THE RELATIONSHIP BETWEEN TWO ETHICAL DECISION-MAKING MODELS AND COUNSELOR TRAINEES' RESPONSES TO AN ETHICAL DISCRIMINATION TASK AND THEIR PERCEPTIONS OF ETHICAL THERAPEUTIC BEHAVIOR

by

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ABSTRACT

Ethics education is considered vital in preparing counselor trainees to be responsible clinicians. However, the effectiveness of ethics education is debatable. Ethical decision-making models are recommended to counselor educators as effective means to assist trainees and professionals in maintaining ethically defensible behavior. Yet, no published empirical research on the effectiveness of ethical decision-making models exists.

The purpose of the present study was to examine two ethical decision-making models, the A-B-C-D-E Worksheet (Sileo & Kopala, 1993) and the Ethical Justification model (Kitchener, 1984) on 52 counselor trainees' responses to the Ethical Discrimination Inventory (EDI, Baldick, 1980; Lipsitz, 1985) and to Borys' (1988) Therapeutic Practices Survey (TPS). In addition, trainees' responses to the EDI and the TPS were evaluated on the basis of 3 individual variables and 2 training variables. The individual variables were idealism, relativism and analytical ability. Idealism and relativism were assessed by the Ethics Position Questionnaire (EPQ, Forsyth, 1980) and analytical ability by the Graduate Record Exam (GRE). The training variables were graduate courses in ethics and practicum. The data were analyzed using a multiple analysis of covariance for a randomized block design at an alpha level of .0167.

Several significant results occurred in this study: two main effects on the EDI, one interaction effect on TPS total scores and one main effect on a TPS factor score. With respect to the main effects on the EDI, participants in the Ethical Justification treatment condition scored significantly higher on the EDI than did participants in either the A-B-C-D-E or placebo treatment conditions. Secondly, participants who completed a graduate course in ethics scored significantly higher on the EDI than did participants who had not

completed the ethics class. In other words, participants were able to correctly discern significantly more ethical issues embedded in different counseling situations (i.e. the EDI) if they were trained in the Ethical Justification model or if they had completed the required ethics class.

Participants received a total score and three factor scores for their performance on the TPS. A significant interaction effect occurred on TPS total scores among participants with different levels of practicum experience and who were trained in the A-B-C-D-E Worksheet treatment condition. Specifically, participants who had not completed a graduate course in practicum and who were trained in the Worksheet model rated the ethicality of all clinical behaviors higher significantly more often than all other participants. Likewise, participants without practicum and trained in the Worksheet condition rated the ethicality of dual role behaviors (i.e., factor 3) higher significantly more often then participants without practicum and trained in the other two treatment conditions (i.e., main effect on factor 3). In other words, training in the Worksheet condition coupled with no practicum experience led participants to rate clinical behaviors in general and dual role behaviors specifically less cautiously than all other participants.

These results were discussed in terms of the value of ethics education and the advantages of using ethical decision-making models in counselor preparation programs. In addition, recommendations were made for the future inquiry of ethical decision-making models.

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CHAPTER I

INTRODUCTION

Ethical issues are often complex, multifaceted, and defy simplistic solutions (Corey, Corey, & Callanan, 1993). Hence, counselor educators view preservice ethics education as critical to ensure the ethical responsibility of counselor trainees (Cottone, Tarvydas, & House, 1994; Patterson, 1989). However, the research in evaluating the effectiveness of ethics education is mixed. For example, Haas, Malouf, and Mayerson, (1988) found no relationship between ethical training and moral behavior among psychologists when faced with an ethical dilemma. Baldick (1980), however, found that counseling and clinical psychology interns scored significantly higher on an ethical discrimination task than those interns who had not received formal ethics training.

Researchers investigating the effectiveness of ethics education often assume that if counselors have knowledge of professional ethical codes (e.g., Ethical Standards of the American Counseling Association, 1995) then they will behave ethically (Welfel & Lipsitz 1984). This assumption; however, is not always true. Drane (1982) asserts that the reason that knowledge of ethical codes does not lead necessarily to ethical behavior is because ethical codes do not provide counselors with the necessary resources to make ethical choices. Ethical tasks faced by counselors are often complex and require the counselor to behave in ways not clearly defined by the codes of ethics. Consequently, decisions requiring ethical knowledge are often not made by using ethical principles (Gladding, 1995).

Counselor professional ethical codes advise counselors to respect autonomy, to maintain confidentiality, to avoid harm, to promote well-being, and to value honesty (Wilson, Rubin, & Millard, 1991). Ethical codes do not however, prepare counselors to

deal with decision-making situations which present an ethical dilemma, i.e., a conflict between ethical principles (MacKay & O'Neill, 1992). Inherent gaps and internal contradiction of ethical codes restrict their ability to provide sufficient guidance for resolving ethical dilemmas (Wilson et al., 1991; Kitchener, 1984; Mabe & Rollin, 1986). For example, the counselor working with a socially irresponsible AIDS client encounters the dilemma of preserving the client's right to privacy while protecting unsuspecting sexual partners from infection (Erikson, 1990). The Ethical Standards of the American Counseling Association (ACA, 1995) require counselors to "respect their client's right to privacy and to avoid illegal and unwarranted disclosures of confidential information" (p. 576). When harm to others by the AIDS client is perceived, a limit to the confidentiality of client disclosures is recommended by most codes of ethics. However, the ACA code also directs counselors to "minimally" disclose essential information to uninformed third parties in relationship with the client and who are at "high risk" of contracting contagious, fatal diseases. The counselor in this example is left to his or her own judgment in evaluating the extent to which the third party may be at risk and in estimating the minimal amount of information to disclose to the third party. The counselor must rely on even more of his or her judgment when the third party has not yet been clearly identified. The ACA code of ethics (1995) does not provide counselors substantial guidance in breaching one ethical principle (e.g., confidentiality) in favor of maintaining another ethical principle (e.g., duty to warn).

When counselors must breach one ethical principle in favor of another and are faced with minimal guidance by their professional code of ethics, they rely on and are influenced by other processes and factors to guide them in their decision-making process. Researchers have investigated several "individual variables" believed to influence counselors' ethical decision-making and moral judgments, e.g., level of moral

(Blasi, 1980); locus of control (Trevino, 1986); ethical position (Schlenker & Forsyth, 1977; Forsyth, 1980); gender (Gilligan, 1982; Forsyth, Nye, & Kelley, 1988); perceptions of costs and benefits (Kimmel, 1991); and notions of the term "ethical" (Walker, 1994). Setting variables are also believed to influence counselors' ethical decision-making and moral judgments, e.g., ethical training (Haas et al., 1988); managerial style, rewards, and punishments (Trevino, 1986); and social learning (Stead et al., 1987).

The results of these studies indicate that individual variables and setting variables appear to influence helping professionals' appraisal of ethical situations and helping professionals' behavior. However, the research investigating the influence of individual and setting variables is far from conclusive. For example, Tymchuk (1986) and Haas et al. (1988) observed that when helping professionals are faced with an ethical dilemma they report their actions arising from a range of ethical reasons and that a particular reason gives rise to more than one ethical action. In other words, similar behavior among helping professionals is attributed to different variables, and similar variables influence helping professionals differently. What one helping professional may state as the reason for their actions another helping professional may state a different reason yet behave in the same way as the latter helping professional.

Moral reasoning is one such individual variable that influences persons' behavior differently. Blasi (1980) reviewed the literature on moral reasoning and moral behavior and noted on logical as well as empirical grounds the nonequivalence of moral reasoning and moral behavior. In other words, a person who evaluates an ethical situation at some level of moral judgment may or may not behave at a level equivalent to their level of moral reasoning. For example, a counselor may know that he/she should accurately report their professional activities to their clients' insurance companies. Yet because the insurance

insurance company may only pay a percentage of the counselor's fee, the counselor raises his or her fee charged to the client in order to receive full payment from the insurance company. The counselor knows, or morally judges, that reports to third parties ought to be accurate, yet changes his or her fees for personal financial gain.

In addition to the differing influence of individual variables on helping professionals' ethical behavior, Gookin (1989) found that the saliency of an ethical dilemma also elicited varying responses. Gookin found that psychologists were able to discriminate ethical issues, and select appropriate ethical actions among options given, if they were presented with dilemmas with salient ethical issues such as sexual misconduct, confidentiality, and possible client dangerousness. Ethical dilemmas with less salient issues (e.g., advertising, test security and interpretation) elicited more variability in responses from psychologists in spite of receiving formal training in ethics.

The saliency of ethical issues, the diverse influence of individual and setting variables, and the limited guidance provided by ethical codes all contribute to the complexity of a counselor's responsibility to practice ethically appropriate behavior. Thus, several individuals have suggested incorporating ethical decision-making models into the formal training of counselor trainees as one way to equip future counselors to more adequately address ethical issues. According to Tymchuk (1986), ethical decision-making paradigms facilitate ethical training of counselors by providing consistent and systematic approaches to both reactively and pro-actively address ethical issues. Ethical decision-making models can be used to facilitate counselors' evaluation of ethical dilemmas and provide guidance to them in making ethical decisions. Tarvydas (1987) stated that "decision-making models provide guidance regarding process components essential to arriving at the most appropriate ethical judgments. The process is largely skill

and knowledge based, thus moving ethical judgment beyond the simplistic realm of 'good personal moral fiber' or merely 'knowing where to look in the code'" (p.50).

Tarvydas's (1987) and Tymchuck's (1986) efficacious claims of ethical decision-making models are repeated throughout the literature (Pelsma & Borgers, 1986; Rest, 1984; Kitchener, 1984; Tennyson & Strom, 1986; Drane, 1982; Sileo & Kopala, 1993). In response to these assertions numerous models have been developed for use in a wide variety of settings and with diverse client populations. However, whether or not ethical decision-making models facilitate counselors' evaluations of ethical dilemmas and provide guidance to them in making ethical decisions is not known. No published empirical research exists that investigates the influence of ethical decision-making paradigms on counselor trainees' or counselors' ethical evaluation and therapeutic practice.

Significance of this Study

Because the profession of counseling is devoted to promoting human welfare, counselors have an obligation to act in an ethically consistent and thoughtful manner (Kitchener, 1984; Wolman, 1982). The limited guidance provided by codes of ethics coupled with the variety of factors that influence counselors' ethical decision-making presents a challenge to counselors and counselor educators alike. This study will seek to provide new information regarding the influence of ethical decision-making models on counselor trainees' evaluation of ethical dilemmas and their perceptions of therapeutic practice. To date, no empirical inquiry on the influence of ethical decision-making models has been made.

Theoretical Constructs

Ethical codes appear to be patterned after ethical hierarchialism theory (Geisler, 1971; in Feinberg & Feinberg, 1993). Ethical hierarchialism maintains that there are many norms that are universal.,Those norms are hierarchically ordered on the basis of their importance. When norms conflict, this theory states individuals must determine which norm is of greater significance and respond to it. For instance, in the example of the socially irresponsible AIDS client stated earlier, the ACA (1995) code of ethics directs the counselor to breach confidentiality with the AIDS client in order to inform a third party who is at risk of contracting a communicable and fatal disease. In this example, the duty to warn and protect the third party at risk is of greater importance than maintaining confidentiality with the client.

The theory of ethical hierarchialism seems consistent with the ACA code of ethics' directives to counselors in situations where third parties are at risk. Moreover, this theory seems applicable to MacKay and O'Neill's (1992) description of an ethical dilemma: an apparent conflict of ethical values in a given situation.

Some situations are not as explicit as the above case. These can be conflicts between ethical norms that require counselors to assess which ethical norm or principle is most significant. For example, Kitchener (1984) argues that the principle of nonmaleficence (i.e., not to do harm) is implicit in ethical codes; however, nowhere does the code specifically identify what constitutes "harm" to clients or under what circumstances harm to clients is "justifiable." Counselors are left with "determin[ing] what constitutes harm and in distinguishing the discomfort and stress which are frequent temporary side effects of treatment from the long-term harm that is in some cases an outcome of counseling" (p.48).

Distinguishing temporary discomfort and stress from long-term harm requires counselors to have a knowledge of ethical codes and treatment interventions as well as skill in arriving at the most appropriate ethical decisions. According to Drane (1982) and consistent with ethical hierarchialism, counselors must be able to distinguish the unique characteristics as well as common aspects of every counseling case. When the counselor can accomplish this, then he or she can systematically implement general or "universal" principles to resolve individual cases in the most ethically defensible manner. "Without these [general ethical principles and methodology] there can be neither continuity, nor consistency, nor systematic progress in professional ethics for psychotherapists" (p.45).

The purpose of this study is to provide counselor trainees' with two different methods for making ethical decisions, the A-B-C-D-E Worksheet (Sileo & Kopala, 1993); and the Ethical Justification Model (Kitchener, 1984) and to evaluate whether or not these methods improve trainees' ability to evaluate ethical situations.

Research Questions

This study investigates the relationship between counselor trainees' evaluation of ethical dilemmas and their perceptions of ethical therapeutic behavior with training received in one of two ethical decision-making models and a placebo model. The two ethical decision-making models and the placebo model serve as the independent variables of this study. Counselor trainees' evaluations of ethical dilemmas and their perceptions of ethical therapeutic practice are the two dependent variables. In addition, participants' performance on the two dependent variables are evaluated with respect to three individual variables: idealism, relativism and analytical reasoning ability; and two training variables: ethics class and practicum. Idealism, relativism, ethics class, and practicum are treated as blocking variables, while analytical reasoning ability is used as a covariate.

The research questions addressed in this study are:

1. Do counselor trainees who received training in using a decision-making model evaluate ethical dilemmas differently than those trainees who did not receive training in a decision-making model?
2. Are there differences in counselor trainees' evaluations of ethical dilemmas between participants who received training in one versus another ethical decision-making models?
3. Do trainees' evaluations of ethical dilemmas vary with respect to their level of idealism in moral attitudes?
4. Do trainees' level of idealism interact with the training they received so as to influence their evaluations of ethical dilemmas?
5. Do trainees' evaluations of ethical dilemmas vary with respect to their level of relativism toward moral rules?
6. Do trainees' level of relativism interact with the training they received so as to influence their evaluations of ethical dilemmas?
7. Do differences among trainees' evaluations of ethical dilemmas vary with respect to heir analytical ability?
8. Do trainees who received training in using a decision-making model perceive ethical therapeutic practice differently than those trainees who did not receive training in a decision-making model?
9. Are there differences in perceptions of ethical therapeutic behavior between counselor trainees who received training in the two different ethical decision-making models?
10. Do trainees' evaluations of ethical dilemmas vary with respect to their level of idealism in moral attitudes?

11. Do trainees' level of idealism interact with the training they received so as to influence their evaluations of ethical dilemmas?
12. Do trainees' evaluations of ethical dilemmas vary with respect to their level of relativism toward moral rules?
13. Do trainees' level of relativism interact with the training they received so as to influence their evaluations of ethical dilemmas?
14. Does completing a required graduate class in ethics influence trainees' evaluations of ethical dilemmas?
15. Does completing a required graduate class in ethics influence trainees' evaluations of ethical dilemmas differently depending on the type of training they received?
16. Does practicum experience influence trainees' evaluations of ethical dilemmas?
17. Does practicum experience influence trainees' evaluations of ethical dilemmas differently depending on the type of training they received?
18. Do differences among trainees' perceptions of therapeutic behavior vary with respect to their analytical reasoning?

Definitions

The following section offers definitions of terms that will be used throughout the proposal.

Ethics and morals: Terms like "ethics" and "morals" are used here synonymously. To act ethically or morally means to act in accord with accepted rules of conduct which cover moral matters (Feinberg & Feinberg, 1993).

Counselor: The term "counselor" is used when referring specifically to counseling professionals who are licensed to practice counseling.

Counselor trainee: The term "counselor trainee" is used when referring to master level counseling students enrolled in a graduate counselor education program and when referring to the specific participants of this study

Mental health professional: The term "mental health professional" is used when referring to counseling professionals such as counselors, psychotherapists and/or psychologists or to unspecified participants in studies cited in this study. Whenever possible, the specific specialties of mental health professionals are mentioned in the studies that are cited.

Ethical dilemma: The term "ethical dilemma" involves an apparent conflict of ethical values in a given situation, e.g., the ethical obligation to respect privacy conflicts with the obligation to guard the welfare of consumers (MacKay & O'Neill, 1992). Said differently, a "a dilemma is a situation in which there are good reasons to take different courses of action" (Kitchener, 1984; p. 53).

Individual difference variable: The term "individual difference variable" refers to variables or characteristics that help identify or describe an individual, e.g., gender. Idealism, relativism and analytical ability are three individual variables used in the current study.

Idealism: The term "idealism" refers to one of two variables (the other variable is relativism) that underlie individual variation in moral judgments. Individuals who are idealistic in their moral attitude believe that moral absolutes or universal moral rules are helpful in addressing moral issues (Forsyth, 1980).

Relativism: The term "relativism" refers to the extent to which an individual rejects universal moral rules in favor of relativism when drawing conclusions about moral questions (Forsyth, 1980).

Analytical reasoning ability: Participants' analytical reasoning ability was measured by the Analytical Reasoning (A) scale on the Graduate Record Exam (GRE). Analytical reasoning ability (GREA) refers to an individual's "analytical and logical reasoning abilities that includes inferences, deductions, and analysis" (Ethington & Wolfe, 1996; cited in DeBell & Montgomery, 1996, p. 5).

Training variable: The term "training variable" refers to two variables: ethics class and practicum experience.

Ethics class: The term "ethics class" refers to the class in ethics that the counselor education program requires all counselor trainees to complete prior to enrolling in practicum.

Practicum experience: The term "practicum experience" refers to whether or not a trainee has completed a practicum class. It does not refer to a specific practicum setting or to the number of practicae completed.

Autonomy: The term "autonomy" refers to both freedom of action (i.e., freedom to do what one wants as long as it does not interfere with similar freedoms of others) and freedom of choice (i.e., freedom to make one's own judgments) (Kitchener, 1984; in On Stroh, Mines, & Anderson, 1995).

Beneficence: The term beneficence is defined as contributing to health and welfare, or doing good for others (Kitchener, 1984; in Von Stroh, Mines, & Anderson, 1995).

Fidelity: The term "fidelity" is defined as "faithfulness, promise keeping, loyalty" (Kitchener, 1984, p.51).

Justice: The term "justice" is defined in a broad sense meaning fairness (Kitchener, 1984; in Von Stroh, Mines, & Anderson, 1995).

Nonmaleficence: The term "nonmaleficence" is defined as not doing harm (Kitchener, 1984).

Delimitations

The following delimitations provide the boundaries of this study. First, the population of this study was selected from master level counselor trainees enrolled in a major university located in the southwestern United States. Curriculum and training experiences vary from institution to institution and between types of counseling programs. Thus, to generalize the results of this study to counselor trainees enrolled in counseling programs at different institutions might be inappropriate.

A second delimitation of this study involves the use of the two ethical decision-making models. The results of this study are limited to the training paradigms selected and should not be generalized to ethical decision-making models in general.

Limitations

The following limitations in this study are conditions that are beyond the control of this researcher. The limitations of this study include issues associated with the use of the decision-making models by the participants, the validity of the training and the independence of replica assumption.

The first limitation of this study is the researcher's reliance on participants to use the decision-making models when completing the Ethical Discrimination Inventory (EDI) and the Therapeutic Practice Survey (TPS). Since this study is designed to evaluate the effectiveness of the decision-making models by means of the dependent measures, the researcher must rely on participants' self report that they did in fact use the model to complete the measures.

A second limitation of this study involves evaluating whether the training is sufficient in teaching the ethical decision-making models to the participants. The decision-making models may be effective in influencing participants' responses to the EDI and TPS, however, the training may not be sufficient in preparing participants to use the models. In other words, the models may be effective to influence participants' responses yet the training may not be sufficient or adequate enough to prepare participants to use or implement the models when responding to the dependent measures.

Lastly, the group component of each training module threatens the independence of replica assumption. Trainees were assigned to a treatment condition (i.e., placebo, Worksheet and EJ) and participated in a training module. Each training module involved several components: lecture, group discussion and individual practice using the model. An effort was made to monitor the content of the group discussion so that the information discussed in each training module was similar. Likewise, an effort was made to encourage equal participation among trainees and to minimize any one trainee from dominating the group discussion. Although these efforts were made, the group interaction in each training module was not identical. It is possible that a participant's performance on the dependent measures could be influenced by another participant or a comment made unique to his or her training module. It is arguable that a participant's performance on the dependent measures is dependent on the group constiuents of the training module and not solely on the content of the module. Hence, a replication of this study may vary in outcome from the current study due to the different participants involved in the training modules.

CHAPTER II

REVIEW OF THE LITERATURE

The literature review for this study focused on three areas: (1) variables affecting the ethical decision-making process, (2) research evaluating the effectiveness of codes of ethics and ethics education on mental health workers' behavior, and (3) ethical decision-making models. This review provided a framework for investigating the influence of two different ethical decision-making models on counselor trainees' ethical discrimination and perception of ethical therapeutic behavior.

Variables Affecting Ethical Decision-Making

Empirical inquiry of ethical decision-making dates back nearly a century ago (Sharp, 1898). Sharp, a psychologist interested in the study of moral judgments, complained that his research was hindered by a lack of agreement among his subjects concerning what was moral and what was not. He noted that even among individuals with apparently the same characteristics often came to opposite conclusions concerning another person's moral worth (Forsyth, 1980).

Over the last three decades, the research literature on moral issues has grown enormously. According to Kurtines (1986) three theoretical perspectives have dominated this period: "the cognitive developmental approach (e.g., Kohlberg, 1969; Kohlberg and Candee, 1984; Piaget, 1932/1965), individual differences/trait dispositional approaches (e.g., Hoffman, 1975; Hogan, 1974; Staub, 1984), and behavioral/learning approaches (e.g., Burton, 1976; Liebert, 1984 and Mischel and Mischel, 1976)" (p. 784).

