coding. Your coding on these practice interviews will be compared with others' coding the same material to increase the consistency in coding between coders. This process will be repeated and refined until the coders are rating the sample text in a similar manner consistently.

As you read, consider each coherent distinct thought in the response individually. A distinct thought may be a sentence or a phrase, or occasionally may be more than one sentence. For instance, the sentence "I understand that they have a situation which is very hard on them, but they should still obey the rules," contains two independent thoughts: (1) "I understand that they have a situation which is very hard on them," and (2) "they should obey the rules." However, the sentence "Kids really do love their parents even though they act like they do not," only contains one coherent thought, because the phrase "even though they act like they do not" cannot stand alone and make any sense. A complete thought may at times, be more than one sentence.

Consider whether the distinct thought is moral statement or not. A statement should be considered moral if it considers conflicting values and makes choices among

those values. Each time a distinct thought indicates that the self is thinking about a conflict, making a choice, or giving reasons for a choice, the distinct thought should be considered a moral statement.

Terms which may be clues to moral language include words, such as: desire, consider, choose, evaluate, commit, judge, ask, resist, refuse, try, explore, found, abstain, feel, learn, realize, think, question, decide, want, know, believe, and similar words. It is not necessary to find any of these particular words, nor does the appearance of the words necessarily indicate moral consideration. Instead, the context of the story (i.e., related statements preceding or following, the general tone of the interview, any other evidence that appears to assist in clarifying the intent of the statement of interest) should be considered to help decide whether or not an individual statement is a moral statement. A conscious decision to do nothing should be considered an active choice and therefore underlined.

Do not underline details that seem unrelated to the moral conflict. These would be asides, disconnected thoughts, or stories which are not directly related to the larger conflict or the decision to be made. If the informant describes someone else's perception of or statements about the conflict, the statement should be underlined only if the informant indicates agreement or disagreement with the statement. For instance, the informant's description of his/her colleague's attitude should not be underlined, unless he/she indicates agreement or disagreement.

Once you have identified a moral statement, you will need to decide whether the statement is a care or justice

statement, or whether it is not clear what orientation is being described. Care approaches will be identified by their emphasis on issues or relatedness, mutual dependence, and the obligation to avoid hurt or selfishness. Justice approaches will be identified by their focus on abstract principles, rationality, and the tendency to distance oneself from the individuals involved in a dilemma. The last five page of the manual clarify the care and justice approaches. Please carefully read and study these descriptions before doing any ratings. Be sure that you understand both concepts clearly. If you have any questions please do not hesitate to discuss them with the investigator.

Use a red pencil to underline care considerations. Use blue for justice. Be sure to consider the context for each statement (the statement proceeding and following and any other relevant information) rather than individual words. If a statement is surrounded by another color, think carefully about whether the informant really is changing the point of view before marking a different color. Short statements which give no reason should not be underlined.

Similar words may be used in either care or justice considerations, but the underlying understanding of the dilemma will be different in each approach as described on the last two pages of the manual. You will have to carefully consider all the information available to you and consider all the possible ways of interpreting each individual statement in order to correctly interpret this underlying meaning. Some statements will remain unclear even after careful consideration. These ambiguous statements should not be underlined.

It is not necessary to memorize the instructions. Refer to this manual as often as you need to as you make the ratings.

In summary, the procedure is to first read the whole interview for a general understanding. On the second reading, first identify each distinct coherent thought in the response. Then decide whether the coherent statement is a moral statement or not, using the guidelines from the manual. If it is not a moral statement, do not underline it. If it appears to be a moral statement, decide whether it is a clear care statement, a clear justice statement, or ambiguous. If it is ambiguous, do not underline it. If it is clearly an example of one approach, underline the care statements in red and the justice statements in blue.

CARE

Concerned with the complexities of attachment within relationships, attempts to find a balance to meet everyone's needs

Vulnerability is connected with abandonment

Tolerance of exceptions to the rules

Greater use of innovation

Inattention to details of rules

Trusts feelings, logic or reasoning may be used to identify individual needs or consequences for individuals

Strives to meet needs and to be inclusive

JUSTICE

Concerned with issues of fairness, individual rights, and adherence to standards or principles, principles may be in conflict

Vulnerability is connected with oppression & injustice

Tolerance of individual harm when necessary to allow adherence to principle

Greater regard for precedent

Elaboration of rules

Trusts logic, reasoning and logic focus on rules and principles, what is right or wrong

Strives for equity and consistency

Interested in personal details about the individuals in a particular situation

Metaphor is network or web, connection

Organizing dimension is attachment/detachment

Greatest evil is hurt

Moral question is "How to respond?"

Self perceives and responds, reliance on personal experience

Effort to teach understanding, argument should be avoided if possible, understanding is more important than agreement

Listening is important tool

Detached or impartial in decision making, personal details seen as irrelevant

Metaphor is hierarchy or balance, separation or individuality

Organizing dimension is inequality/equality of treatment

Greatest evil is injustice

Moral question is "What is just?"