More recently, the theoretical literature has begun a transformation from conceptualizing moral decision-making from an individualistic approach to an interactionist model, incorporating both individual variables and setting or environmental variables (Damon, 1976; Kurtines, 1986; Trevino, 1986; Trevino & Youngblood, 1990).

Perhaps the work of Blasi (1980) stimulated researchers the most to begin to formulate theories of moral decision-making beyond the realm of individual variables only. Prior to Blasi's research, most of the research on moral decision-making emphasized the influence of cognitive moral development. However, Blasi's critical review of the literature found that moral cognition explained approximately nine percent of moral action ($r = 30$). Although this relationship has been demonstrated to be significant, according to Borg and Gal (1989) correlations ranging from .20 and .35 are of little value in practical prediction studies. Consequently, the current concern or challenge in the area of understanding ethical reasoning and behavior is broadening the influence of both individualistic and environmental variables to account for the variance in ethical decision-making behavior (Blasi, 1980).

Individual Differences

According to Forsyth (1980), individual differences must be taken into consideration when examining moral judgments. This appears consistent with Haas et al.'s (1988) observation that helping professionals' report their ethical actions stemming from a range of ethical reasons and that a specific reason gives rise to more than one ethical action. This variability may, in part, be explained by individual differences among helping professionals. Perhaps the most frequently investigated individual variables are cognitive moral development (CMD, Kohlberg, 1969) and Locus of Control (LC, Rotter, 1966). An additional variable, ethical ideology (EI, Forsyth, 1980), is a relatively new

individual variable that has gained a respectable position in the literature addressing ethical behavior since the early 1980's. These three individual variables are discussed in detail below.

Cognitive Moral Development (CMD)

CMD (Kohlberg, 1969) is an individual difference construct believed to influence ethical decision-making behavior. CMD is a useful tool for exploring questions related to how individuals think about ethical dilemmas, particularly how they determine what is right or wrong in a particular situation. Kohleberg's model emphasized the reasoning aspect of moral decision-making. It addresses how the cognitive processes of moral decision-making move from less complex operations to more sophisticated operations with development. The stress is on cognitive decision-making process, the reasons an individual uses to justify a moral choice, rather than the decision itself (e.g., the outcome) (Trevino, 1986).

Kohlberg's (1969) framework provides a hierarchical continuum of three levels with two stages at each level. With each successive stage, the individual's moral judgment grows less and less dependent on outside influences. In addition, the individual moves from a self-centered conception of what is right to a broader understanding of the importance of social contracts and principles of justice and rights.

Assessing individuals' cognitive moral development stage has been accomplished through three different methods or instruments: Kohlberg's (1969) "Standard Issue Scoring," the Defining Issues Test (DIT, Rest, 1979), and the Social Reflection Questionnaire (Gibbs & Widaman, 1982). Longitudinal and cross cultural studies have investigated a variety of moral behaviors, i.e., cheating, and lying, that have established credible validity of Kohlberg's model of cognitive development (Gibbs et al., 1982).

Locus of Control (LC)

Rotter (1966) developed a 29-item forced-choice Social Reaction Inventory to measure individuals' perceptions of an event being the result of chance, fate, or luck, or the result of an individuals' characteristics or behavior (Rotter, 1966). An individual with an internal LC believes that outcomes are the result of his or her own efforts. The individual with an external LC believes that life events are beyond control and can be attributed to fate luck, or destiny. Individuals who are "external" are less likely to take personal responsibility for the consequences of ethical/unethical behavior and are more likely to rely on external forces. Individuals who are "internal" are more likely to take responsibility for consequences and rely on their internal determination of right and wrong to guide behavior (Trevino, 1986).

Rotter's (1966) measure of LC is often investigated in ethical decision-making research (Gibbs et al., 1982; Rest, 1977; Forsyth, 1980; Trevino & Youngblood, 1990). For example, Trevino et al. (1990) reported that LC exhibited a greater effect on managers ethical decision-making behavior than did CMD, as measured by the DIT

Ethical Ideology (EI)

Schlenker and Forsyth (1977) asserted that individual variations in moral judgment may be described by taking into account two basic factors. The first is the degree to which an individual rejects universal moral rules in favor of relativism. The second dimension focuses on the degree of idealism in one's moral attitudes. These Two dimensions, relativism and idealism, are the bases of an individual's system, or philosophy, of ethics and thus directs the individuals "approach" to evaluating moral situations and making moral judgments.

The Ethical Position Questionnaire (EPQ, Forsyth, 1980) , which measures EI, has been used to study ethical orientations and their relation to moral behaviors, i.e., willingness of college students to cheat on a test (Forsyth & Berger, 1982), and lying in a research setting (Forsyth & Nye 1990). Moreover, an individual's EI has been investigated regarding individuals' moral values and attitudes on contemporary moral issues (Forsyth, 1980, 1981; Forsyth & Pope, 1984).

Summary. Individual differences are likely to account for some of the variability in ethical reasoning and behavior among persons. Specifically, individuals' ethical position, locus of control and cognitive moral development are three variables believed to influence ethical reasoning and behavior.

Ethical Codes and Education

Welfel and Lipsitz (1984) reviewed the literature regarding ethical misconduct of psychologists. They concluded that "5-10% of psychologists appear substantially insensitive to the ethical dimensions of their work" (as cited in Gookin, 1989). The most common unethical behavior addressed in their review were violations of confidentiality and sexual intimacies with clients, which are explicitly prohibited in the codes of ethics of various professional organizations (e.g., ACA, 1995). Several researchers confirmed Welfel et al.'s (1984) finding on psychologists' sexual conduct (Coleman & Shaefer, 1986; Holroyd & Bouhoutsos, 1985; Pope, Tabachnick & Keith-Spiegel, 1986).

Sexual intimacies with clients and the importance of maintaining the confidentiality of clients are issues clearly in professional codes of ethics and in ethics education. After a review of the development of professional codes, the efficacy of ethics education is reported.

Codes of Ethics and Ethics Education

In an effort to reduce unethical behavior of mental health workers, organizations such as the American Counseling Association (ACA), and the American Psychological Association (APA) developed codes of ethics designed to regulate counseling practice (ACA, 1986, 1988, 1995; APA, 1977a, 1977b, 1981, 1989). Commentaries and case books have also been published to support the guidelines and provide examples of application to practice (APA, 1967, 1984, 1985, 1987; Callis, 1976). Cases adjudicated before ethics committees are periodically published to illustrate interpretation of the codes in actual ethically questionable situations (APA, 1986; Hall & Hare-Mustin, 1983; Sanders & Keith-Spiegel, 1980) (Gookin, 1989).

Gookin (1989) reviewed several studies that investigated the presumed connection between knowledge of professional codes and ethical behavior. She found that most of these studies were analogue studies that used questionnaires or other paper and pencil instruments based on the codes of ethics, case books, and commentaries prepared by various professional organizations. Studies based on the codes of ethics addressed demographic variables such as education level of participants, type of ethics education experiences during training, years of psychotherapy experience, age and gender. Other variables also have been investigated including the scope of dilemmas faced by psychotherapists in their practice (Haas et al., 1986), degree of consensus regarding the most ethical solution to dilemmas (Tymchuk et al., 1982; Haas et al., 1986) and the sources of information consulted when making ethical decisions (Gookin, 1989).

A questionnaire developed by Tymchuk et al. (1982) evaluated the extent to which a sample of clinical psychologists concurred with the proposed solutions to a set of 12 hypothetical ethical situations. The predominant finding of this study was that consistency in ethical decision-making across the participants exists in some situations but

not in others. The vignettes that elicited the strongest consensus reflected salient topics such as confidentiality, sexual behavior and possible client dangerousness. Less salient issues such as test security, advertising and interpretation elicited a great deal more variability in responses. Amount and type of ethics education varied widely; however, supervisory experiences were the primary means of ethical education reported by this sample. Many participants indicated a desire for more exposure of ethics and the decision-making process. This study supported Tymchuck's (1981) proposal that decision-making protocols are needed, especially for those situations that are not addressed by codes of ethics or, if addressed are less salient in ethical content (Gookin, 1989). Tymchuck's recommendation for decision-making paradigms is furthered supported by those who have recognized the complexity involved in making ethical decisions (Rest, 1979; Drane, 1982) and the restriction an individual's intuitive moral sense provides the counselor (Kitchener, 1984).

In a similar study, Haas et al. (1986) assessed choices psychologists made in concrete problematic situations. Participants were given 10 vignettes that involved an ethical dilemma and were asked to choose one alternative from those provided. Each participant was to specify one of eight reasons for selecting the option they chose. The highest degree of consensus regarding the appropriate choice for resolving the ethical dilemmas was obtained on vignettes involving conflict of interest, competence, confidentiality, and mandatory reporting. These findings resemble those of Tymchuk (1986). The two issues rated most serious were sexual misconduct of colleagues and confidentiality. The types of ethics education listed as most helpful were graduate course work and collegial discussion.

Summary

The influence of professional codes and ethics education on mental health workers' ethical evaluation appears most helpful when coupled with the opportunity for collegial collaboration. Moreover, codes and formal ethics training seem to provide consistent guidance when mental health workers are addressing salient issues.

Ethical Decision-Making Paradigms

Decision-making paradigms allow for consistent and systematic approaches of reactively or pro-actively addressing ethical issues. They facilitate ethical training of students and provide a consistent methodology for collecting data regarding ethical issues (Tymchuk, 1986).

Ethical decision-making models can be categorized in two general areas: descriptive and applied. Descriptive models delineate levels or stages of decision-making. They are commonly hierarchical and are somewhat theoretical in nature. Applied models operationalize ethical principle(s) into several steps and normally address the concerns of a specific populations, e.g., the aged.

Descriptive models are reviewed first. They are classified into three categories: ethical justification, developmental, and multidimensional.

Descriptive Models

Ethical Justification Model

The ethical justification model (Kitchener, 1984; see Table 2.1), suggests that moral reasoning and actions occur on two levels: intuitive, and critical-evaluative. The intuitive level refers to individuals "immediate, prereflective response to most ethical situations" (p. 44). The basis of ethical actions are formulated at this level. The critical-

evaluative level of ethical reasoning is formed by the ethical principles of autonomy, beneficence, nonmaleficence, fidelity, and justice. These principles are considered to have prima facie validity. In other words, they are assumed to be valid until a stronger ethical obligation overthrows them. This concept aids individuals in avoiding completely situational ethical analysis (Tarvydas, 1987).

Kitchener suggests that our intuitive moral sense is critical in guiding us in situation were: (1) ethical implications have not been previously consider, (2) an immediate decision is necessary, and (3) there are not convenient professional rules on which to rely. However, the intuitive moral sense can not always be trusted to lead to good ethical decisions. Note, for example, situations in which counselors and clients become involved in sexual intimacies. It is probable that the counselors are aware that such acts are professionally unacceptable and violate the ACA ethical code (ACA, 1995). It is likely that they convince themselves that in their particular situation, ordinary moral standards do not apply. According to Hare (1981), "a critical-evaluative level of moral reasoning is necessary to guide, refine, and evaluate our ordinary moral judgment" (cited in Kitchener, 1988, p. 44).

The critical-evaluative level outlines three tiers of increasingly general and abstract forms of ethical justification. If the first form of justification, ethical codes, fails to guide the counselor, they may move to the next tier and so on. The critical-evaluative level is used to illuminate our ordinary moral judgment and to redefine the bases for our actions. "The critical-evaluative level can build up an improved set of ethical rules and principles which will ultimately become part of our redefined intuitive sense" Kitchener, 1984; p. 45). Kitchener's model describes the process with which counselors' respond, evaluate, and refine their moral reasoning abilities.

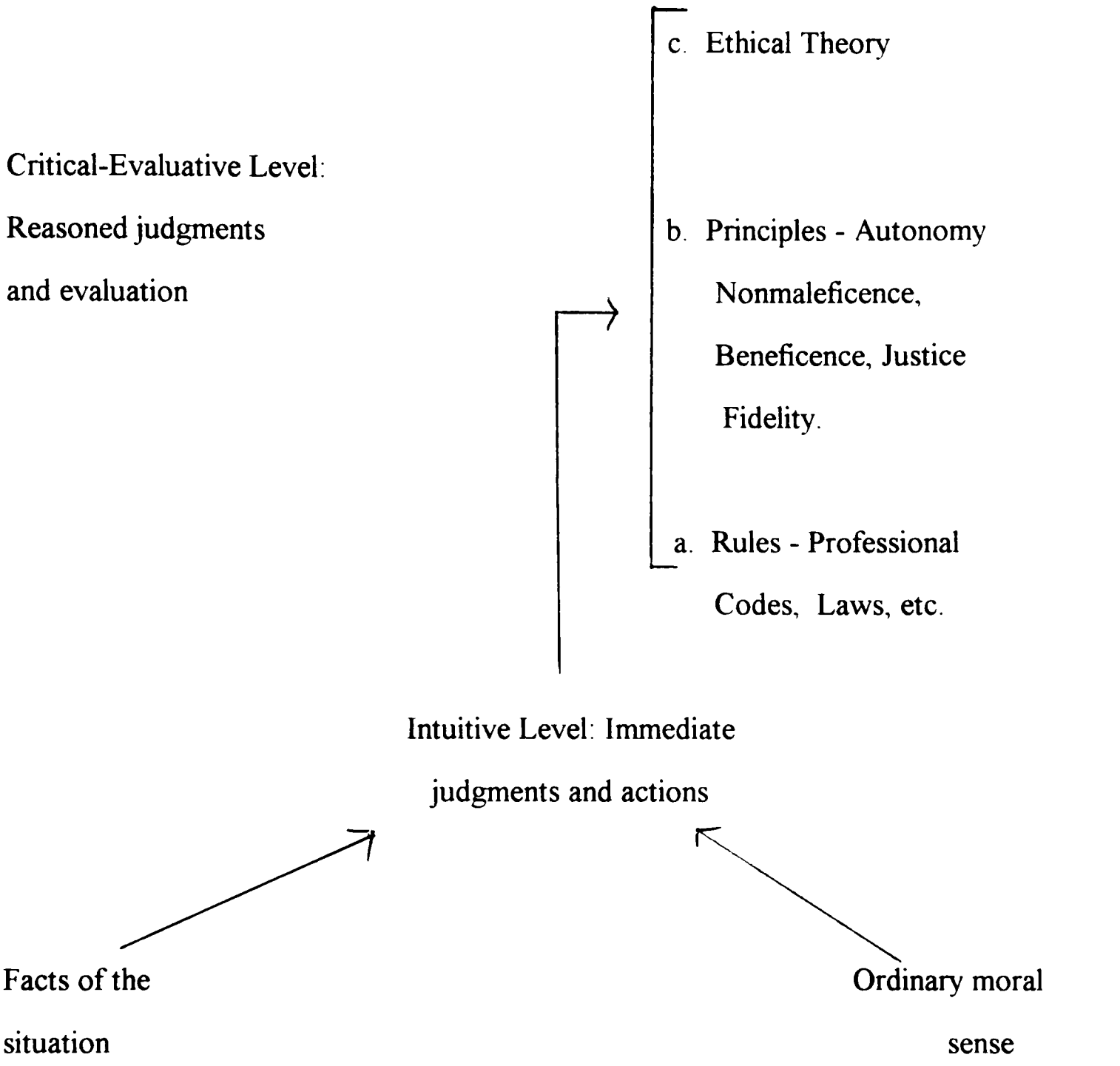

Figure 2.1. A Model of Ethical Justification.

Note. From: "Intuition, critical evaluation and ethical principles: The foundation for ethical decisions in counseling psychology," by K. S. Kitchener, 1984, Counseling Psychologist, 12(3-4), 42-55.

Summary. Kitchener's (1984) critical-evaluative model identifies the processes individuals experience when encountering an ethical situation. The model postulates two levels of evaluation, intuitive and critical-evaluative, used to formulate a basis for resolving an ethical dilemma.

Similar to Kitchener's model, Drane (1982) identified four levels at which ethical decisions are made. The four levels he identifies resemble the content of each tier described by Kitchener's ethical justification model. However, Drane's (1982) description is general and lacks the evaluative processes described by Kitchener.

Developmental Model

According to Van Hoose and Paradise (1979), individuals construct a personal system of ethical behavior, and can develop sophisticated ethical reasoning processes through self-reflection and evaluation. Influenced by the work of Kohlberg (as cited in Van Hoose & Paradise, 1979) Van Hoose and Paradise identified five qualitatively different ethical orientations stages: punishment, institutional, societal, individual, and principle orientations. Counselor ethical orientation is regarded to influence a counselor's assessment of an ethical situation and the alternative chosen.

Van Hoose et al. (1979) challenge counselors to identify and explore their individual rationale in order to stimulate more sophisticated levels of ethical reasoning (Tarvydas, 1987). The greater a counselor's intent in understanding their ethical orientation, the more likely they will develop a sophisticated personal system of ethical behavior.

Summary. Van Hoose et al. (1979) conceptualize counselors' moral decisions making as evolving from seemingly base appraisals and behaviors to more sophisticated judgments and conduct. Sophisticated judgments develop from these base appraisals as the counselor increases his/her self-awareness and honestly evaluates his/her ethical orientation.

Multidimensional Model

Rest (1984) proposed a model composed of four components (see Table 2.2). Each component attempts to integrate cognitive, affective and behavioral perspectives of moral reasoning. Component I entails interpreting the dilemma in terms of how the counselor's actions affect the welfare of each other person involved in the situation. In Component II, an ethical course of action is formulated once various courses of action, their consequences, and related moral merits are assessed. Component III involves assessing competing ideals and choosing the most fitting action. Lastly, in Component IV the individual implements the select action (Tarvydas, 1987).

Summary. Rest's (1984) eclectic approach to evaluating the components involved in making ethical decisions clarifies the ambiguity often associated with making ethical decisions. He describes four components or ingredients and the requisite skills necessary for counselors to evaluate and implement a decision. However, the requisite skills are seemingly characteristic of a seasoned counselor. Rest's (1984), model is comprehensive, yet it is likely to be overwhelming to the beginning counselor.

Conclusion. The descriptive models described, Kitchener's (1984) ethical justification model, Rest's (1984) multidimensional model, and Van Hoose and Paradise's (1979) developmental model, suggest varying explanations for evaluating and resolving ethical dilemmas.

Kitchener's (1984) assertion that counselors who critically evaluate their reasoned judgments are able to influence their intuitive level of moral reasoning is similar to Van Hoose and Paradise's (1979) claim that sophisticated levels of moral reasoning are accomplished when counselors' explore their ethical orientation. Although similar in this respect, Kitchener's model is more comprehensive than Van Hoose and Paradise's model in describing the process involved in ethical decision-making and the resources available to the counselor in evaluating competing principles.

Ethical orientation and intuitive and critical levels of evaluation are not addressed by Rest's model. Rest's approach to evaluating and resolving ethical situations involves integrating requisite cognitive, affective and behavioral skills. Emphasis is placed on counselors' skill competency and not their developmental orientation (Van Hoose & Paradise, 1977) or their moral sense (Kitchener, 1984).

Applied Models

Applied models operationalize ethical principles into several steps and/or provide a rational outline in assessing a dilemma. These models ore commonly developed to address the concerns of specific populations. Applied models tend to be didactic in nature and do not explain the counselor's internal processes associated with the decision-making process.

Table 2.1

Multidimensional Model

Component	Requisite Ability
1. Counselor interprets how her role affects the welfare of parties involved in the situations.	To perceive others, role-taking, imagining consequences, experiencing related feelings, and drawing inferences.
2. Counselor formulates a moral course of action. She is aware of and assess the possible alternatives, their consequences, and merits.	Decision-making skills, ability to assess competing moral claims, prioritizing, and integrating complex moral perspectives.
3. Preferred moral action is determined, but the corresponding action must be chosen on the value outcomes of competing ideals.	Social understanding motivating goal choice, empathy, and calculation of relative goal utilities.
4. Counselor executes and implements the select action.	Self-regulation and executive skills.

Note. From: "Research on moral development: Implications for training counseling psychologists," by J. R. Rest, 1984, Counseling Psychologist, 12(3), 19-29.

Several models were reviewed for this paper. Most models address specific circumstances of particular populations (Adolescents with problem pregnancies, Marecek, 1987; The elderly, Greene & Kropf, 1993, and Smith & Weaver, 1987; Child Welfare, Pine, 1987; Duty to warn and protect, Herlihy & Sheeley, 1988; Irresponsible AIDS client, Erickson, 1990; Reporting child abuse, Barksdale, 1989).

Two models were selected for review on the basis of their applicability to ethical situations and of their degree of representation with other models. The first model, the A-B-C-D-E- Worksheet, aims to promote beneficence (Sileo & Kopala, 1993). The second model, the "Deterministic Model," endeavors to respect client autonomy and evaluate the risks and benefits associated with psychological treatment (Tymchuck, 1986). "Prizing," a step from a model developed for use with elderly clients, is reviewed and its efficacy is suggested (Doolittle & Herick, 1992).

Beneficence Model

Sileo and Kopala (1993) developed a Worksheet to promote a beneficence when considering ethical issues (see Table 2.3). In other words, the Worksheet helps counselors resolve ethical issues with the primary purpose to contribute to the health and welfare of their clients (Von Stroh, Mines, & Anderson, 1995). The A-B-C-D-E Worksheet for ethical decision-making models, attempts to make abstract concepts of decision-making models concrete and practical.

The mnemonic, that is, A (for assessment), B (for benefit), C (for consequences and consultation), D (for duty), and E for education), helps the counselor to evaluate ethical dilemmas once they have been identified. The elements are not sequential, nor will every element always be relevant, and at times some elements may seem to overlap.

Sileo and Kopala (1993) acknowledge the impossibility of a formula-driven approach for resolving all ethical dilemmas. However, their model assists the counselor in weighing and considering ethical dilemmas in a systematic fashion. According to Sileo and Kopala, such a systematic approach to resolving ethical dilemmas will ensure that good standards of practice are upheld and the best possible solution is chosen.

Summary. The A-B-C-D-E Worksheet is a practical and comprehensive guide intended to help both the beginning and experienced counselor when faced with an ethical dilemma. No method is included to help counselors identify a dilemma. The A-B-C-D-E Worksheet helps counselors clarify and select an alternative, regardless of their familiarity with professional ethical codes, experience, and training.

A model similar to the A-B-C-D-E Worksheet was developed by Doolittle and Herrick (1992). Their 5-step model is less specific than Sileo and Kopala's Worksheet and is applied specifically to working with the elderly. A step unique to this model is the "prizing" step. Once an alternative to a dilemma is selected and implemented, the decision and the actions involved are valued as the best solution achievable given the available resources and the circumstances of the dilemma. Prizing the alternative chosen affirms the individuals involved in the decision-making process.

"Deterministic Model"

Tymchuck's (1986) model of ethical decision-making incorporates two primary concerns: (1) who should participate in the decision-making process? and (2) What are the risks and benefits of each alternative solution?

A = Assessment

1. What is the client's mental state?

    a. What are his/her strengths, support systems, weaknesses?

    b. Is a psychiatric/medical consult necessary?

2. How serious is the client's disclosure? Is someone at risk for physical harm?

3. Are there cultural values and beliefs which should be considered while assessing the client?

4. What are my values, feelings, and reactions to the client's disclosure?

B = Benefit

1. How will the client benefit by my action?

2. How will the therapeutic relationship benefit?

3. How will others benefit?

4. Which action will benefit the most individuals?

C = Consequences and Consultation

1. What will the ethical, legal, emotional and therapeutic consequences be for:

    a. The client?

    b. The counselor?

        c. Potential clients?

Figure 2.2. The A-B-C-D-E Worksheet for Ethical Decision Making.

2. Have I consulted with colleagues, supervisors, agency administrators, legal counsel, professional ethics boards, or professional organizations?

D = Duty

1 To whom do I have a duty?

a. My client?

b. The client's family?

c. A significant other?

d. The counseling profession?

e. My place of employment?

f. The legal system?

g. Society?

E = Education

1. Do I know and understand what the ethical principles and codes say regarding this issue?

2. Have I consulted the ethical case books?

3. Have I recently reviewed the laws that govern counseling practice?

4. Am I knowledgeable about the clients culture.

5. Have I been continuing my education through journals, seminars, workshops, conferences, or course work?

Figure 2.2: Continued

Note. From: "An A-B-C-D-E Work sheet for promoting beneficence when considering ethical issues," by F. J. Sileo and M. Kopala, 1993, Counseling and Values, 37, 89-95.

This model was developed in light of two basic decisions made in psychological treatment, "the goal of treatment and the actual method of treatment" (p.40). According to Tymchuck (1986) ethical guidelines mandate that clients be involved in both of these decisions. Moreover, facilitating these decisions are consistent with the ethical principles of autonomy (i.e., freedom of choice and freedom of action), beneficence (i.e., contributing to the health and welfare of others), and nonmaleficence (i.e., not doing harm).

Summary. The emphasis this model places on determining who should participate in the decision process and who should decide which alternative to implement, seems most appropriate for individuals with severe levels of mental or physical illness, with the elderly and with children. The model delineates specific steps to be taken in making ethical decisions; however, the model does not provide the means by which each step can be accomplished.

Conclusion

Ethical decision-making models permit counselor to systematically evaluate ethical issues and select appropriate alternatives among competing ethical principles (Tymchuk, 1986). this is particularly relevant since ethical codes are restricted in their ability to provide sufficient guidance for resolving ethical dilemmas (Wilson, Rubin, & Millard, 1991; Kitchener, 1984; Mabe & Rollin, 1986).

This study will empirically examine two different ethical decision-making modes and whether or not they facilitate counselor trainees' evaluation of ethical issues. If ethical decision-making models are found to facilitate professional behavior among counselor trainees, then they could be incorporated into the training of students, and provide a

consistent method for collecting data regarding ethical issues (Tymchuk, 1986). The two models that will be used are Kitchener's (1984) model of ethical justification and Sileo and Kopala's (1993) A-B-C-D-E Worksheet. The latter model was developed to promote beneficence while the former model was developed to facilitate ethical justification. However, according to K. Kitchener and M. Kopala, neither model has undergone experimental investigation (personal communication, Summer, 1995).

CHAPTER III

METHODOLOGY

Ethical choices in situations of conflict are difficult. The ethical task faced by counselors is complicated by the lack of direction provided by ethical codes and the multiple factors that influence counselors' ethical decision-making. It is the opinion of researchers like Sileo and Kopala (1993) and Kitchener (1984) as well as others that ethical decision-making models can assist counselors in making ethical decisions. These researchers argue that ethical decision-making models enable counselors to sort out competing ethical principles more intelligently than when not used. Thus, ethical decisions are not always made by instinct (Drane, 1982; Kitchener, 1984). According to Drane (1982), "methodology is as important in doing ethics as it is in doing psychotherapy" (p. 20).

Purpose of the Study

The purpose of this study is to evaluate the effect of two different ethical decision-making models (the independent variable) on counselor trainees' responses to an ethical discrimination task and their perceptions of ethical therapeutic behavior (dependent variables). The effect of the ethical decision-making models on the dependent variables will be evaluated in conjunction with three individual difference variables: idealism, relativism and analytical ability; and two training variables: ethics training and practicum experience. In other words, separate analysis will be conducted on each combination of the independent variable with the individual difference variables and with the training variables.

Participants

Counselor trainees enrolled in a master's level counselor education program at a large southwestern university served as participants of this study

Instrumentation

Five instruments were used in this study, a demographic questionnaire, the Ethical Attitudes Survey (Dinger & Martin, 1996) the Ethical Discrimination Inventory (EDI, Baldick, 1980; Lipsitz, 1985), the Therapeutic Practices Survey (TPS, Borys, 1988) and the Ethical Position Questionnaire (EPQ, Forsyth, 1980) (see appendix A: Instruments). Trainees' scores on the EDI and the TPS are the dependent variables in this study. Participants' level of relativism and idealism will be assessed by the EPQ. Trainees' assigned to the placebo condition will complete the Ethical Attitudes Survey.

Participants' consent to allow the researcher to access their Graduate Record Exam (GRE) scores was requested on the demographic instrument. Specifically, participants' scores on the Analytical Reasoning scale of the GRE will be used as a covariate. Each instrument is reviewed below and a rationale for the use of the Analytical Reasoning scale of the GRE is provided. The demographic questionnaire, the Ethical Attitudes Survey, the EDI, TPS and the EPQ are included in Appendix A. Instruments.

Demographic Questionnaire

The following demographic information was collected from the participants: (a) gender, (b) age, (c) ethnicity, (d) relationship status, (e) obtained level of education, (f) GRE Analytical score, (g) track, i.e., school counselor, school counselor certification, or community counselor, (h) number of hours completed in program, (i) courses completed,

(j) courses enrolled in, (k) career goals, (l) practicum settings completed, (m) type of supervision received, and (n) religious involvement.

The Ethical Attitudes Survey

Participants assigned to the placebo condition completed the Ethical Attitudes Survey. The survey quires participants' opinions regarding the term "ethics," the importance of ethical codes and ethics training. The survey requests participants to answer each question and explain their response. The following questions from the survey illustrates the type of questions on the survey and the task required of the participants assigned to the placebo condition: "When you think of the term 'ethics' what words come to mind?" and "What should be the goal of training and or course work in ethical decision-making?"

The Ethical Discrimination Inventory (EDI)

Baldick (1980) developed the EDI to assess whether doctoral level students in clinical and counseling psychology internships could discern the ethical principles contained in various clinical.

The EDI requires participants to read 12 different counseling scenarios. After each scenario is read, participants identify what ethical issues are present in each scenario. Each participant receives one point for each ethical issue correctly identified. The greater number of ethical issues correctly identified the higher the participant's score. Participants receive a total score by summing correct responses across all scenarios. However, the scoring instructions provided by Lipsitz (1985) require participants' responses to be scored twice by two different raters. Agreement on the number of points earned on each

scenario by a participant must not vary more then 1 point between raters. Participants' final score is an average of the raters' scores.

The EDI originally contained 20 clinical situations. Items were chosen from journal articles, books, and actual clinical experiences in an effort to establish content validity (Anastasi, 1982). Each constructed episode contains several ethical dilemmas, problems, or considerations that deal with counseling. A panel of three licensed psychologists who had taught or written about ethics independently outlined the scope of the ethical problems or considerations in each situation. A key was compiled from each of the panel members' evaluations and then submitted to the entire panel for reevaluation and consideration. Each panel member unanimously agreed that the resultant key contained the ethical considerations for each situation.

Eight of the situations were then eliminated because of ambiguity and or redundancy of ethical principles contained in the incidents. The remaining 12 situations provided the basis for quantification of the instrument to yield a maximum score of 44. Therefore, a total of 44 ethical considerations are embedded in the 12 situations. The test participant receives one point for every ethical consideration correctly identified.

To assess the EDI's reliability and validity, Baldick used varying levels of graduate and undergraduate students. Originally, Baldick (1980) administered the EDI to two concurrent ethics seminars: a 4 week seminar designed for upper level undergraduate students in psychology, and a seminar designed for graduate students in counseling psychology, N = 12. "A sign test was performed on the resultant scores from pre- and post testing. The significance level was .001" (p. 278).

In a latter study, Baldick (1980) used a one way analysis of variance (ANOVA) to assess any differences in counseling psychology interns' ability to discriminate ethical situations as a function of their level of ethics education. He found that interns who had

received formal education in ethics significantly discriminated more incidents than those students who had not received formal ethics training.

Lipsitz (1985) conducted a pilot study to further establish the EDI's reliability and validity prior to using it in his dissertation. His investigation lead him to refine the directions of the EDI after consulting with Baldick (Lipsitz, 1985). Lipsitz was interested in whether doctoral students at different points in their training score significantly differently on the EDI, and what affect, if any, did the use of an outdated version of the American Psychology Association (APA) code of ethics (1977) had on Baldick's scoring key? Lipsitz also measured the interrater reliability of the EDI.

As a consequence of Lipsitz's pilot study, Baldick's (1980) original scoring key was updated using the 1981 APA ethical standards. The updated scoring key went through several revisions by an expert panel before its final form was accepted. The revisions involved expansion and clarification of the scoring rules and the directions for the EDI. Using the updated key, Lipsitz's (1985) found that doctoral students significantly varied in their EDI score as a result of their level of training. Lastly, interrater reliability between scores was assessed by calculating a Pearson's Product Moment Correlation coefficient. The reliability coefficient was found to be high and positive (r=.95).

Lipsitz's (1985) pilot study lends support to the EDI's reliability and validity. However, Lipsitz's dissertation investigation of counseling interns did not show significant differences in EDI scores between interns with varying types of ethical training. This finding is in contrast to Lipsitz's pilot study and Baldick's (1980) investigation. The difference in significance between Lipsitz's pilot study and his dissertation likely occurred because the number of levels of training among participants was different in both studies. In other words, the pilot study was comprised of participants with a much wider range of

ethical training than was the dissertation study (i.e., second and fourth year students versus counseling psychology interns, respectively). According to Cohen, Swerdlik and Smith (1992) if the range of a variable (i.e., ethical training) is restricted, then the resulting correlation between that variable and some other variable (i.e., the EDI) tends to be lower. Thus, by limiting the levels of training among participants in his dissertation study, Lipsitz made it more difficult to find a significant relationship between ethical training and performance on the EDI. This factor, limiting the range of ethical training, was also a factor in the different outcomes of Lipsitz's dissertation and Baldick's (1980) study. Also, the differences in significant outcomes between Lipsitz's dissertation and Baldick's (1980) investigation can be attributed to the differences in sample sizes of two studies (i.e., N=91 vs. N=234, respectively). Consequently, Lipsitz's study required a much larger F value than did Baldick's investigation in order to find significance.

Summary. The EDI has demonstrated reasonable evidence of reliability and validity. Although its use has demonstrated variable results, these seem to be a consequence of methodological differences between studies and not due to the instrument, specifically Hence, the EDI seems satisfactory to be used in this study to measure the discrimination ability of counselor trainees.

The Therapeutic Practices Survey (TPS)

The TPS (Borys, 1988) is a 20 item instrument that assess participants' perceptions of the ethical nature of specific clinical behaviors with an adult population. Participants indicate how ethical they consider each behavior to be by responding on a six point Likert-type scale. Responses range from "ALWAYS ETHICAL" to "NOT SURE". "ALWAYS ETHICAL" responses are awarded a numerical value of "5," and "NOT SURE" responses are awarded a value of "0". The following are a sample of the

instrument's items: "Providing therapy to a then-current employee," "Disclosing details of one's current personal stresses to a client," "Engaging in sexual activity with a client after termination" and "Going out to eat with a client after a session." An explanation of the scoring procedures follows a review of how the TPS was developed.

The TPS addresses a range of behaviors on which therapists may engage as part of their clinical practice. The items were assembled from a review of malpractice and ethics complaint cases and from the available research and clinical literature in ethics. Value and gender-neutral descriptors were developed for each behavior (e.g., "Going out to eat with a client after a session). Items were arranged so as to engage respondents' interest in the items early, decrease the likelihood of establishing a social desirability response set and making it difficult for respondents to compare their ratings of items with similar themes.

A random sample of psychiatrists, psychologists and social workers, stratified by gender, were the participants in Borys (1988) study (N=2400; each group was equally represented in number). Borys surveyed the participants and factor analyzed their responses. Three items were excluded from the factor analysis: "Accepting a handshake offered by a client," "Feeling sexually attracted to a client" and "Engaging in sexual activity with a current client." The first two were excluded because they were utilized as social desirability items. The third item was excluded due to the restricted range of responses obtained (i.e., more then 97% of respondents rated the behavior as "NEVER ETHICAL").

When the remaining 17 items were factor analyzed, three conceptually different factors with eigen values greater than one were extracted. Three items loaded highest on the first factor and described "one-time" events or special occasions in which the therapeutic roles were altered at the initiation of the client. The first factor was labeled "Incidental Involvements" and accounted for 69.8% of the common variance. Ten items

loaded highest on the second factor and described the involvement of the therapist and client in extra-therapeutic social, financial or business activities. The second factor was labeled "Social/Financial Involvements" and accounted for 17% of the common variance. Lastly, a third factor was identified by four items concerning the therapist engaging in dual professional roles. Accordingly, the third factor was labeled "Dual Professional Roles" and accounted for13.2% of the common variance.

Participants ratings of the clinical behaviors on the TPS are scored and evaluated by each factor and by a total score. Total scores are achieved by averaging the participants' ratings of all behaviors on the TPS. Similarly, factor scores are achieved by averaging participants' ratings of the items associated with one of the three factors described above. Participants' total scores and factor scores can then be evaluated against the same rating scale the participants used in evaluating the clinical behaviors. For example, the highest total score a participant could receive is a 5 (20 items X a rating of 5 [i.e., "ALWAYS ETHICAL"] = 100/20 items = 5). This score indicates that the participant perceived the clinical behaviors on average as always ethical.,

Summary. The TPS addresses a range of behaviors on which therapists may engage. The participants in this study responded to each item by indicating how ethical they consider each behavior to be. The EDI is composed of 20 ethical situations and requires participants to identify the ethical issues embedded in each ethical situation. The EDI and the TPS are the two dependent measures in this study.

The Ethical Position Questionnaire (EPQ)

The EPQ (Forsyth, 1980) was developed to assess what ethical philosophy an individual uses when making ethical judgments. Forsyth (1980) proposes that individuals adopt one of four different philosophies, or ethical positions, when making ethical

judgments: situationism, absolutism, subjectivism, and exceptionism. Forsyth, Nye, and Kelley (1988) argue that individual differences in moral thought are attributable to a person's ethical position. For example, Forsyth (1980) reported differences in moral condemnation among individuals responding to issues concerning test-tube babies, mercy killing and marijuana use as a function of their ethical position. Individual differences in judgments of social psychological research (Forsyth & Pope, 1984) and in information processing during moral judgment (Forsyth, 1985) have also been attributed to an individuals' ethical position.

According to Forsyth (1980), a person's ethical position is determined by whether a person espouses idealistic or non-idealistic values and believes moral rules are universal or relative. The EPQ is comprised of a series of 20 attitude statements, 10 concerning idealism and 10 concerning relativism. Individuals' respond to each statement by using a 9-point Likert-type scale. Responses range from "Completely disagree" to "Completely agree." The following are examples from the idealism items and relativism items respectively: "A person should make certain that their actions never intentionally harm another even to a small degree" and "There are no ethical principles that are so important that they should be a part of any code of ethics."

Participants' receive two scores on the EPQ: an idealism score and a relativism score. Scores are obtained by averaging the participants' responses to the idealism attitude statements and averaging their responses to the relativism statements. The higher an individual's score, the more idealistic (or relativistic) is their ethical attitude toward moral and ethical issues. Conversely, the lower an individual's score, the less idealistic (or relativistic) is their ethical attitude toward the same issues.

Items for the EPQ were initially derived from the responses of 65 undergraduate psychology students' to 55 items subjectively judged to be indicant of the two dimensions

of ethical ideology (i.e., idealism and relativism). Item and factor analysis were used to select 14 questions for the idealism scale and 13 questions for the relativism scale. A different sample of 56 subjects completed the two preliminary scales. Items were deleted if they did not correlate significantly ($p < .01$) with the overall mean of each scale. After the EPQ was administered to 462 undergraduate psychology students, items were further deleted using a principle components factoring procedure.

Forsyth et al. (1988) evaluated the EPQ using a principle components factoring procedure. They reported finding 2 factors that contributed 42.4% of the variance (i.e., 22.4% and 20.0% for idealism and relativism respectively). A third factor accounted for 7.8% of the variance. A study conducted by Dinger (1994) also found 2 primary factors that accounted for approximately 31.0% of the variance (i.e., 12.85% and 18.04% for idealism and relativism respectively). Forsyth et al. (1988) and Dinger's (1994) investigations substantiate the theoretical constructs of idealism and relativism as measured on the EPQ.

In addition to assessing the psychometric properties of the EPQ, Forsyth et al. (1988) examined the relationship between Gilligan's (1982) theory of moral thought and Forsyth's (1980) two-dimensional model of personal moral philosophies. Gilligan proposed that "people vary in the extent to which they base their moral decisions on an ethic of caring, the principle that inflicting hurt is considered selfish and immoral in its reflection of unconcern, while the expression of care is seen as the fulfillment of moral responsibility" (p. 73).

The relationship between Gilligan's ethic of caring and Forsyth's (1980) two-dimensional model of personal moral philosophies was examined by assessing the relationship between the EPQ's relativism and idealistic dimensions with a brief (i.e., 10 items) self-report measure of Gilligan's ethic of caring developed by Forsyth et al. (1988).

Factor and item analysis of the ethic of caring scale indicated that the 10 items formed a unidimensional scale with an internal consistency of .85.

Forsyth et al. found that idealism and relativism were not correlated, $r = -.05$, yet both scales were significantly correlated with an ethic of caring, $r = .53$ and $-.13$, $p<.001$ and .05, respectively. "These correlations suggest that, as idealism increased, endorsement of an ethic of caring increased, to a much lesser extent, an increase in caring was also associated with a reduction in relativism" (p. 246). In addition, men and women did not differ in their endorsements of idealism, relativism, or an ethic of caring.

Summary. The EPQ has demonstrated reasonable psychometric properties to evaluate individual's differences in appraising moral situations. Participants' performance on the idealism and relativism scales will serve as blocking variables in this study.

Graduate Record Exam Analytical Score (GREA)

The Analytical Reasoning scale was added to the GRE in 1977. This scale was designed to assess individuals' "analytical and logical reasoning abilities that includes inferences, deductions, and analysis" (Ethington & Wolfe, 1986, p. 57, cited in DeBell & Montgomery, 1996).

The analytical aptitude measured by the GREA seems characteristic of the skills necessary to making appropriate ethical decisions. Several researchers have described the following skills as necessary components of the decision-making process: logic and evaluative reasoning skills (Geisler, 1971; Kitchener, 1984; Tymchuck, 1986; Tarvydas, 1987) inductive reasoning ability (Larkin, 1987) and deductive reasoning and inference capabilities (Drane, 1982). Given the similarities stated in the literature between the skills described as necessary in making appropriate ethical decisions and the analytical aptitude

measured by the GREA, the relationship between participants' analytical ability and performance on the dependent measures will be evaluated.

In summary, a relationship between participants' analytical ability and performance on the dependent measures will be appraised. The Ethical Discrimination Inventory (EDI) has demonstrated sufficient validity and reliability criteria to assess individuals ability to discriminate ethical concerns embedded in ethical dilemmas. The Therapeutic Practice Survey (TPS) will assess participants' perceptions of therapeutic clinical behaviors. In addition, the TPS will provide a benchmark to compare participants' perceptions of therapeutic behaviors against the normative group's perceptions of the same behaviors.

Procedures

This section details the treatment conditions, the ethical decision-making models used and the selection and assignment of participants. Once the procedures are reported, a list of the hypotheses in this study is provided. A review of the experimental design and data analysis used to test the hypotheses concludes the chapter.