Self judges, setting an example is a concern

Effort to reach agreement, through argument if necessary, or by appeal to authority

Respect is important tool

Detachment is seen as a problem, not a virtue

Responsive

Decisions tentative

Assumes a basis for agreement and understanding which is unlearned and without structure

Happiness or emotional satisfaction are the goals

Considers special needs of the individual

Relationships: Involve networks of relationships caring, responsiveness to needs

Responsibilities: Stem from relationships to others, vary according to the situation and person, awareness of need

Care is seen as a mercy, a decision to modulate strict demands of justice

Active

Decisions final

Assumes an external structure will be needed to reach agreement (e.g. logic, law, religious beliefs). Rules must be taught.

Independence and autonomy are the goals

Treat all persons the same regardless of special needs

Relationships: Involve hierarchies or authority, balance, tit for tat, role models

Responsibilities: Stem from rules of conduct, agreements, or form position, are invariant among situations and

persons, rules may need elaboration or exception for specific situations

Fairness: Arises when each person's needs are meant

Fairness: Arises when each person is treated equally or according to rules or agreements

Rights: Derive from relationships, considers the context

Rights: Derive from rules and the obligation to treat persons equally

Trust: Being sure the person will react in a loving and caring manner

Trust: Being sure the person will react in a fair and just manner, or will follow rules agreed upon

Decisions: Made by becoming involved with the feelings and needs of those involved

Decisions: Made by distancing oneself from personal involvement, using logic

Selfishness: Is a concern for the interpersonal harm it will cause to persons

Selfishness: Is a judged wrong, a cause of injustice

Wrong: Hurt, insensitivity, carelessness

Wrong: Violation of principles or rules

Guilt: Stems from causing

Guilt: Stems from violation

hurt or damaging the
relationship

Keywords: Hurt, sacrifice,
caring, relationship,
selfishness, isolation,
interdependence, need,
response, acceptance

of rules or principles

Keywords: Justice,
rationality, rights,
principles, independence,
obedience, autonomy,
fairness

Care Statement Examples

1. Considering how one person's attitude will affect others.
2. Talking about what a person needs is nearly always care.
3. The need to "walk in someone's shoes" or to understand is care.
4. Concerns about the effect of certain actions on the whole family are care.
5. Considering the special circumstances relevant to a person's age, experience, knowledge is care.
6. Trying to make a choice for the individual as the individual would want the choice made is care.
7. Wanting to know more details or gather more information before making a decision is care.
8. Concern about resolving conflicts in a manner that restores relationships or connections between people is care.
9. Concern that good will come to others or that hurt/suffering will be stopped is care.
10. Considering the interdependence of people in relationships or considering relationships as webs is care.

Justice Statement Examples

1. A concern with reputation or good name.
2. If a statement is supported because "That's the way I was raised." or a concern with teaching the person right from wrong.
3. Avoiding second thoughts, sticking to a course of action or decision regardless of consequences. Standing up for what one believes in.
4. Talking about something that would be "just as bad" as something else.
5. An attempt to "make it up," in other words to balance the scale or compensate.
6. "It's the Lord's will" and similar statements are justice.
7. Wanting to be an honest, upright, law abiding person.
8. Wanting to treat everyone equally.
9. Concerns about obligation and duty related to equality and fairness in relationships are justice.

Differentiating Care and Justice

1. Statements that talk about feelings of support, not being in it alone, knowing that others understand are care. If they just acknowledge that others have had the same experience while focusing on fairness issues, that is justice.
2. A focus on consequences for the individual, such as a jail term if they steal and how that will affect the relationships, is care. If the jail term is considered deserved punishment for wrongdoing, that is justice.
3. When considering the best thing for the individual, if the concern is the individual's emotional well-being or individual needs and wishes or how others will react to the individual that's care. If the concern stems from the therapist's position as the responsible person making judgements without reference to the individuals reaction, that's justice. This type of concern will often be unclear unless the additional elements indicating either care or justice are present.
4. If considering the individual's trust or confidence in the therapist, concern with the individual's emotional state is care, concern with maintaining the individual's obedience or respect is justice. This may also often be unclear.
5. Concern with consistency is care if the reason for the concern is to avoid confusing the individual or a concern about the individual's reaction. A concern with consistency, sticking with a decision not changing or doubting a decision reflects justice reasoning if these other concerns are not present.

6. When considering interactions between the therapist and client, the concern is justice if the person is considering the therapist as role model or teacher. The concern is care only if the concern is for how the client will feel or react.
7. Wanting the client or other professional to listen in order to obey or follow rules is a justice concern. Wanting them to listen in order to understand is a care concern.
8. A concern with weighing options is justice. However, this must be differentiated from considering the consequences for individuals which is a care concern.
9. A concern with balancing various needs is a justice concern if the emphasis is on balance or fairness, care if the emphasis is on considering individual needs.
10. "Black and white" is justice. "Shades of gray" is care.
11. Loyalty is usually care unless the loyalty stems from a sense of duty, respect for the person, or the person's position.