Treatment Conditions

Two different models of ethical decision-making and a placebo condition comprise the three levels of the independent variable. The two models are the A-B-C-D-E Worksheet (Worksheet, Sileo & Kopala, 1993) and the Ethical Justification model (EJ, Kitchener, 1984).

Presentations of each decision-making model were delivered in a lecture/discussion format to those participants randomly assigned to each model. In other words, participants randomly assigned to the Worksheet model received only the presentation of that model while participants randomly assigned to the EJ model received

the EJ presentation. Each presentation, or treatment, followed the format M. Kopala (personal communication, October 5, 1995) uses when teaching students and counselors how to use the Worksheet. (An effort was made to contact K. Kitchener to ascertain how she teaches the Ethical Justification model. However, she has yet to respond to my inquiry). Kopala's format includes the following steps: (a) identify what constitutes an ethical dilemma in a short lecture, (b) divide participants into small groups, (c) present to the groups a case involving ethical issues, (d) distribute a handout that details the case, and (e) discuss the salient issues embedded in the case while using the Worksheet as a guide.

Pilot Study

Using Kopola's format, a pilot study was conducted in order to practice presenting the Worksheet and Ethical Justification models. A sample of master level counselor trainees (N=25) served as the participants. The practice gained from presenting the models as well as the feedback received from the pilot participants clarified the researcher's understanding of how to use Kopala's format. As a result of the pilot study, two adjustments were made to Kopala's format. First, instead of using a single case study for participants to practice using a model, four case studies were used. Providing participants with cases that presented different clinical issues afforded them the opportunity to practice applying the model with different clinical situations. The second adjustment made to Kopala's format involved an additional learning exercise. After participants evaluated the case studies, they were asked to reproduce each model by memory. This exercise was included as an effort to help participants commit to memory each model as well as help the researcher identify components of each model that might have been unclearly communicated in the lecture describing the models. Accordingly,

each model was briefly reviewed to address specific components that were not understood by participants.

The pilot study provided the researcher the opportunity to practice delivering each model as well as learn how to facilitate participants' learning of each model. The adjustments seem to have strengthened the delivery of each model as well as facilitated participants' learning each model. Consequently, Kopala's format described above was edited with the adjustments just described.

Specifically, the experimental treatment followed the adjusted format. More specifically, the lecture that was delivered (in the Worksheet and Ethical Justification conditions) identified what constitutes an ethical dilemma and detailed one of the two decision-making models. MacKay and O'Neill's (1992) research on what constitutes an ethical dilemma was used for the former while Kitchener's (1984) and Sileo and Kopala's (1993) research was used for the latter.

After the lecture, participants within each treatment condition (excluding the placebo condition) were presented orally and in written form four different case studies (see Appendix B). The treatment condition facilitator (i.e., the principal investigator in this study) read the case to the participants and then distributed to each participant a handout that detailed the case. Once this was accomplished, a discussion followed where the salient issues were inductively explored and identified with the aid of one of the ethical decision-making models. The salient issues in each case were discovered by the participants using one of the decision-making models rather than by the facilitator during the lecture. According to Larkin (1987), the inductive method appears to be "more effective for participants to discover [ethical issues] than to be lectured about ethical principles" (p.144).

The cases evaluated were the same in both treatment conditions. The only difference between the Worksheet and EJ treatment condition was the ethical decision-making model used by the participants. The case studies evaluated did not duplicate any ethical situation contained on the Ethical Discrimination Inventory.

Once participants evaluated the case studies, each was asked to duplicate from memory the model they were taught on a piece of paper. Participants were affirmed in their attempt to duplicate the model and given opportunity to compare their work with a copy of the model provided by the facilitator. The duplication exercise was an attempt to help the participants commit to memory the model and to recognize components of the model that may not have remembered or understood.

The above training procedure took approximately 1 hour and 45 minutes. Following the training, participants were given a 15 minute break. Participants were asked to complete both dependent measures (i.e., the EDI and the TPS) when they returned from the break. Participants were allowed to use the decision-making model when they completed the measures. It took participants approximately 30 minutes to complete both measures. Once participants completed the dependent measures they were thanked for their participation and excused from the training module.

Placebo Condition

Trainees assigned to the placebo condition did not participate in the same procedure as did the trainees assigned to the Worksheet and EJ condition. Trainees in the placebo condition were not taught what an ethical dilemma was or trained in using a decision-making model. Rather these participants were asked to complete the Ethical Attitudes Survey. The survey queried their attitudes towards ethics education and their ideas about how ethics ought to be taught. Once participants completed the survey and

given opportunity to discuss their responses, they completed the EDI and the TPS. Most participants completed the placebo condition within one hour and 45 minutes.

Selection of the Decision-making Models

The A-B-C-D-E Worksheet, based on the ethical principle of beneficence, was selected as one of the treatment conditions. It is considered to be a practical and comprehensive guide intended to help both the beginning and experienced counselor promote client welfare. The Worksheet helps counselors clarify competing ethical issues and select an appropriate alternative, regardless of their familiarity with professional ethical codes, experience, and training (Sileo & Kopala, 1993).

Kitchener's (1984) Ethical Justification (EJ) model was selected as the other treatment condition. The model comprehensively describes the process involved in ethical decision-making and the resources available to the counselor in evaluating competing principles. The EJ model, hierarchical in nature, identifies the ethical evaluation of moral issues on two levels: intuitive and critical-evaluative. The intuitive level refers to individuals' "immediate, prereflective response to most ethical situations" (p.44). Whereas the critical-evaluative level of ethical reasoning is formed by ethical codes and laws, the ethical principles of autonomy, beneficence, nonmaleficence, fidelity, and justice and ethical theory. Kitchener (1984) asserts that the above ethical principles are considered to have prima facie validity.

Although both models include the ethical principle of beneficence, each model is unique. The Worksheet directs the user to weigh and consider ethical dilemmas in a systematic and somewhat formula driven fashion with the primary objective of promoting the client's welfare. More specifically, the Worksheet assists counselors to evaluate ethical dilemmas by reviewing the ethical situation on the basis of the A-B-C-D-E

mnemonic: A (for assessment), B (for benefit), C (for consequences and consultation), D (for duty), and E (for education).

The EJ model describes the processes individuals experience when encountering an ethical situation. Kitchener's (1984) model includes the ethical principle of beneficence and like the Worksheet, is systematic (i.e., an evaluation of an issue moves from the intuitive level of reasoning to the critical-evaluative level), but it also identifies the processes involved in making ethical judgments and the multiple resources available to the counselor (i.e., an individual's immediate, prereflective response; ethical codes and ethical principles).

Selection of Participants

The principle investigator obtained permission from counselor educator faculty to recruit students enrolled in counselor education classes during the Spring and Summer of 1996. Permission was granted unanimously from the faculty.

Each faculty member introduced the investigator to their classes and briefly explained my intent: to ask for students to volunteer for a research project on ethics. Both the faculty member and the investigator emphasized the voluntary nature of the project so as prevent or minimize the demand influence students may feel to participate. Once the faculty member emphasized the voluntary nature of the students participation, he or she left the room. The investigator explained in more detail the nature of the commitment involved, assured students that confidentiality would be maintained and the benefit they would receive from their participation. Benefits included learning more about ethics and being eligible to participate in a lottery for one nights lodging at an area hotel and dinner for two at local restaurant. The estimated value of the lodging and dinner was one hundred dollars.

Students who volunteered were asked to sign a consent form and to complete the demographic questionnaire and the Ethical Position Questionnaire. Students who chose not to volunteer were thanked for their time and given the option to leave the class early or to stay and work quietly while the volunteers completed the above instruments.

Assignment of Participants

Participants were randomly assigned to one of the three treatment conditions (i.e., placebo, Worksheet or EJ). Randomization occurred using a table of random numbers and by following a "with replacement" procedure. Once all participants were assigned, the investigator contacted each participant by phone to inform them of the date, place and time their treatment condition would occur. Participants who did not attend their assigned treatment condition were reassigned and contacted by phone.

Hypotheses

The hypotheses for this study concern the influence of two ethical decision-making models (i.e., the independent variable) on counselor trainees' ethical discrimination ability and trainees' perceptions of ethical therapeutic behavior (i.e., the dependent variables). Also, this study investigates the relationship of three individual variables, idealism, relativism and analytical reasoning; and two training variables, ethics class and practicum experience on the dependent variables. Specifically, the hypotheses of this study are:

1. Participants who receive training in the A-B-C-D-E Worksheet model of ethical decision-making (group 2) will not score significantly differently on the Ethical Discrimination Inventory (EDI) and the Therapeutic Practices Survey (TPS) than those participants who received training in the Ethical Justification model (group 3).

2. Participants in group 2 will score significantly differently on the EDI and the TPS than those participants who did not receive training, i.e., the placebo condition (group 1).
3. Participants in group 3 will score significantly differently on the EDI and the TPS than those participants in group 1.
4. Participants' performance on the EDI and TPS will not vary significantly with respect to their level of idealism in moral attitudes.
5. Participants' level of idealism will not interact with the training they received so as to influence their evaluations of ethical dilemmas.
6. Participants' performance on the EDI and TPS will not vary significantly with respect to their level of relativism toward moral rules.
7. Participants' level of relativism will not interact with the training they received so as to influence their evaluations of ethical dilemmas.
8. There will not be significant differences between participants' scores on the dependent variables as a function of their completion of the required ethics class.
9. There will not be a significant interaction effect between participants' scores on the dependent variables and their completion of the required ethics class.
10. There will not be significant differences between participants' scores on the dependent variables as a function of their practicum experience.
11. There will not be a significant interaction effect between participants' scores on the dependent variables as a function of their practicum experience.
12. Participants' performance on the dependent variables will not vary significantly as a function of their analytical ability (GREA).

Experimental Design

The research design for this study was a 3 X 2 factorial design. More specifically, a multiple analysis of covariance (MANCOVA) for a randomized block design (Tabachnick & Fidell, 1989) evaluated the influence of the treatment conditions, individual difference variables and the training variables on the two dependent variables. The covariate in this study was participants' analytical ability. Separate analysis were conducted on each combination of the independent variable (i.e., placebo training, A-B-C-D-E Worksheet training, and Ethical Justification training) with the individual difference variables and training variables.

Data Analysis

The data gathered from this 3 X 2 factorial were analyzed using a multiple analysis of covariance (MANCOVA) procedure for randomized block designs. This approach assessed mean differences on the dependent variables between treatment conditions while experimentally and statistically controlling for error, the blocking variables and the covariate respectively. The presence of an interaction effect between the level of treatment and the blocking variable was also assessed. Type 1 error was controlled by using a family wise error rate (Kirk, 1995). Three families were identified: the relationship of training in ethical decision-making to performance on the Ethical Position Questionnaire (i.e., participants' level of idealism and relativism), to participants' prior ethical training (i.e., ethics class) and to participants' practicum experience. Accordingly, alpha for each MANCOVA analysis was set at .05/3 = .0167.

CHAPTER IV

RESULTS

The purpose of this study was to evaluate the effect of two ethical decision-making models (the independent variable) on counselor trainees' responses to an ethical discrimination task and their perceptions of appropriate therapeutic practice (the dependent variables). The effect of the ethical decision-making models on the dependent variables were evaluated in conjunction with three individual difference variables and two training variables. The individual difference variables were participants' idealism and relativism scores and analytical reasoning ability; and the two training variables were participants' prior ethical training, and participants' practicum experience. In other words, separate analysis were conducted on each combination of the independent variable with the individual difference variables and the treatment variables.

The independent variable consisted of three levels of training in ethical-decision making: placebo, A-B-C-D-E Worksheet model (Sileo & Kopala, 1993), and the Ethical Justification model (Kitchener, 1984). Each individual difference variable had two levels, e.g., practicum versus no practicum experience. In addition, an effort was made to reduce experimental error by using participants' analytical scores on the Graduate Record Exam (GREA) as a covariate Thus, the primary analysis conducted in this study was a 3 X 2 multiple analysis of covariance (MANCOVA) for each analysis. To control for Type 1 error, the MANCOVA analyses were grouped by "families" of similar research questions (Kirk, 1995), using the family as the unit of error-control. Three families were identified: the relationship of training in ethical-decision making to performance on the Ethical Position Questionnaire (EPQ), to participants' completion of an ethics class and to

participants' practicum experience. Accordingly, alpha for each MANCOVA analysis was set at .05/3 = .0167.

The remainder of this chapter is organized into five parts. First, how participants were selected and assigned to the treatment groups will be reported. Secondly, participants' demographic information will be detailed. The third part of this chapter, instrumentation, reports how participants performed on the instruments used in this study. Fourth, the outcome of the correlational analyses are reported. Finally, the results of the MANCOVA analyses are reported.

Selection of Participants

The participants in this study were 52 graduate students enrolled in a counselor education program in a large university located in the southwestern part of the United States. Participants were solicited and data were collected two times (hereafter referred to as "Time 1" and "Time 2"). During Time 1, the researcher solicited approximately 130 students enrolled in courses during the Spring semester, 1996. Seventy-four students (56%) volunteered to participate in this study. Of those students, 41 completed the study (response rate = 55%). Two attempts were made to reschedule the 33 students who did not attend the training modules. Most individuals cited scheduling conflicts and illness as reasons not attending the training module.

The second time (i.e., Time 2) participant solicitation and data collection occurred was during the first week of the first summer session, (1996) approximately one month following Time 1. Twelve participants were solicited and eleven provided usable data; one student did not complete the demographic information (response rate = 92%). The students who participated in Time 2 did not have prior knowledge of the study. In other words, it was assumed that Time 2 participants' performance was not contaminated by

participants in Time 1. The sum of participants in Time 1 and Time 2 was 52, a response rate = 60%.

Assignment of Participants

Participants were randomly assigned to one of three treatment groups: placebo, A-B-C-D-E Worksheet training, and Ethical Justification training. Randomization was accomplished using a table of random numbers. As a result of conducting a "without replacement" random assignment procedure, treatment groups sizes were not equal: placebo (n=14), Worksheet (n=17) and Ethical Justification (n=21). However, chi-square analysis demonstrated that treatment groups did not vary significantly with respect to size, $X^2(2) = 1.425$, $p < .05$.

In summary, 52 participants completed this study. Participants were randomly assigned to and trained in one of three ethical decision-making models. Solicitation, training and data collection occurred across two times. Each Time period and set of participants was independent from the other.

Demographic Information

The demographic variables were organized into two categories: personal attributions and educational standing. "Personal Attribution" included age, gender, ethnicity and relationship status. "Educational Standing" included highest degree accomplished, current degree pursuing, number of hours completed in the counselor education program, number of hours currently enrolled in, counseling track enrolled in, career aspirations, ethics class, additional training in ethics and practicum class. A summary of the participants' personal attributes and educational standing is provided at the end of each category.

Personal Attributes

Age

The median age of the sample was 31.5 years. Participants ranged in age from 21 to 59 years (M = 34.38, SD = 9.62 and mode = 26). The distribution was not normal but positively skewed (.598) and somewhat flat (-.5151).

Gender

Seventy-three percent of the participants were women (n=41). Twenty-seven percent were men (n=11). Even though there was nearly a 4 to 1 ratio of women to men, treatment groups did not differ significantly with respect to gender, $X^2(2) = 5\ 423$, p = .071.

Ethnicity

The sample was predominantly Caucasian (88%); 8% were Hispanic. One participant indicated they were "Asian" and one participant did not indicate their ethnicity.

Relationship status

The majority of participants were married (53.8%); while 28.8% were single. The remaining 17% of the participants were either divorced , partnered, separated or widowed.

In summary, the samples' personal attributes indicate that participants were predominately Caucasian, female and between the ages of 26 and 36. Approximately 25% of the sample was male and nearly 50% indicated that they were not in a committed relationship.

Educational Standing

Highest degree accomplished

The majority of participants indicated that they had received a bachelors degree, (79%, n=41). Master's and doctoral degrees were indicated by 17% (n = 9) and 3% (n = 2) of the participants, respectively.

Current degree pursuing

Of the 52 participants, 83% of the students were pursuing a master's degree in education (n = 43), 3% of the participants indicated they were pursuing a doctorate in education (n = 2) and 13% of the participants indicated they were neither pursuing a master's degree or a doctoral degree in education (n = 7).

Hours completed in counselor education program

This variable was not normally distributed. The median number of hours completed was reported to be 27 (M = 23 44, SD = 18.05). The range of hours completed was from 0 hours (5% of the sample) to 99 hours (1% of the sample).

Hours currently enrolled

This variable was also not normally distributed. The median of the distribution was reported to be 6 (M = 7.21, SD = 4.52). The range was from 3 (10% of the sample) to 9 (95% of the sample).

Counseling track enrolled in

Participants were enrolled in 3 different counselor education programs: community counseling 65% (n = 34), school counseling 21% (n = 11) and non-degree

certification only as a school counselor 3% (n = 2). In addition, 10% of the participants indicated they were enrolled in both the community counseling program and the school counseling program (n = 5).

Career aspirations

Sixty-two percent of the participants (n = 32) indicated they were pursuing licensure as a professional counselors while 25% of the participants indicated they wanted to be school counselors (n = 13). Three percent (n = 2) of the participants indicated that they wanted to be both a licensed professional counselor and a school counselor while approximately 8% of the participants (n = 4) indicated their career aspiration as "other" than a school counselor or a licensed professional counselor. One participant did not indicate their career goal.

Ethics class

Participants indicated on the demographic inventory whether or not they had completed the three-hour ethics course required by the counselor education program. Participants who were enrolled in the ethics course during Time 1 of the data collection were grouped together with the participants who had already completed the class. This was done because data were collected from participants during the last three weeks of the semester. Thus, students enrolled in the ethics course were considered to have a more similar experience with those students who had completed the ethics class than students who had not taken the ethics class. Contrarily, when data were collected during Time 2 (the first week of the summer semester) participants enrolled in the ethics class were grouped together with those participants who had not yet taken the ethics course. The experience of participants beginning their training in ethics was considered to be similar to

those students who had not yet enrolled in the ethics course. Consequently, 46% (n = 24) of the participants were considered to have completed the ethics course in the counselor education program while 54% (n = 28) of the participants were considered not to have had the ethics course in the counselor education program. A chi-square analysis of ethical training by treatment group demonstrated that treatment groups did not vary significantly, $X^2(2) = 181$, $p = .914$. In other words, participants who had completed the ethics class and participants who had not completed the ethics class were equally distributed among each of the treatment conditions (i.e., the independent variable).

Additional training in ethics

Participants were also given an opportunity to indicate if they had received training in ethics other than the required ethics class in the counselor education program. Approximately 28 % (n = 15) indicated they had received additional training in ethics while 72% (n = 37) indicated they had not received additional training in ethics.

Practicum class

Participants were asked to indicate if they had taken a practicum class, to indicate what settings they had worked at or were currently working in and the type of supervision that best described their experience at each setting. Forty-four percent of the participants had not completed a practicum (n = 23) and thus had not worked in a practicum setting. Fifty-six percent of the participants indicated that they had completed a practicum class (n = 29).

In summary, participants in this study were mostly master level students who had completed more than half of their training in counseling. Approximately two-thirds of the participants were enrolled in the community counseling track and were pursuing licensure

as a professional counselor. Nearly one-fourth were enrolled in the school counseling program and aspired to be school counselors. Nearly half of all participants had completed the ethics class and at least one practicum class.

Instruments

The instruments used in this study were the revised Ethical Discrimination Inventory (EDI, Lipsitz, 1988) the Therapeutic Practice Survey (TPS, Borys, 1988) and the Ethical Position Questionnaire (EPQ, Forsyth, 1980). The EDI and the TPS served as the two dependent measures. The EPQ measures the individual's level of idealism in moral evaluations and degree to which moral absolutes are considered relative. These two variables, idealism and relativism, were the two individual difference variables investigated. In addition participants' analytical scores from the Graduate Record Exam (GREA) were used as the covariate in this study. A brief description of each instrument and participants' performance on each instrument is reported below. In addition, the procedures followed in retrieving GREA scores is provided. This section is organized into three categories: dependent variables, individual difference variables and GREA as a covariate.

Dependent Variables

The dependent variables in this study were the Ethical Discrimination Inventory (EDI) and the Therapeutic Practice Survey (TPS). The dependent variables were found to be orthogonal to one another ($r = .11$, $p > .42$). The reliability of participants' performance on each variable and an overview of scoring procedures for each variable are given below.

Ethical Discrimination Inventory (EDI)

The EDI requires participants to read 12 different counseling scenarios. After each scenario is read, participants identify what ethical issues are present in each scenario. Each participant receives one point for each ethical issue correctly identified. The greater number of ethical issues correctly identified the higher the participant's score. Participants receive a total score by summing correct responses across all scenarios. However, the scoring instructions provided by Lipsitz (1985) require participants' responses to be scored twice by two different raters. Agreement on the number of points earned on each scenario by a participant must not vary more then 1 point between raters. Participants' final score is an average of the raters' scores. A description of the distribution of average EDI scores and the interrater reliability is given below.

The distribution of participants' average EDI scores was normally distributed (M = 13.15, SD = 3.68). Scores ranged from a low of 6.5 to a high of 21. The interrater reliability was moderate and significant (r = .840, p > .0001). These results are in contrast to Lipsitz's (1985) study of doctoral interns' performance on the EDI (M = 18.7, SD = 3.9). The doctoral interns ranged in EDI scores from a low of 12 to a high of 27.5.

Therapeutic Practice Survey (TPS)

The TPS is a 20 item instrument consisting of three factors: incidental involvements, financial/social involvements and dual professional roles. Each item describes a behavior that therapists may engage in as part of their clinical practice. Participants are instructed to rate each behavior according to how ethically appropriate they consider the behavior. Ratings range from low, "Never Ethical" to high "Always Ethical." Participants can also choose a "Not Sure" rating. "Never Ethical" ratings receive a score of 1 while "Always Ethical" ratings receive a score of 5. "Not Sure"

ratings receive a score of 0. The higher the score earned on the TPS the more ethical the participant perceived the behaviors described by each item. A description of the distribution of TPS scores and the reliability of the instrument is given below

In this study, the distribution of TPS scores was normally distributed ($\underline{M}$ = 27.12, $\underline{SD}$ = 6.31). Total scores ranged from a low of 12 to a high of 44. The reliability was assessed using Cronbach's index of internal consistency (α = .82). Table 4.1 compares participants' average scores with the normative groups' average scores for each item, total score and factor.

In summary, the performances on both dependent measures were normally distributed and reliable. The homogeneity of variance assumption was evaluated by following the procedures outlined by Tabachnick and Fidell (1989). The homogeneity of variance assumption was not violated.

Individual Difference Variables

The individual difference variables reported below are those specifically derived from the EPQ, namely idealism and relativism. The EPQ is briefly described followed by the procedures used to categorize participants' idealism and relativism scores into high and low positions. The distribution of each scale and its reliability is reported.

Ethical Position Questionnaire (EPQ, Forsyth, 1980)

The Ethical Position Questionnaire (EPQ, Forsyth, 1980) is a 20 item instrument consisting of two scales: idealism and relativism. The median, mean and median of each scale is reported. Reliability coefficients were assessed using Cronbach's alpha. Reliability coefficients are given for both scales and the overall instrument.

An individual's ethical position is determined by taking the median split of each scale and then crossing each scale to form four different quadrants or positions, i.e., high idealism high relativism, high idealism low relativism, etc. Because of the limited number of participants in this study, it was decided to evaluate individuals by their score on each scale and not by their ethical position.

Participants' scores on the relativism scale were normally distributed and ranged from a low of 23 to a high of 72. The mean of the distribution was 50.15 (SD = 12.4, MD = 48.5). Cronbach's alpha was used to assess the reliability of the relativism items (α = .82).

Parcticipants' scores on the idealism scale were not normally distributed. Scores ranged from 26 to 83 (Mdn = 66, M = 65, SD = 12.18). Reliability for the idealism scale was assessed at .82.

GREA as a Covariate

Graduate Record Exam (GRE) - Analytical Score (GREA). Consent to retrieve participants' analytical scores from the college's records was obtained. Four participants had not yet taken the GRE. Thus, GREA scores were not available for these participants. Consequently, the median (Mdn = 520) of the GREA distribution of participants' was assigned to the participants that had not taken the GRE. This seemed reasonable since the distribution of GREA scores were normally distributed (M = 508, SD = 106).

Table 4.1
Comparisons Between Participants' and Normative Groups' Average Total Scores on the TPS

Item[a]	Factor	Counselor Trainees[b]	Normative Group[c]
Gift under $10	1	2.15	3.54
Client's special occasion	1	2.19	2.87
Service/product as tx payment	2	1 73	2.62
Friends after termination	2	1.86	2.39
Sell product to client	2	1 17	1.31
Gift over $50	2	1.19	1.67
Therapy to employee	1	1.19	1.53
Sex after termination	3	1.05	1.28
Discloses own stresses	2	2.09	2.08
Clients at open house	2	2.15	2.33
Employ client	2	1.36	1 70
Go out to eat	2	1.46	1.73

Table 4.1 Continued

Item[a]	Factor	Counselor Trainees[b]	Normative Group[c]
Buy goods/svcs	2	1.55	1.90
Sex during treatment[d]		1.0	1.0
Clients at own party	2	1.46	1.30
Tx to clt's signif. other	3	1.94	2.77
Tx to pupil	3	1.36	1.83
Client in class	3	1.25	1.89
Average Total Score		28.15	35.74
Factor 1		5.53	8.09
Factor 2		15.88	18.68
Factor 3		5.74	8.03

Note. Factor 1 = incidental involvement's, factor 2 = social /financial involvement's and factor 3 = dual professional roles (Borys, 1988).

[a] Items are abbreviated. An unabridged version of the TPS is included in Appendix A.

[b] N=52

[c] N=2400 (Borys, 1988).

[d] Borys (1988) omitted this item from the analysis due to lack of variation in responses among participants.

Correlational Analysis

A correlational analysis of the EDI average scores and the TPS total scores with the individual difference variables was conducted using the Pearson correlation coefficient statistic. In addition to participants' idealism and relativism scores, participants' age and GREA scores were included in the correlational analysis. Variables that correlated significantly with the EDI and the TPS are reported first. See Table 4.2 for an overview of the correlational analysis.

Idealism and GREA correlated significantly with participants' performance on the EDI: participants' GREA scores correlated significantly positively with EDI performance ($r = 42$, $p < .001$), and participants' idealism scores correlated significantly negatively with EDI performance ($r = -.32$, $p < 01$). With respect to the former (i.e., GREA and EDI performance), the higher a participant's analytical score the more ethical concerns he or she correctly identified on the EDI. Regarding idealism and EDI performance, the more idealistic a participant was in their moral attitude, the fewer ethical concerns he or she correctly identified on the EDI. No variable correlated significantly with the TPS. In other words, none of the variables included in the correlational analysis were related to participants' performance on the TPS.

Participants' idealism score was significantly negatively correlated with participants' GREA scores ($r = -.38$, $p < .005$). The more idealistic an individual was the lower their analytical ability. Similarly, participants' age was significantly negatively correlated with participants' relativism score ($r = -.41$, $p < .001$). The older a participant was the less relativistic they were in their moral attitudes.

Table 4.2

Correlations Between Individual Difference Variables, Covariate and the Dependent Variables

Subscale	1	2	3	4	5	6
1. Idealism	--	.16	-.05	-.38**	-.32*	-.23
2. Relativism		--	-.41***	-.04	-.03	.22
3. Age			--	-.07	-.22	12
4. GREA				--	.42***	.13
5. EDI					--	.11
6. TPS						--

*p<.01, **p<.005, ***p<.001

The outcome of the correlational analyses confirmed the use of MANCOVA. GREA scores were used as a covariate in each analysis. Participants' idealism scores were evaluated as to their influence on the dependent variables as an individual difference variable and not as a covariate. The results in Table 4.3 demonstrate that no interaction between GREA and the independent and individual difference variables occurred in any of the MANCOVA analyses. This illustrates that the covariance assumption of parallelism of the regression planes (Kirk, 1995) was met for each analysis.

MANCOVA Analyses

Six 3 X 2 multivariate analysis of covariance (MANCOVA) procedures were performed on two dependent variables (DVs) associated with participants' ethical decision-making skill: ethical discrimination inventory (EDI) and perceptions of therapeutic behavior (TPS). The independent variable had 3 levels: placebo, A-B-C-D-E Worksheet and Ethical Justification. More specifically, the analyses were: treatment by idealism score, treatment by relativism score, treatment by ethics class, and treatment by practicum class. In other words, in each analysis, treatment is evaluated against a different individual difference variable, i.e., idealism score, relativism score, ethics class, and practicum class. In addition, a 3 X 2 MANCOVA was conducted on the treatment by practicum factorial using each factor of the TPS as dependent variables. The latter analysis was conducted to analyze the interaction effect between level of treatment and

Table 4.3

Evaluation of a Treatment and Individual Difference Variable by Covariate Interaction

Variable	F	Num Df	Den Df	p > F
Analysis 1				
Treatment	1.62	4	88	1752
Idealism	2.39	2	43	.1032
Analysis 2				
Treatment	1.32	4	88	.2668
Relativism	1.54	2	43	.2253
Analysis 3				
Treatment	1.73	4	88	.1494
Ethics	.88	2	43	.4193
Analysis 4				
Treatment	1.40	4	88	.2387
Practicum	.02	2	43	.9767

Note. No interaction between the covariate (GREA) and the independent and individual difference variables occurred in any of the MANCOVA analyses. This illustrates that a linear relationship between the dependent variable and the covariate exists, and that the slope of the regression line is the same for each group.

level of practicum experience on the TPS. Mean differences were evaluated in each analyses by the lsmeans test. Type 1 error was controlled for by using a family wise error rate. Three families were identified: the relationship of training in ethical decision making to performance on the Ethical Position Questionnaire (EPQ), to participants' prior ethical training and to participants' practicum experience. Accordingly, alpha for each MANCOVA analysis was set at .05/3 = .0167

The results of each analyses are reported by the two dependent variables. In other words, the overall F test, main effects and interaction effects for the EDI and the TPS are reported separately. In addition, a multivariate test was included in each MANCOVA analysis. This test measures the relationship between the covariate (GREA) and the dependent variables. The outcome of the multivariate test (see Table 4.4) demonstrated that a significant relationship between performance on the GREA and EDI and the TPS exists. The relationship between the covariate and the dependent variables was further evaluated by comparing the proportion of variance in the dependent variables accounted for by the covariate (see Table 4.5). The difference between the adjusted and unadjusted R^2 values (in Table 4.5) demonstrate the proportion of variance in the dependent variables attributed to participants' GREA scores.

Table 4.4

The Relationship Between the Dependent Variables and the Covariate

Multivariate Statistics and F approximations				
	S = 1	M = 0	N = 23.5	
	F	Num DF	Den DF	Pr > F
Pillai's Trace	5.56	2	49	.0066

Note. Pillai's Trace statistic is recommended to test the relationship between the dependent variables and the covariate when cells are not equal (Tabachnick & Fidell, 1989). The obtained F value demonstrates that a significant relationship between the dependent variables and the covariate exists.

Table 4.5

The Proportion of Variance Explained in the Dependent Variables (R^2) by the Independent and Individual Difference Variables and the Covariate

Dependent Variables	EDI	TPS
Analysis 1		
Unadjusted[a]	.35	.27
Adjusted	.30	.19
Difference[b]	.05	.08
Analysis 2		
Unadjusted	.35	.20
Adjusted	.27	.19
Difference	.08	.01
Analysis 3		
Unadjusted	.46	.26
Adjusted	.40	.23
Difference	.06	.03
Analysis 4		
Unadjusted	.36	.17
Adjusted	.32	.29
Difference	.04	(.08)[c]

Note. [a]The unadjusted R^2 is the proportion of variance explained in the dependent variables without considering the presence of the covariate (GREA). [b]The difference between the unadjusted and the adjusted R^2 value is the proportion of variance in the dependent variables attributed to GREA. [c]The increase in R^2 after adjustment for the covariate is attributable to an increase in error.

Analysis 1

Treatment by Idealism

A 3 X 2 multivariate analysis of covariance (MANCOVA) was performed on the DV's: ethical discrimination ability (EDI) and perceptions of therapeutic behavior (TPS). The independent variable had 3 levels: placebo, A-B-C-D-E Worksheet and Ethical Justification. The individual difference variable, idealism, had two levels: high idealism and low idealism. Participants' scores on the idealism scale of the EPQ were categorized high or low depending if scores fell above or below the median idealism score for the sample. Adjustment was made on the two dependent variables by participants' analytical score on the Graduate Record Exam (GREA).The overall F test on the EDI was significant, $F(8,43) = 4.16$, $p>.008$. However, the main effect for treatment, $F(2,49) = 3.61$, $p> .0353$, for idealism, $F(1,50) = 2.45$, $p>.1242$ and the interaction effect between treatment and idealism, $F(2,49) = .10$, $p>.9094$, were not significant. The significant F test on the EDI was further evaluated by Pillai's Trace statistic. This statistic evaluates the main effects on the dependent variable by adjusting for differences in cell sizes. Neither main effect for treatment , $F(4,90) = 3.063$, $p>.0198$, or the main effect for idealism $F(2,44) = 1.514$, $p >.2312$, were significant at the alpha level set a priori (.0167).

The significant overall F test on the EDI demonstrates that a significant difference(s) between treatment groups (main effect A) or between the high and low idealism groups (main effect B) exists. However, when the influence of each main effect and the interaction effect is evaluated separately, the degrees for freedom of each effect is smaller than that for the overall test (8,43 vs. 2,49). Consequently, a larger F value is required for the individual tests. Even when cell sizes were adjusted, no significant main effects were found. It is likely that a larger sample would increase the power of this

analysis such that the significance found in the overall F test could be pinpointed to either of the main effects. In other words, treatment in ethical decision making or participants' level of idealism could be attributed to the difference found in participants' performance on the EDI.

Unlike the overall F test on the EDI, the overall F test on the TPS was not significant, $F(8,43) = 1.85$, $p>.1101$. Accordingly, the main effects for treatment, $F(2,49) = 2.55$, $p> .0894$, and idealism, $F(1,50) = .79$, $p>.3779$, were not significant. In other words, neither treatment nor idealism significantly influenced participants ratings of therapeutic clinical behaviors (i.e., the TPS).

Post hoc analysis. A post hoc content analysis of high and low idealistic participants' responses on the EDI was conducted. The responses under consideration were those that were not correct. Incorrect responses were operationalized into three categories: process comments, query comments and error comments. Error comments were responses that falsely identified an ethical issue. For example, a participant may have mentioned that client welfare was in jeopardy when in fact it was not. Query comments were responses that reflected the participants' desire for more information in order to clarify the ethical issues involved. Query comments like "Was a formal contract entered into?" or "Is the student a client" are examples. Process comments were statements that individuals made about a scenario or a component of a scenario. Process comments tended to be moralistic in nature and often reflected the participants' personal values. For example, process comments were frequently made regarding the scenario of receiving an invitation from a licensed colleague to attend a nude marathon. Several individuals made comments such as "This is against my values" or "Participation in a nude event is unacceptable". These comments do not identify the specific ethical issues involved in the scenario but rather reflect the participants' personal beliefs about the ethical content.

The post hoc analysis was conducted to see if participants who were highly idealistic in their moral evaluations made more process comments on the EDI than low idealistic participants. A content analysis of 28 EDI inventories was conducted. Inventories were equally represented by high and low idealistic participants (i.e., 14 high and 14 low). The number of process comments for the two groups of participants was tallied. High idealistic participants made a total of eight process comments as compared to a total of one process comment by low idealistic participants. A significant difference in number of process comments between high and low idealistic participants was found, $X^2(2) = 5.44$, $p = .02$. In other words, participants who were highly idealistic in their moral evaluations made significantly more process comments on the EDI than participants who were idealistically low in their moral evaluations.

Analysis 2

Treatment by Relativism

The MANCOVA procedure conducted in analysis 2 varies from the procedure in analysis 1 by the individual difference variable, i.e., relativism. Participants' scores on the relativism scale of the EPQ were categorized high or low if scores fell above or below the median relativism score for the sample.

The overall F test on the EDI was not significant, $F(8,43) = 2.81$, $p>.0209$. Accordingly, the main effect for treatment, $F(2,49) = 2.92$, $p> .0643$, for relativism, $F(1,50) = .04$, $p>.8507$ and the interaction effect between treatment and relativism, $F(2,49) = .09$, $p>.9114$, was not significant. In other words, neither the level of treatment a participant received (i.e., training in a ethical decision-making model) or the level of relativism in participants' moral attitudes significantly effected participants' performance on the EDI.

The overall F test on the TPS was not significant, $F(8,43) = 1.79$, $p>.1233$. In addition, the main effects for treatment, $F(2,49) = 2.87$, $p> .0670$, for relativism, $F(1,50) = 1.78$, $p>.1884$ and the interaction, $F(2, 49) = .66$, $p> .5203$ were not significant. Hence, the level of treatment and the level of relativism in participants' moral attitudes did not significantly effect participants' performance on the TPS. No further evaluation of analysis 2 was conducted due to the lack of significance found on the overall F test for either dependent variable.

Analysis 3

Treatment by Ethics Class

The 3 X 2 MANCOVA procedure conducted in analysis 3 involved evaluating the influence of the independent variable (training in ethical decision making) and ethics class versus no ethics class. Adjustment was made on the two dependent variables by the same covariate as the above analyses, i.e., GREA.

The overall F test on the EDI was significant, $F(8,43) = 5.11$, $p>.0005$. The main effect for treatment, $F(2,49) = 4.03$, $p> .0246$ was not significant while the main effect for ethics was significant, $F(1,50) = 10.14$, $p>.0026$ (see Figure 4.1). No interaction effect between treatment and ethics class was present, $F(2,49) = .03$, $p> .9678$.

The significant main effect for ethics indicates that participants who had completed the required ethics class in the counselor education program scored significantly higher on the EDI than did participants without the ethics class. In other words, participants who completed the ethics class identified significantly more ethical issues embedded in counseling scenarios depicting unethical behavior than did the participants without ethics class.

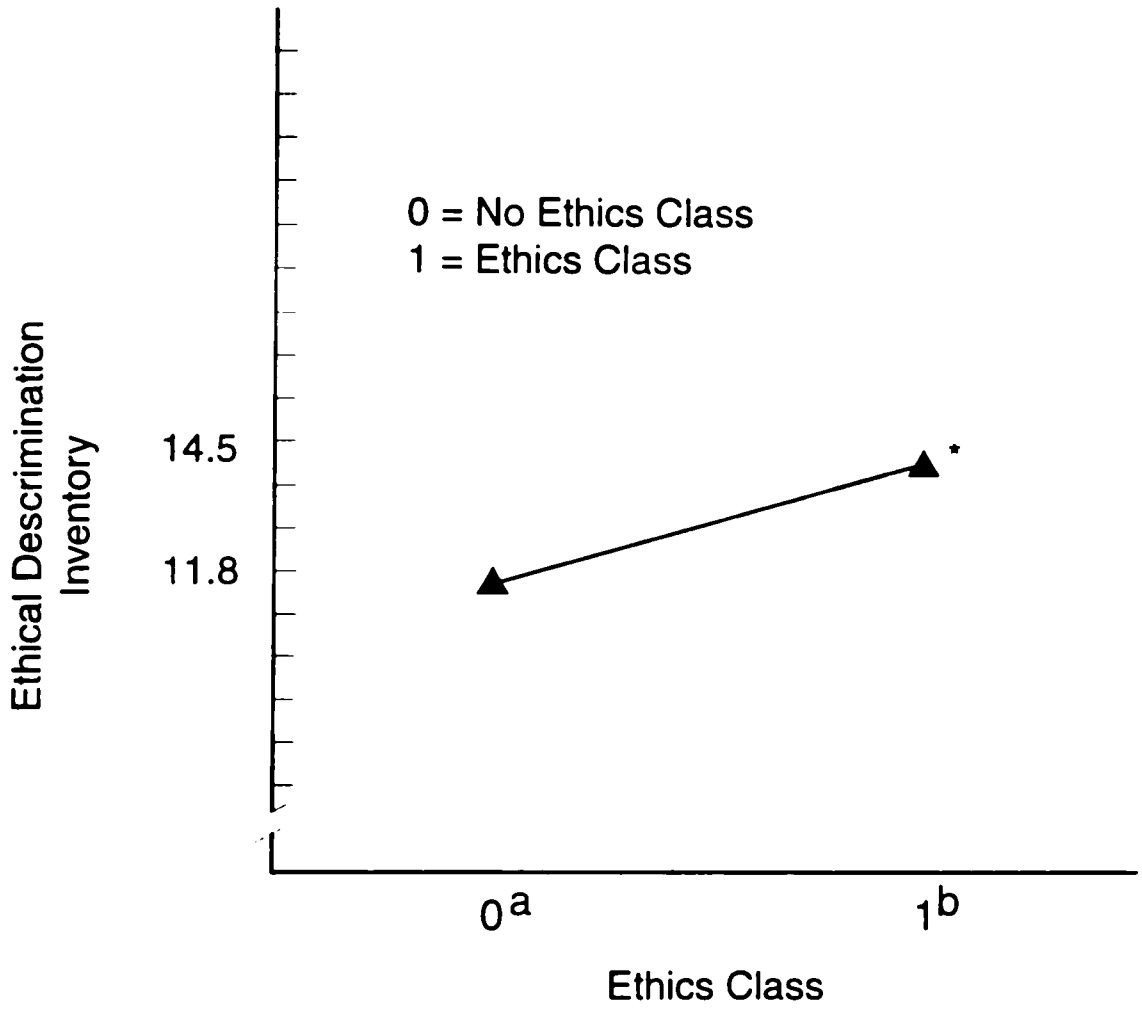

Figure 4.1. Main effect for ethics class on the Ethical Discrimination Inventory (EDI). Participants who completed the required ethics class scored significantly higher on the EDI than participants who had not completed the required ethics class.

[a] $n = 28$. [b] $n = 24$.

* $p < .0026$.

Unlike the significant differences found on the EDI between those participants who had the required ethics class and those who did not have the ethics class, no significant differences were found on the TPS. More specifically, the overall F test on the TPS was not significant, $F(8,43) = 2.36$, $p>.0458$. Accordingly, the main effects for treatment, $F(2,49) = 3.26$, $p> .475$, ethics class, $F(1,50) = 4.25$, $p> .0451$ and the interaction effect between treatment and ethics class, $F(2,49) = .85$, $p> 4340$, were not significant. These results indicate there was no relationship between treatment and performance on the TPS and between ethics class and performance on the TPS.

The influence of the independent variable on the dependent variables was further evaluated by Pillia's Trace (Tabachnick & Fidell, 1989). Pillia's Trace is a statistic that adjusts for sample size differences between treatment conditions. When adjustment for sample size differences was made, a significant main effect for treatment was present, $F(4,90) = 3.6419$, $p> .0085$. An inspection of the adjusted means on both dependent variables demonstrated that the main effect for treatment occurred on the EDI (see Figure 4.2). The significant main effect for treatment occurred wherein the Ethical Justification group scored significantly higher on the EDI than did either of the other two treatment groups: placebo and A-B-C-D-E Worksheet. However, neither the placebo group or the A-B-C-D-E Worksheet group significantly differed from each other. Said differently, participants in the Ethical Justification treatment group were able to identify ethical issues embedded in counseling scenarios significantly more often than were participants in either the A-B-C-D-E Worksheet group or the placebo group. Furthermore, participants in the A-B-C-D-E Worksheet group did not benefit from the training they received any more than the participants who were in the placebo condition.

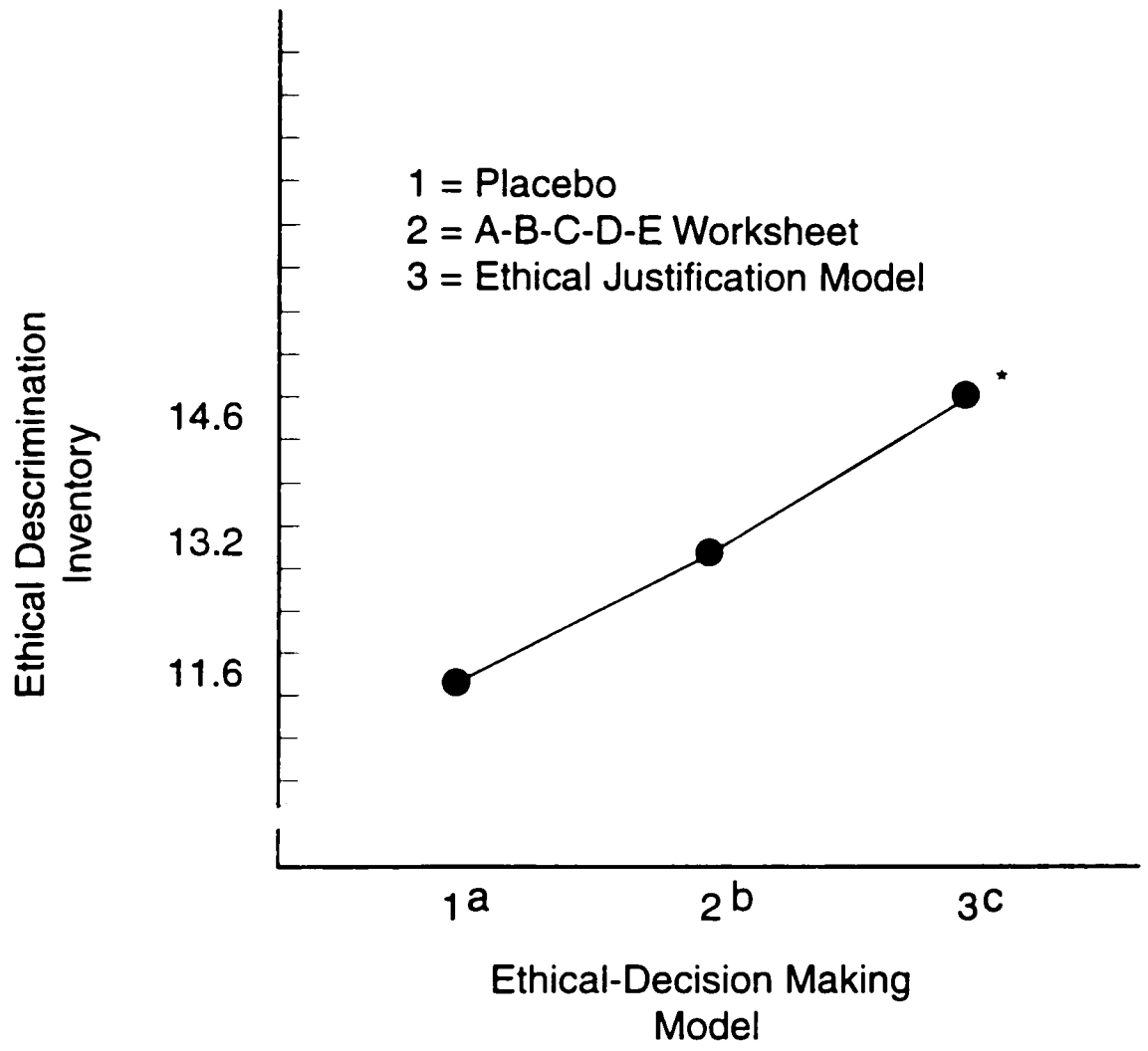

Figure 4.2. Main effect for treatment on the Ethical Discrimination Inventory (EDI). Participants in the Ethical Justification treatment condition scored significantly higher on the EDI than did participants in the other two treatment conditions. The A-B-C-D-E Worksheet treatment condition and the placebo treatment condition did not significantly differ from each other.

[a] $n = 14$. [b] $n = 17$. [c] $n = 21$.

*$p < .0068$.

Analysis 4

Treatment by Practicum Class

The 3 X 2 MANCOVA procedure conducted in analysis 4 evaluated the influence of the independent variable and practicum class versus no practicum class on the DV's. Adjustment was made on the two dependent variables by participants' GREA scores.

The overall F test for the EDI, $F(8,43) = 3.58$, $p > .0055$, was significant. However, neither of the main effects for treatment, $F(2,49) = 3.25$, $p > .04$ or practicum $F(1,50) = 2.33$, $p > .1338$ were significant. Accordingly, the interaction between treatment and practicum on the EDI was not significant, $F(2,49) = .49$, $p > .6168$. The overall significant outcome of the analysis coupled with no significant main effects or interaction effect lead to evaluating the significant overall F test using Pillia's Trace. This test did identify a significant main effect for treatment, $F(4,90) = 3.98$, $p > .005$ on the EDI. Figure 4.3 demonstrates the significant differences between treatment groups. The significant outcome in this analysis is similar to the significant main effect for treatment on the EDI in the previous analysis, i.e., the Ethical Justification group scored significantly higher on the EDI than did either of the other two treatment groups. In addition, neither the placebo group or the A-B-C-D-E Worksheet group differed significantly from each other on the EDI.

The overall F test for the TPS, $F(8,43) = 3.07$, $p > .0133$, was significant. In addition, the main effect for treatment, $F(2,49) = 4.76$, $p > .0133$, and the interaction effect between treatment and practicum, $F(2,49) = 4.72$, $p > .0138$, was significant (see Figure 4.4). The main effect for practicum, $F(1,50) = .00$, $p > .9767$, was not significant.

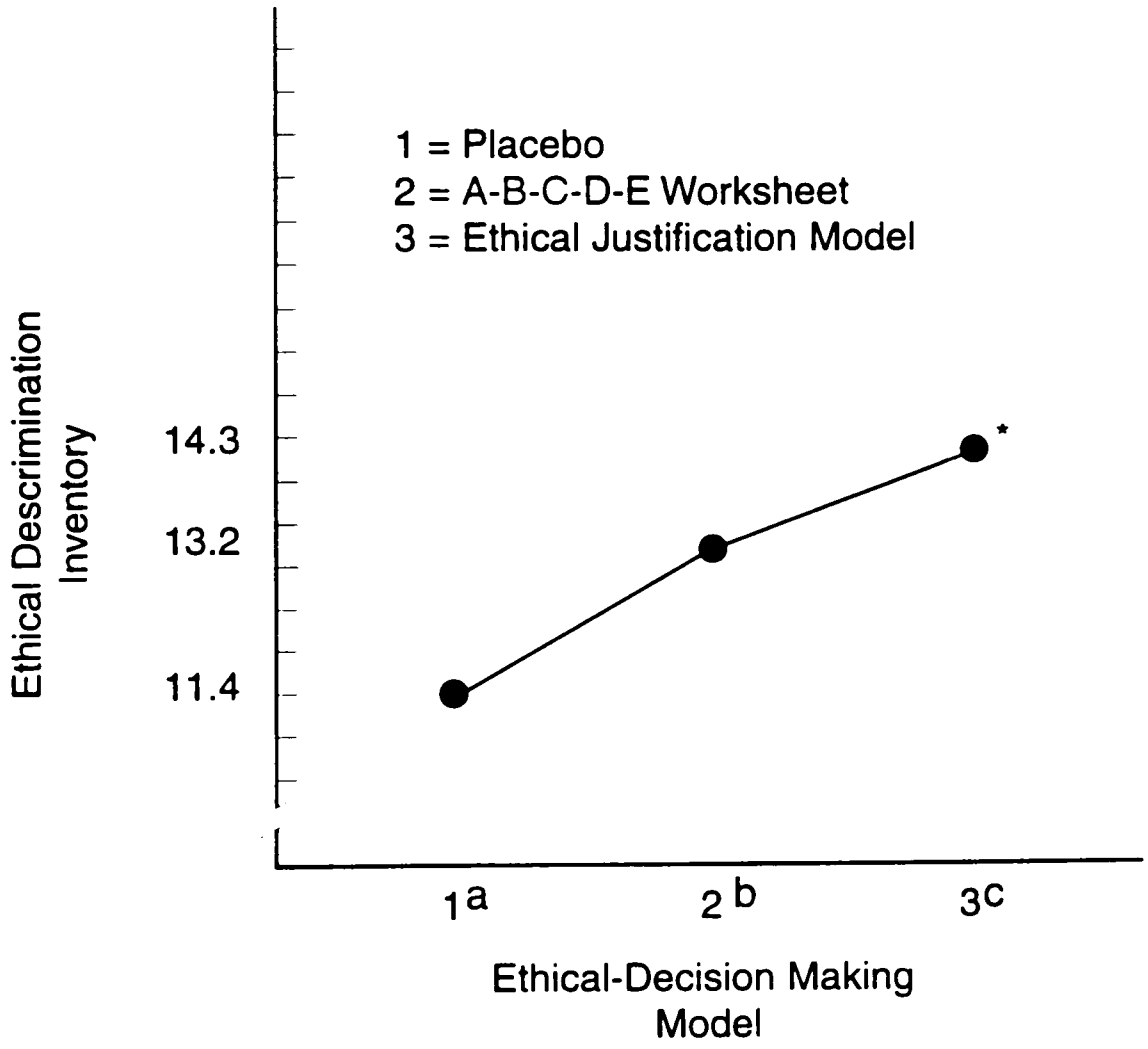

Figure 4.3. Main effect for treatment on the Ethical Discrimination Inventory (EDI). Participants in the Ethical Justification treatment condition scored significantly higher on the EDI than did participants in the other two treatment conditions. The A-B-C-D-E Worksheet treatment condition and the placebo treatment condition did not significantly differ from each other.

[a] $n = 14$. [b] $n = 17$. [c] $n = 21$.

*$p < .0143$.

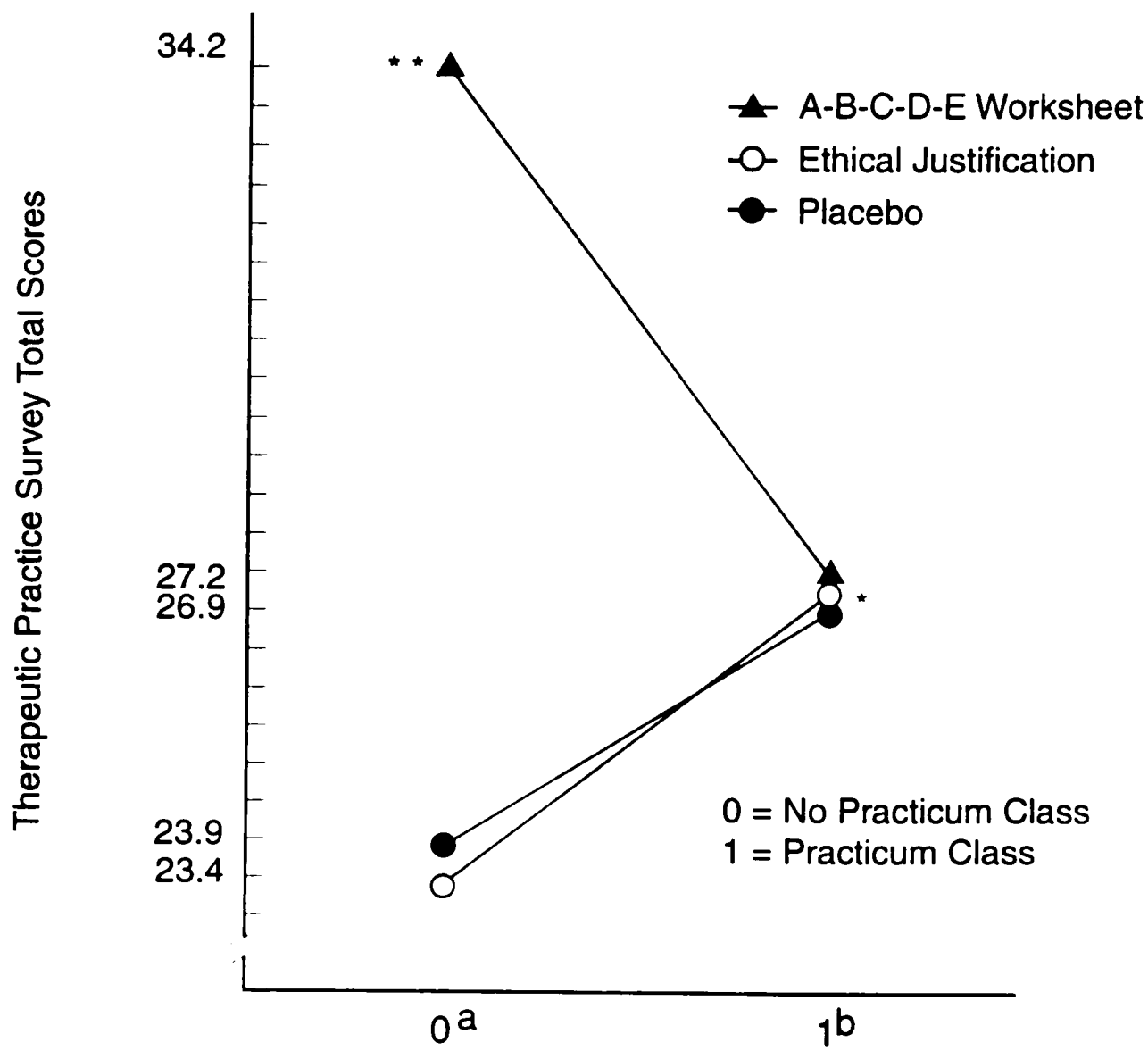

Figure 4.4. Interaction effect between the A-B-C-D-E Worksheet treatment condition and practicum level on the Therapeutic Practice Survey (TPS). Participants without practicum and in the Worksheet condition rated the ethicality of clinical behaviors higher significantly more often than participants without practicum and in the two other treatment conditions. Furthermore, all participants with practicum rated the same clinical behaviors lower significantly more often than the high scoring no practicum group.

[a] $n = 23$. [b] $n = 29$.

* $p < .0167$ ** $p < .0034$

Figure 4.4 illustrates the MANCOVA procedure described above. First, participants who did not have practicum but were in the A-B-C-D-E Worksheet training condition rated the ethicality of clinical behaviors significantly higher more often than those participants without practicum experience and in the other two treatment conditions. Secondly, participants with practicum experience and in all three treatment conditions did not rate the same behaviors significantly differently from each other or significantly differently from participants without practicum experience and in the placebo group and the Ethical Justification group. However, all participants with practicum experience rated the ethicality of the behaviors lower significantly more often than the high scoring no practicum group. In other words, the participants without practicum and in the A-B-C-D-E Worksheet treatment condition rated the ethicality of clinical behaviors of therapists higher more significantly more often than all other participants. Moreover, the lack of main effect for practicum illustrates that the significant differences between groups can be attributed to the A-B-C-D-E Worksheet condition coupled with no practicum experience.

In summary, participants without practicum and in the Worksheet condition rated the ethicality of the behaviors higher significantly more often than either of the other two groups (see Table 4.6). This suggests that the A-B-C-D-E Worksheet training influenced participants who did not have practicum to be less cautious in their ratings of clinical behaviors than the other participants without practicum. Moreover, participants with practicum experience and in the A-B-C-D-E condition rated the ethicality of clinical behaviors lower significantly more often than their no practicum counterparts.

The interaction of treatment by practicum can be further understood by examining the performance of each group by the three different factors on the TPS rather than TPS total scores. The outcome of that analysis follows.

Table 4.6

Mean Comparisons of TPS Total Scores by Treatment Groups Across Practicum Levels and the Normative Group

Treatment Group x Practicum Level	Mean Score	Normative Group
Placebo x No Practicum	23.97	35.74
Placebo x Practicum	26.97	
A-B-C-D-E x No Practicum	34.17**	
A-B-C-D-E x Practicum	27.24*	
Ethical Justification x No Practicum	23 43	
Ethical Justification x Practicum	27.21	

Note. Although ratings varied significantly between treatment groups and across practicum levels, the ethicality of all therapeutic behaviors were rated lower by participants in the current study than by the normative group.

*$p < .0167$, **.0034

Evaluation of ratings on the TPS by factors

A 3 X 2 MANCOVA was performed where each factor on the TPS was used as a dependent variable instead of TPS total scores and EDI scores. This strategy was employed to evaluate what treatment conditions influenced participants' factor ratings differently for each level of practicum. An item from each factor will illustrate the content of the factor followed by the outcome of the MANCOVA procedure. As in the above analysis, GREA scores were used as a covariate.

Factor 1. Factor 1, incidental involvement's, is illustrated by the following item, "Accepting a gift worth under $10 from a client." The overall F test was not significant, $F(6,45) = .99$, $p > .4438$. Accordingly, the main effects for treatment $F(2,49) = .62$, $p > .5450$, for practicum experience $F(1,50) = .14$, $p > .7117$ and the interaction effect between treatment and practicum, $F(2,49) = 1.39$, $p > .2587$ were not significant on factor 1. The lack of significant differences on factor 1 demonstrates that all participants rated incidental involvement's similarly. Whether or not participants experienced a particular treatment condition or had taken a practicum class did not influence them to evaluate incidental involvement's significantly differently. Table 4.7 reports the means of every treatment group at each level of practicum for each factor. The means from the normative group on each factor are included in the table for comparison.

Figure 4.5 illustrate the participants' ratings on factor 1. Visually, the graph depicts an interaction for the A-B-C-D-E Worksheet and the Ethical Justification model. However, mean differences between treatment conditions and between levels of practicum were not significant. It is probable that significant differences between treatment conditions and practicum levels would result from increasing the sample size.

Table 4.7

Mean Comparisons of TPS Factor Scores by Treatment Groups Across Practicum Level and the Normative Group

Factor 1	Mean Score	Normative Group
Placebo x No Practicum	5.68	8.09
Placebo x Practicum	5.75	
A-B-C-D-E x No Practicum	6.25	
A-B-C-D-E x Practicum	5.45	
Ethical Justification x No Practicum	4.45	
Ethical Justification x Practicum	5.83	
Factor 2		
Placebo x No Practicum	13.21	18.68
Placebo x Practicum	16.02	
A-B-C-D-E x No Practicum	19.78	
A-B-C-D-E x Practicum	15.78	
Ethical Justification x No Practicum	14.92	
Ethical Justification x Practicum	15.27	
Factor 3		
Placebo x No Practicum	5.07	8.03
Placebo x Practicum	5.19	
A-B-C-D-E x No Practicum	8.13	
A-B-C-D-E x Practicum	6.00	
Ethical Justification x No Practicum	4.05	
Ethical Justification x Practicum	6.10	

Note. The A-B-C -D-E Worksheet group without practicum rated the ethicality of therapeutic behaviors higher on factors 2 and 3 than all other participants and the normative group on the same factors.

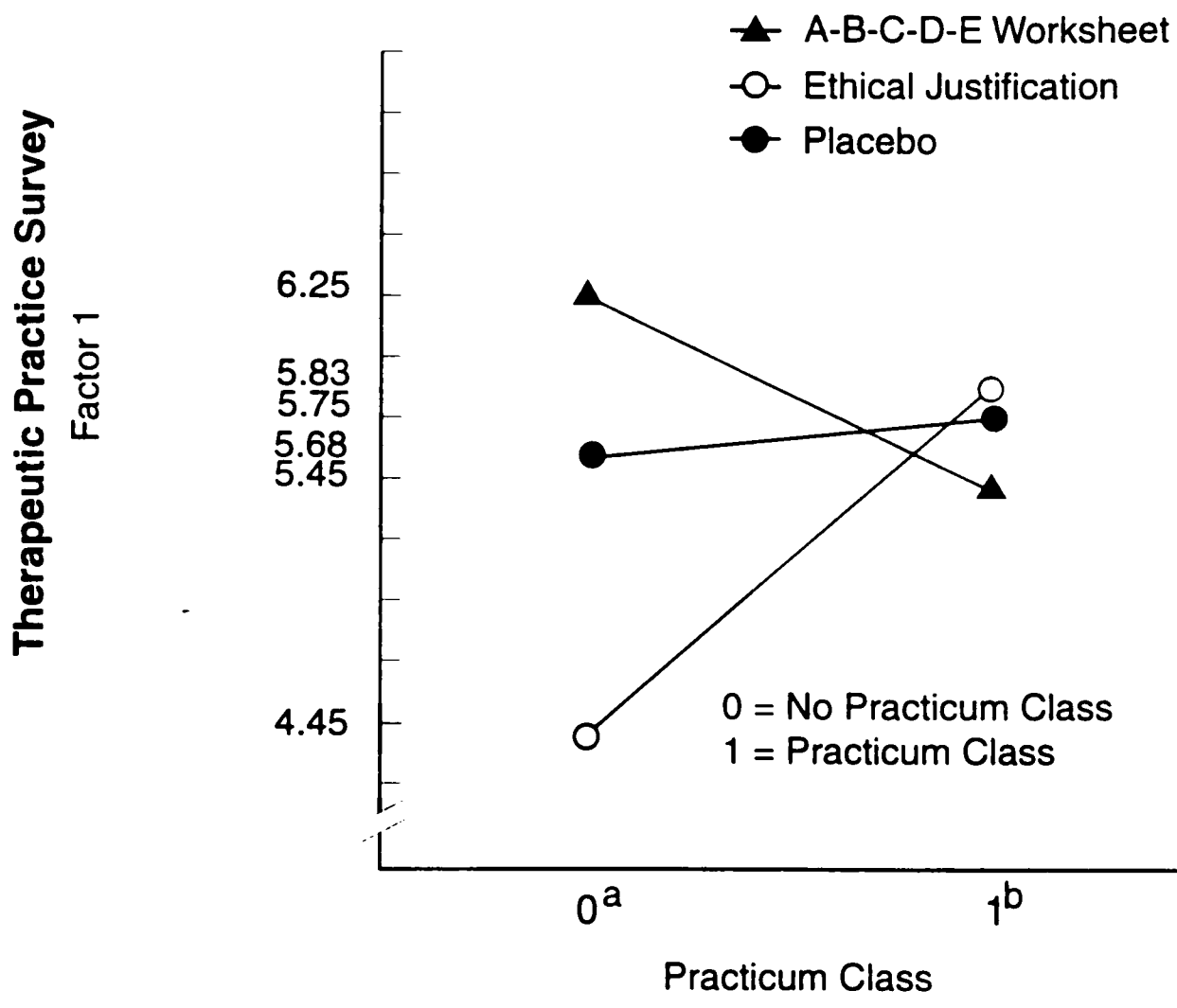

Figure 4.5. No significant mean differences in ratings of clinical behaviors occurred on factor 1 between types of treatment and levels of practicum.

[a] $n = 23$. [b] $n = 29$.

Factor 2. Similar to factor 1, no significant differences were found on factor 2. Factor 2, social/financial involvements, is illustrated by the following item, "Becoming friends with a client after therapy." The main effect for treatment $F(2,49) = 3.46$, $p > .04$ and the interaction of treatment by practicum effect was not significant, $F(2,49) = 3.36$, $p > .0438$. No significant differences were found between practicum levels, $F(1, 50) = .07$, $p > .7915$. However, participants in the no practicum Worksheet condition rated the ethicality of factor 2 items higher than did the normative group (see Table 4.7). This suggests, that no practicum experience coupled with A-B-C-D-E training resulted in participants underestimating the ethical nature of social/financial involvements.

Figure 4.6 illustrates the outcome on factor 2. Again, the differences between treatment conditions and levels of practicum appear to interact for the A-B-C-D-E Worksheet and the Ethical Justification conditions. However, neither treatment condition nor level of practicum experience resulted in participants to rate the ethicality of social/financial involvements between a therapist and his or her client significantly differently. As in the case of factor 1, an increase in the sample size would likely result in significant differences between treatment means at the different levels of practicum.

Factor 3. Factor 3, dual professional roles, is illustrated by the item "providing therapy to a current employee." Unlike participants' ratings on factors 1 and 2, participants did score significantly differently on factor 3. Both the main effect for treatment, $F(2,49) = 5.42$, $p > .0078$, and the interaction effect for treatment by practicum, $F(2,49) = 5.29$, $p > .0087$, were insignificant. The main effect for practicum was not significant, $F(1,50) = .00$, $p > .9824$ (see Figure 4.7).

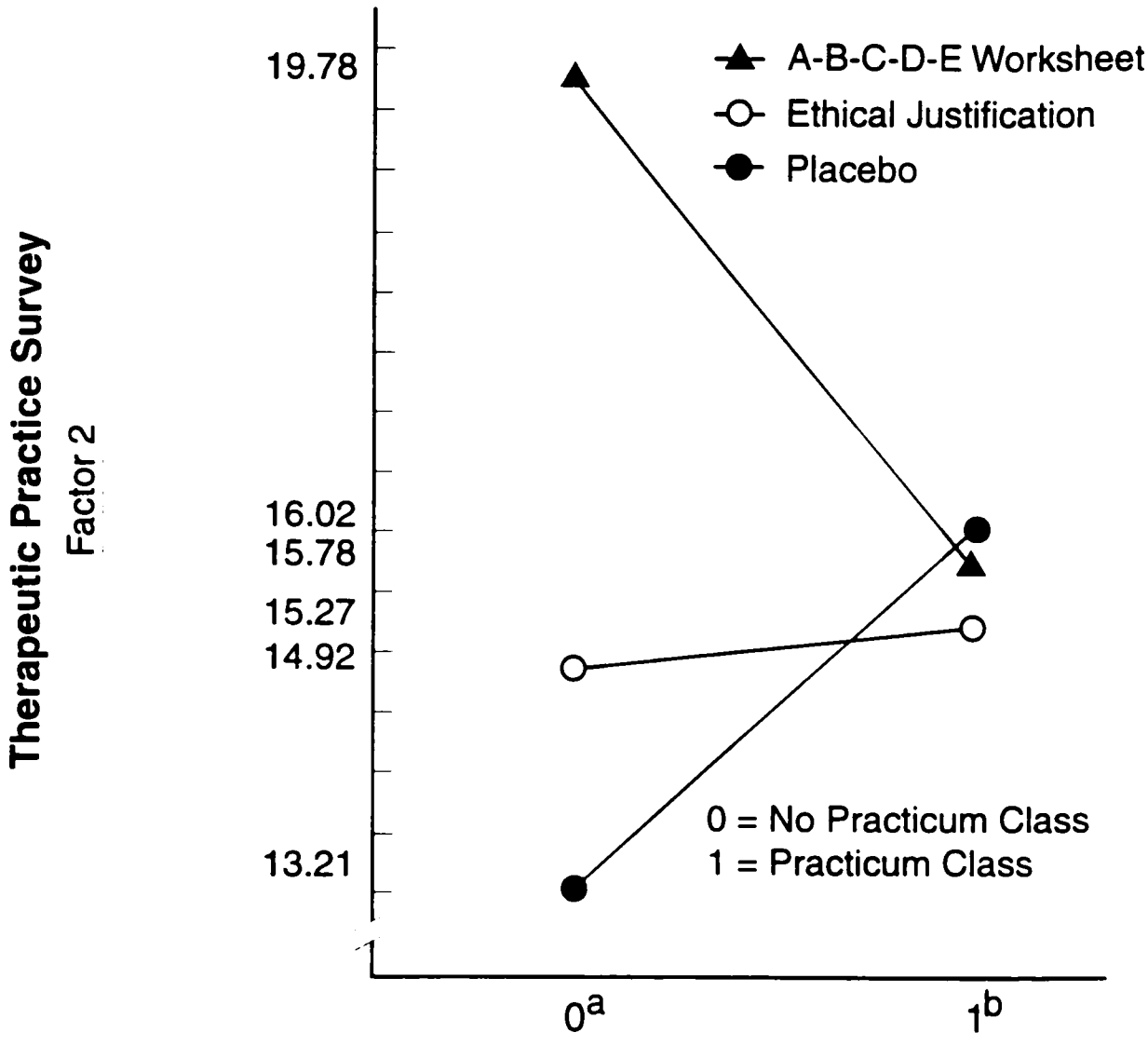

Figure 4.6. No significant mean differences in ratings of clinical behaviors occurred on factor 2 between types of treatment and levels of practicum.

[a] $n_{-} = 23$. [b] $n = 29$.

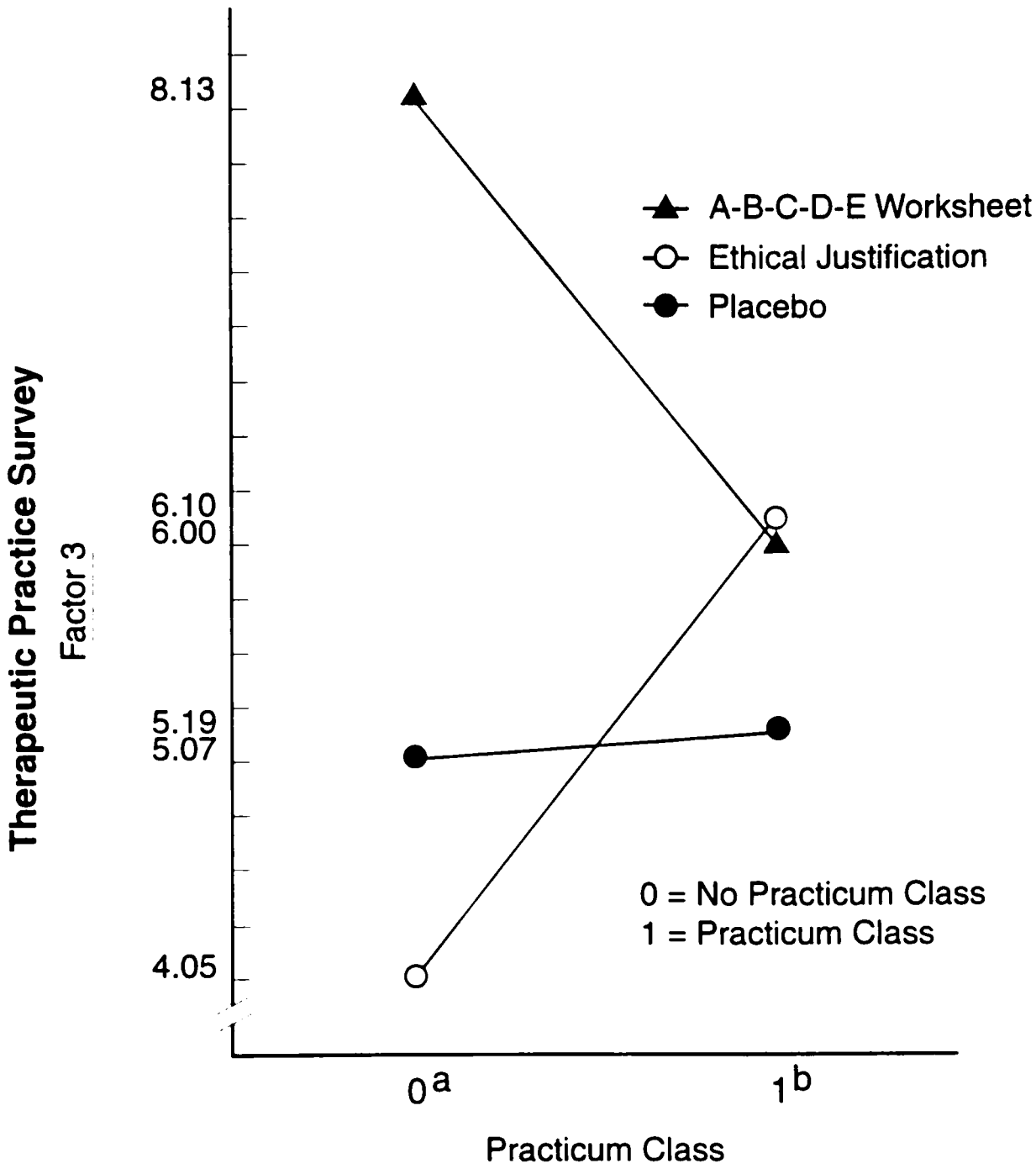

Figure 4.7. The no-practicum Worksheet condition rated the ethicality of dual role behaviors higher significantly more often than participants without practicum and in the other two treatment conditions. In addition, the F test identified interactions occurring within the Worksheet treatment condition and the Ethical Justification treatment condition. However, when each interaction was evaluated separately the necessary F value was not reached.

[a] $n = 23$. [b] $n = 29$.

* $p < .0078$

Figure 4.7 presents the data showing that one main effect and two interaction effects occurred. The main effect occurred where by the A-B-C-D-E Worksheet group without practicum rated the ethicality of dual role behaviors higher significantly more often than did participants without practicum experience in either of the other two groups. Said differently, the high scoring no-practicum group discerned the ethical nature of dual role behaviors significantly less often than did participants without practicum but trained in either of the other two models. Moreover, as seen in Table 4.7, participants without practicum and in the Worksheet condition rated the ethicality of dual role behaviors on average higher more often than did the normative group. The difference between the former and the latter is similar to the comparison between these same groups on factor 2. Participants without practicum experience who were trained in the Worksheet condition underestimated the ethical nature of dual role behaviors and of social/financial involvements.

With respect to the interaction effects, the F test identified interactions occurring within the Worksheet group and the Ethical Justification group across the levels of practicum. Although significance was reached in the F test, when each interaction was evaluated separately the necessary F value was not reached. Table 4.7 illustrates the mean differences between treatment groups across practicum level for factor 3. A future studywith a larger sample should explore the relationship between training in ethical decision-making and level of practicum experience.

In summary, participants trained in the A-B-C-D-E Worksheet and who did not have practicum experience rated the ethicality of dual role behaviors (factor 3) higher significantly more often than participants in either the placebo group or the Ethical Justification group. In addition, the no-practicum Worksheet group rated the ethicality of dual role behaviors and social/financial involvements on average higher than the normative

group. Although the frequency of ratings on factor 3 between treatment conditions significantly differed, no significant differences in ratings occurred between treatment conditions for either social/financial involvement's or incidental involvement's, factors 2 and 1, respectively. However, when treatment groups and level of practicum were evaluated for TPS total scores, a significant interaction was found. Participants in the no-practicum A-B-C-D-E Worksheet condition rated the ethicality of therapeutic behaviors between therapist and client higher significantly more often than all other participants. However, the high scoring no-practicum group did rate behaviors more often as unethical than did the normative sample.

CHAPTER V

DISCUSSION

The purpose of this study was to evaluate the influence of ethical decision-making models, of individual difference variables and of two training variables on counselor trainees' ability to evaluate ethical situations and their perceptions of clinical behaviors. Two ethical decision-making models, the A-B-C-D-E Worksheet and the Ethical Justification model were the two decision-making models evaluated. The influence of each model and a placebo model on the dependent variables were measured. The dependent measures were: the Ethical Discrimination Inventory (EDI) and the Therapeutic Practice Survey (TPS). In addition to the ethical decision-making models, three individual difference variables: participants' endorsement of idealistic and relativistic moral attitudes and their analytical reasoning ability; and two training variables: ethics class and practicum, were evaluated as to their influence on the dependent measures.

This chapter discuses the results of the MANCOVA analyses reported in chapter four. The discussion is preceded by a summary of the purpose and procedures followed in this study. The chapter concludes with a discussion regarding the implications this study has toward conceptualizing the utility and future inquiry of ethical decision-making models.

Summary of Purpose and Procedures

The research evaluating the influence of ethics training on helping professionals' ability to evaluate ethically laden material is not conclusive. Helping professionals appear to be influenced by a variety of individual and training variables and by the saliency of ethical issues. Consequently, evaluations of ethical issues often differ and give rise to

seemingly opposite courses of action among professionals (Haas, Malouf and Mayerson, 1988). Ethical codes were developed in part to establish normative standards of practice for helpers. And yet, ethical tasks faced by counselors are often complex and require the counselor to behave in ways not clearly defined by the codes of ethics (Corey, Corey, and Callanan, 1993; Drane,1982). As a result, counselors often make ethical decisions without the aid of ethical codes or principles (Gladding, 1996).

Counselor educators have recommended that ethical decision-making models be incorporated into the formal training of counselor trainees as one way to equip future counselors to more adequately address and respond to ethical issues (Tymchuk, 1986; Tarvydas, (1987). In response to counselor educators' recommendation, numerous models have been developed for use in a wide variety of settings and with diverse client populations. However, whether or not ethical decision-making models facilitate counselors' evaluations of ethical issues and provide guidance to them in making ethical decisions has not been empirically investigated.

The purpose of this study was to evaluate the effect of two ethical decision-making models on two dependent variables: trainees' ability to discriminate ethical issues embedded in counseling scenarios, the Ethical Discrimination Inventory (EDI); and trainees' perceptions of therapeutic behavior, the Therapeutic Practice Survey (TPS). The A-B-C-D-E Worksheet model (Sileo & Kopala, 1993) and the Ethical Justification model (Kitchener, 1984) were the two ethical decision-making models investigated. The effects of both models were evaluated against each other as well as against a placebo model. The placebo model was included in the design of this study rather than a control group so that participants' expectations induced by the treatment condition (i.e., the Hawthorne Effect) would be equal for participants assigned to either of the three treatment conditions.

Fifty-two master-level counselor trainees were randomly assigned to one of the three decision-making models (i.e., the placebo model, the A-B-C-D-E Worksheet, or the Ethical Justification model). Participants not assigned to the placebo model were taught what an ethical dilemma was, the decision-making model they were assigned and given opportunity to practice using the model by evaluating four case studies depicting ethical issues. Once participants finished evaluating the case studies, they completed the EDI and the TPS.

Participants' assigned to the placebo treatment group were not trained in using a decision-making model or informed of what an ethical dilemma was. The "training" these participants received entailed completing the Ethical Attitudes Survey (Dinger & Martin, 1996). The survey queried participants' opinions regarding the term "ethics," the importance of ethical codes and ethics training. Once the survey was completed, participants discussed their responses to the items on the survey Following the discussion, participants completed both dependent measures.

In addition to the effect of the independent variable (i.e., the treatment groups) on the dependent measures, the influence of three individual difference variables and two training variables on the dependent variables were also evaluated. The individual difference variables were participants' endorsement of relativistic and idealistic moral attitudes and participants' analytical ability. The former were measured using the Ethical Position Questionnaire (Forsyth, 1980) and the latter by participants' analytical scores on the Graduate Record Exam. The training variables were the required ethics class in the counselor education department and a practicum class in the counselor education department. With the exception of participants' analytical scores, each individual difference variable and training variable had two levels: high and low relativism, high and low idealism, ethics class vs. no ethics class and practicum class vs. no practicum class.

Participants' analytical scores were kept as a continuous variable and used as a covariate in the analysis of this study.

Separate 3 X 2 multiple analysis of covariance (MANCOVA) procedures were conducted on each combination of the independent variable with the individual difference variables and the training variables. An effort was made to reduce experimental error by using participants' analytical scores on the Graduate Record Exam (GREA) as a covariate. To control for Type 1 error, the MANCOVA analyses were grouped by "families" of similar research questions (Kirk, 1995), using the family as the unit of error-control. Three families were identified: the relationship of training in ethical-decision making to performance on the Ethical Position Questionnaire (EPQ), to participants' completion of an ethics class and to participants' completion of a practicum class. Accordingly, alpha for each MANCOVA analysis was set at .05/3 = .0167.

To summarize, this study investigated three areas: the influence of ethical decision-making models, of individual difference variables and of ethics and practicum training on counselor trainees' ability to discern ethically laden counseling scenarios and their perceptions of therapeutically appropriate behaviors. Fifty-two master level counselor trainees were randomly assigned to one of three treatment conditions. Once participants completed the treatment condition, they completed the Ethical Discrimination Inventory and the Therapeutic Practice Survey. A discussion of each analysis follows.

Ethical Decision-Making Models

The first objective for this study was to evaluate if ethical decision-making models (i.e., the independent variable) influenced counselor trainees' ability to discern ethical issues embedded in counseling scenarios and their perceptions of therapeutic behavior (i.e., the dependent variables). The relationship between the independent variable and the

two dependent variables was tested by the MANCOVA procedure described above. A brief review of the results of the MANCOVA procedure precedes the discussion of the relationship between the independent variable and the dependent measures. Suggestions for future inquiry are provided.

Training in Ethical Decision-Making and Performance on The Ethical Discrimination Inventory (EDI)

Counselor trainees in the Ethical Justification (EJ) treatment condition were able to correctly identify significantly more ethical issues embedded in counseling scenarios (i.e., the EDI) than trainees in either the A-B-C-D-E Worksheet condition or the placebo condition. Moreover, no significant differences occurred between trainees' in the latter two groups. In other words, participants trained in the Worksheet model performed on the EDI as well as participants trained in the placebo model. Hence, training in the Worksheet condition did not improve participants' ability to correctly identify ethical issues. Only participants trained in the EJ model were equipped to discern more thoroughly the ethical nature of the scenarios on the EDI.

An explanation of why the EJ model and the Worksheet model influenced participants' performance on the EDI differently is attributed to several factors: (1) the rationale for the EJ model and the Worksheet differ significantly; (2) the content of each model is notably different; and (3) the broad scope of ethical issues contained on the EDI. Each of these factors is explained below.

The rationale and content of each model

The rationale of the EJ model and the Worksheet model notably differ from each other. Neither Kitchener (1984) nor Sileo and Kopala (1993) specifically identify the theoretical basis of their models. However, Kitchener's Ethical Justification model seems

to closely resemble ethical hierarcialism theory (Geisler, 1971; in Feinberg & Feinberg, 1993). Ethical hierarchialism states that many norms are universal and hierarchically ordered on the basis of their importance. When norms conflict, this theory states that individuals must determine which norm is of greater significance and respond to it. The content of the EJ model is hierarchically ordered such that the most "just" decision will be accomplished when evaluating ethical principles that conflict.

Sileo and Kopala (1993) do not identify a theoretical basis for their model but rather follow the convention of most professional organizations by establishing client welfare as prima facie (cf. the American Counseling Association's and the American Psychological Association's code of ethics as cited in Gladding, 1996). More specifically, Sileo and Kopala established the Worksheet on the single principle of beneficence. Kitchener (1984) argues that establishing a specific principle or an ordering of principles as prima facie is problematic. Problematic because ethical decision-making models based on pre-established conventions cannot always anticipate issues that arise. Consequently, according to experts, models like Sileo and Kopala's Worksheet are too narrowly defined to address the multifaceted and often complex ethical issues that counselors encounter. It is possible that participants trained in the Worksheet condition were not equipped to discern the breadth of ethical issues contained on the EDI.

Unlike the Worksheet, the EJ model is not based on a single ethical principle nor are the ethical principles ordered by some pre-established convention. Rather, the ethical principles are simply one component of the EJ model. Kitchener's (1984) model is based on the following two assumptions: first, ethical actions are formulated at the individual's immediate, prereflective response to an ethical situation(s), and secondly, that an individual's immediate response may not always lead to the most ethical action. Accordingly, her model recommends that individuals value their immediate reaction to an

ethical situation but also to critically evaluate that response by considering the ethical code, ethical principles and if necessary, ethical theory. The EJ model provides individuals a framework that enables them to integrate their intuitive moral sense with professional codes, ethical principles and ethical theory. The model describes the process with which counselors' respond, evaluate, and refine their moral reasoning abilities. Kitchener proposes that the most "just" or correct action can be taken when counselors evaluate ethical situations according to the intuitive and the critical evaluative process rather than by a pre-established convention. The EJ treatment condition may have equipped participants to apply their learning more comprehensively to the EDI than participants trained in the Worksheet model. The narrow aim of the Worksheet as compared to the broader scope of the EJ model may have contributed to the significant difference in participants' identification of the ethical issues contained on the EDI.

In summary, the difference in performance on the EDI between participants trained in the Ethical Justification model and the Worksheet was attributed in part to the rationale and content of each decision-making model. Kitchener (1984) developed the EJ model on the assumption that counselors will make the most comprehensive evaluation when they consider their intuitive moral sense and critically evaluate professional codes, ethical principles and ethical theory. Sileo and Kopala (1993) developed a systematic approach to evaluate ethical issues from the premise that maintaining client welfare was most important. The comprehensive nature of the EJ model, as compared to the narrow aim of the Worksheet, may have prepared participants to discern more ethical issues on the EDI than did the Worksheet.

The scope of ethical issues contained on the EDI

The EDI consists of 12 scenarios that deal specifically with counseling and psychotherapy. Each scenario involves several ethical dilemmas, problems or considerations. The ethical content of each scenario includes several different categories. The range of categories per scenario ranged from a minimum of two to a maximum of five. The categories are as follows: consumer welfare, counselor competence, confidentiality, legal and moral standards, professional relationships, professional responsibility, assessment techniques and public statements. The above categories are listed in order of frequency occurring across all scenarios. In other words, consumer welfare was the most frequently occurring ethical consideration on the EDI. The last three categories in the above list (i.e., professional responsibility, assessment techniques and public statements) were equally represented and occurred the least across all scenarios.

Although the ethical content of the scenarios was categorized by an older version of the Ethical Standards of Psychologists (APA, 1982; as cited in Lipsitz, 1985), the categories represent seven of the eight categories included in the most recent version of the Ethical Standards of the American Counseling Association (ACA, 1995; as cited in Gladding, 1996). In other words, the ethical content on the EDI addresses nearly all issues related to the responsible practice of counselors.

The breadth of ethical issues on the EDI likely contributed to the differences in performance on the EDI between participants in the Worksheet condition and the EJ condition. The purported narrow aim of the Worksheet may not have prepared participants to address the comprehensive nature of the EDI. Although client welfare was the most frequently occurring ethical concern on the EDI and the Worksheet is based on beneficence, participants in the Worksheet condition were not able to identify as many

ethical issues on the EDI as were participants in the EJ condition. This outcome may question the validity of the Worksheet. Although the objective of the Worksheet is to clarify complex ethical situations so that counselors are able to arrive at a decision that promotes their clients' welfare, trainees in this study were not able to significantly identify any more issues than participants trained in the placebo condition.

Future inquiry may clarify whether or not the scope of ethical issues on the EDI contributed to the differences in participants' performance. A content analysis of participants' responses may clarify the relationship between the ethical issues described on the EDI and the differences in responses illicited by individuals trained in different ethical decision-making models. It is factual that participants in the Worksheet condition correctly identified fewer ethical issues on the EDI than participants in the EJ model. However, what ethical issues were correctly identified by participants in both treatment conditions was not evaluated in this study Kitchener's (1984) argument that ethical decision-making models based on pre-established conventions cannot always anticipate issues that arise is sensible. Yet, an analysis of the type of responses participants made was not conducted in this study. Hence, attributing differences in EDI performance to the scope of ethical issues contained on the EDI can not be concluded from this study. Future research evaluating the types of issues identified on the EDI by individuals trained in different ethical decision-making models may help clarify if a relationship exists between responses to the ethical issues on the EDI and the rationale of different ethical decision-making models.

In conclusion, the content and rationale of the decision-making models and the scope of ethical issues contained on the EDI and may have contributed to the differences in participants' performance on the EDI. Each of these factors was discussed. In addition, future inquiry was suggested as means to further clarify the relationship between

performance on the EDI and training in ethical decision-making. The relationship between training in ethical decision-making models and participants' performance on the second dependent measure, the Therapeutic Practice Survey, (TPS) is discussed next.

Training in Ethical Decision-Making and Performance on The Therapeutic Practice Survey (TPS)

Participants trained in the EJ model did not rate clinical behaviors between therapists and their clients (i.e., the TPS) significantly differently from participants trained in the Worksheet model. Furthermore, participants trained in these two models did not vary significantly in their ratings from those participants in the placebo condition. In other words, the training in ethical decision-making did not influence participants' ratings of clinical behaviors.

Although not significant, notable differences in ratings of clinical behaviors were present between participants in the three treatment conditions. Participants in the Worksheet condition rated clinical behaviors less cautiously than did participants in either the EJ model or the placebo model. Again, this difference was not significant and needs to be further explored. Whether or not this finding occurred by chance could be further evaluated in a future study with more participants. Perhaps the difference in participant ratings did not occur by chance but rather represents an actual difference in influence of the treatment condition. A study with more statistical power than the current study would help clarify if training in ethical decision-making influenced individuals ratings of clinical behavior. In conclusion, the assertion that ethical decision-making models facilitate counselors' evaluation of ethical dilemmas was mixed. In some instances, this assertion was confirmed and in others it was not supported.

Individual Difference Variables

Forsyth (1980) proposed that individual variation in ethical evaluations was due to personal moral philosophies. An individual's moral philosophy is made up of the degree to which they reject universal moral rules in favor of relativism and the degree of idealism in his or her moral attitudes. Participants' level of relativism and idealism were measured by the Ethical Position Questionnaire (EPQ, Forsyth, 1980). Both variables were evaluated as to their relationship to each other, the dependent variables (i.e., EDI and TPS) and to the covariate (i.e., GREA). In addition to discussing the results of participants' relativism and idealism scores and their relationship to ethical decision-making, participants' analytical scores on the Analytical Reasoning scale of the Graduate Record Exam (GREA) is discussed. The relationship between individual difference variables and performance on the dependent measures are grouped according to three different hypotheses. A brief review of the results reported in chapter four will precede the discussion of each individual difference variable. The individual difference variables will be discussed in the following order, GREA, relativism and idealism.

Analytical Score on the Graduate Record Exam

Participants' performance on the GREA was significantly and positively correlated with their performance on the EDI. The higher a participant scored on the GREA the more ethical scenarios he or she correctly identified on the EDI. The Analytical Reasoning scale of the Graduate Record Exam was designed to assess "analytical and logical reasoning abilities that includes inferences, deductions, and analysis" (DeBell & Montgomery, 1996, p. 5). Participants with greater analytical and logical reasoning abilities performed better on the EDI. Conversely, participants with low analytical ability correctly identified fewer ethical issues on the EDI.

The task of correctly identifying ethical issues in the counseling scenarios contained on the EDI requires individuals to analyze the scenario, deduce what ethical issues are involved and infer what consequences may result from breaching a particular ethical principle. For example, the following scenario from the EDI illustrates the analytical ability required of participants to identify the ethical issues on the EDI:

> A psychologist serving a small city was consulted by the local high school guidance counselor and asked if he would "look over" M.M.P.I. profiles of certain students from time to time and write a "rough" interpretation so that the counselor can help the students better understand themselves. (Baldick, 1980; Lipsitz, 1985, p. 124)

Participants could earn a total of four points for discerning the ethical issues embedded in this scenario. The ethical issues involved in this scenario are: competence, confidentiality, welfare of the consumer and assessment techniques. The issues most frequently identified were those involving assessment techniques and confidentiality However, issues regarding informed consent and or client definition (i.e., welfare of the consumer) and competence in understanding psychological or education measurement were frequently missed. The issue of appropriate assessment practices is seemingly obvious in the above scenario, however the question of competence on the part of the psychologist is not as evident. The less salient the issues in a scenario the greater analytical skill required by a participant to discern the ethical content of that scenario.

In summary, participants with high analytical skill were able to discern more ethical issues on the EDI than participants with low analytical skill. The less salient the ethical content contained on the EDI the greater the skill required by participants to analyze the scenario thoroughly. The positive correlation between GREA and performance on the EDI needs to be considered by counselor educators. If this relationship is substantiated by future research with diverse populations than counselor educators will need to consider

how the Analytical Reasoning scale on the GRE may contribute to the admission and training standards of counselor education programs. For example, programs may require a minimum GREA score as one of the conditions for admission. In addition, educators could evaluate how their instructional methods and learning objectives require students to further develop their analytical skills. According to Tarvydas (1987), the process involved in making appropriate ethical judgments is largely skill and knowledge based. Counselor educators need to evaluate how they may contribute to a trainees' analytical skill as well as their knowledge of the counseling process.

Relativism

Participants' relativism score was significantly and negatively correlated with their age. In other words, the older the participant the less relativistic they were in their ethical evaluations, likewise, the younger the participant the more relativistic in their ethical evaluations. However, participants' relativism score was not correlated with either of the dependent measures. The lack of correlation with the dependent measures seems to indicate that although relativism varied significantly with age it did not influence participants' performance on the EDI or the TPS. If Forsyth (1980) was correct in proposing that individual variation is attributed to level of relativism, then it is surprising that participants' relativism score was not correlated with participants' performance on the dependent measures.

The lack of relationship between participants' relativism score and the dependent measures was further confirmed by the MANCOVA procedure. The main effect for relativism was not significant on either of the dependent measures. Individual variation in performance on the dependent measures was not attributed to participants' relativism score. Forsyth (1980) claimed that individual variation in ethical evaluations was

attributed in part to the degree in which a person rejects universal moral rules in favor of relativism. Forsyth's came to this conclusion after evaluating primarily undergraduate psychology students' performance on the EPQ and not graduate level counselor trainees' performance on the EPQ. Nor did he measure individual variation by his participants' performance on the two dependent measures used in this study. It is possible that Forsyth's claim may not be generalizable to counselor trainees nor appropriately evaluated by the dependent measures. Furthermore, the relatively small sample size may have lessened the power of this study such that actual individual variation on the dependent measures attributable to participants' relativism score was not measured.

To summarize, participants' level of relativism in their personal moral philosophies did not account for individual variation in ethical evaluations. This outcome may be attributed to several factors: the lack of generalizability of Forsyth's claim, the use of the EDI and the TPS to measure such a relationship and lastly, the small sample size. Further research directed at addressing these issues would clarify what, if any, individual variation in moral evaluations can be attributed to the degree an individual rejects universal moral rules in favor of relativism. The relationship between individual variation in moral evaluations and degree of participants' endorsement of idealism is discussed next.

Idealism

Idealism and Participants' Performance on the EDI

Unlike participants' relativism score, participants' idealism score was significantly and negatively correlated with one of the dependent measures, the EDI, and with the covariate, GREA. The more idealistic participants were in their ethical evaluations on the EPQ the poorer their performance was on the EDI. That is, the more idealistic, the fewer ethical issues participants correctly identified. Furthermore, highly idealistic participants

had significantly fewer analytical skills. The more idealistic a participant was the lower his or her analytical score was on the Graduate Record Exam. In addition, a post hoc analysis of high vs. low idealistic participants' responses revealed that highly idealistic individuals made moralistic comments regarding the ethical scenarios on the EDI more often than low idealistic individuals. That is, participants' level of idealism appears to be related to the type of responses they made toward ethical issues. An explanation of the relationship between degree of idealism and ethical discernment (i.e., the EDI) may be gained from the post hoc analysis, Kitchener's hierarchical model of ethical justification, and the positive correlation between analytical ability and ethical discernment. How these factors help explain the relationship between idealism and ethical discernment are discussed after a brief review of the idealism construct.

Forsyth (1980) described individuals who were highly idealistic (i.e., scored above the median idealism score) as believing "desirable consequences can with the 'right' action, always be obtained" (p. 176). A highly idealistic individual believes that if they can only find the right way to respond, then harm (for example) will be avoided. In another article, Forsyth, Nye and Kelley (1988) argued that idealism stresses the need to achieve positive, humanitarian consequences. Again, the highly idealistic individual believes that right actions are obtainable, as are wrong actions, and that exercising right actions will ensure client welfare.

According to the post hoc analysis, highly idealistic individuals made moralistic comments in response to ethical scenarios more often than low idealistic individuals. That is, highly idealistic individuals responded more often than low idealistic individuals with value judgments about behaviors presented in each dilemma. For example, one participant responded to the scenario regarding a group therapist having sex with a group member with the following statement: "group [members'] approval does not make it

right." The participant's comment suggests that the group members are wrong for discussing the incident and by doing so they are in some way pardoning the therapist's behavior. This response addresses a non-essential issue and fails to identify any of the ethical issues embedded in the scenario. In another example, a participant responded to a scenario dealing with a colleague inviting them to attend a nude marathon with the following admonition: "Don't go." Instead of addressing the ethical content of the score, the participant responds by stating what they believe is the right response to the invitation. The participant's response demonstrates the prohibition they have toward such an event. Their belief regarding the event is expressed, yet their response fails to analyze the ethical content of the scenario.

Awareness of personal beliefs and values is conceptualized by Kitchener (1984) as the first component in evaluating ethical situations. Kitchener proposed a two tier hierarchical model of ethical-decision making. Kitchener believes that individuals often experience an immediate "prereflective" reaction to ethical or moral situations. Such reactions occur in response to the details or facts of a situation and from the "sum of [a person's] prior ethical knowledge and experience" (Hare, 1981, as cited in Kitchener, 1984, p. 45). In other words, when a person is confronted with an ethical situation (e.g., an invitation to a nude marathon) they respond in a manner that reflects what they have learned about what they ought or ought not do (e.g., "Don't go"). Kitchener identifies this initial prereflective response to ethical and moral issues as the "intuitive level of moral reasoning". Intuitive or prereflective in that it occurs without forethought and may be likened to a person's "gut reaction" to a situation. Intuitive level of moral reasoning is the first tier by which individuals evaluate ethical situations.

The second tier of moral reasoning in Kitchener's model is the critical evaluative level. Kitchener explains that once an individual intuitively responds to a situation they

then must evaluate whether their intuitive response would lead to the most "just" outcome. The critical evaluative process involves analyzing the intuitive response towards the situation within the context of ethical codes, ethical principles and if necessary ethical theory. Because ethical situations are often complex and defy simplistic solutions (Corey et al., 1993), arriving at the most "just" action involves analyzing the relevant components of a situation, considering which ethical codes and principles may apply and inferring what consequences may occur if certain actions are taken. Kitchener's description of arriving at the most just decision is consistent with Tarvydas's (1987) claim that ethical decision-making is largely skill and knowledge based.

Given the analytical skills involved in evaluating ethical issues, the negative correlation between highly idealistic individuals and ethical discernment may be attributed to a third variable, their low analytical skill (as measured by the GREA). Idealism was negatively correlated with analytical ability. The more idealistic an individual was the less analytical skill they demonstrated on the Analytical Reasoning scale of the Graduate Record Exam. Although these individuals were able to express their immediate prereflective response to the ethical content on the EDI (i.e., the first level of ethical-decision making), they did not demonstrate the critical-evaluative skill necessary to identify the ethical issues embedded in the counseling scenarios.

The implications of this discussion may lead a person to believe that individuals who are highly idealistic do not have the skills necessary to think critically of ethical issues. Such a conclusion may be pre-mature. The relationship between idealism and ethical discernment needs to be further evaluated with larger and more diverse samples of counselor trainees. In addition, future post hoc analyses would gain greater credibility if several ratters were involved in performing the content analysis. Repeating the post hoc

analysis on a larger sample with several ratters may validate the types of responses operationalized as well as permit a reliability test between ratters.

Moreover, future inquiry of idealism and ethical discernment ought to be explored within the context of training in ethical decision-making. A larger sample may help clarify if an individual's level of idealism accounts for variation in ethical discernment and if certain ethical decision-making models provide highly idealistic individuals the skills to critically evaluate ethical scenarios. In the present study, highly idealistic individuals seemed to operate at a low level of ethical evaluation according to Kitchener's paradigm. Thus, it is important to learn what decision-making models may equip highly idealistic trainees to discern more thoroughly the ethical content in counseling scenarios.

In conclusion, participants' performance on the EDI was evaluated on the basis of their level of idealism in moral evaluations and their analytical ability. EDI performance was positively correlated with participants analytical ability and negatively correlated with their level of idealism. Participants' level of relativism toward moral laws did not influence their performance on either dependent measure. Suggestions for future inquiry of the relationship between the above variables was made as well as recommendations for counselor educators.

Training Variables

Ethics Class

Each training variable, ethics class and practicum class, was evaluated on both dependent measures, the EDI and the TPS. Each training variable will be discussed separately. Furthermore, the discussion of each training variable is organized by the dependent variables. In other words, the effect of ethics class on participants' performance

on the EDI is discussed separately from their performance on the TPS. This same format is followed for practicum experience.

Ethics class and EDI performance

This variable was defined by whether or not participants had completed the required three hour ethics course in the counselor education program. The participants with the ethics class discerned significantly more thoroughly the ethical nature of the counseling scenarios on the EDI than participants without the ethics class. This result was consistent with Baldick who found that counseling and clinical psychology doctoral student interns who had formal ethics training scored significantly higher on the EDI than interns who had not had formal ethics training (1980).

In this study, participants who had the ethics class were able to tease out or discern significantly more of the ethical issues imbedded in the scenarios than participants without training. The complexity (Corey, Corey, & Callanan, 1993) often associated with ethical issues was less perplexing to participants with the ethics class than participants without ethics class. This outcome lends credence to those who have recommended preservice ethics education as critical to preparing future counselors (Cottone, Tarvydas, & House, 1994; Patterson, 1989).

Although participants with the ethics class scored significantly better on the EDI than those participants without the same class, those who had the class did not score on average higher than about 15 points out of 44 possible. In other words, those participants who completed the class were able to discriminate only 33% of the considerations presented. This may indicate that master level counseling trainees are, as a whole, not fully aware of the scope of ethical problems they may encounter in any one clinical situation. Completing the required ethics class did significantly improve trainees'

evaluations but the improved performance was noticeably lower as well as less than the average performance of participants in Baldick's (1980) and Lipsitz's study (1988).

Participants in the later two studies were doctoral interns who had completed their course work and were working in a clinical setting. Given the status of these participants, it is possible that they may have had more experience with ethical situations and applying ethical guides to their work. In contrast, the participants in the current study had not yet completed their course work and less than half (44%) had any clinical training. The differences between the participants in the current study and those of Baldick's (1980) and Lipsitz's (1988) study may be attributed to these factors.

The differences in the performance on the EDI between participants with and without ethics education in the current study were evaluated by total scores of the EDI. Although this was the same procedure Baldick (1980) and Lipsitz (1988) followed, total scores do not clarify if or to what degree participants varied in their discernment on types of ethical scenarios. In other words, participants who had completed the ethics class discriminated more ethical issues, but the types of ethical issues that were discerned were not evaluated. It can not be assumed that a better overall total score means that participants with ethics class were able to discern more difficult ethical issues than participants without the required ethics class. Rather, the higher scoring participants discerned more ethical issues than those without the required ethics class.

Gookin (1989) and Tymchuk et al. (1982) reported that variance among psychologists' evaluations of ethical scenarios was attributed in part to the saliency of the scenario. The more salient the topic the less variability between psychologists' evaluations. For example, salient topics such as confidentiality and sexual behavior elicited more consensus among psychologists than did less salient topics like test security and advertising (Gookin, 1989). In the current study, this was illustrated by the consensus

among participants who rated the following item on the TPS as "Never Ethical": "Engaging in sexual activity with a current client."

Participants' scores on the EDI were summed across all scenarios without respect to the level of saliency of each scenario. Consequently, the degree of saliency of the scenarios evaluated was not measured. Although the heterogeneity of responses between participants with and without the ethics class was present on total scores, the variability between participants cannot be attributed to the saliency of the ethical issues in each scenario. The degree to which ethics education equipped individuals to discern less salient scenarios more thoroughly than those individuals without ethics education can not be concluded from this study. Future research exploring formal ethics training and saliency of ethical scenarios is warranted. Such research may further clarify the relationship between ethics education and helping professionals' skill in discerning ethical issues. Clarifying such a relationship could help counselor educators develop curriculums that would prepare future counselors with the skills to more thoroughly discern ethical issues.

Ethics class and performance on the TPS

According to the above results, the required ethics class equipped participants to clarify the ambiguity and complexity often associated with ethical situations i.e., the EDI. However, the same training did not influence participants to rate questionable behaviors between a therapist and client (i.e., the TPS) significantly differently than those participants without the ethics class. Overall, participants with and without the ethics class rated on average the ethicality of clinical behaviors low. That is, most clinical behaviors were rated as unethical. However, mean ratings by participants with the ethics class were less cautious than ratings by participants without the ethics class. In other words, participants who had completed the ethics class rated the ethicality of the behaviors

low yet not as low as those participants without ethics class. Interestingly, participants with ethics class rated the clinical behaviors more cautiously than the normative group (Borys, 1988).

The lack of significant differences in ratings between participants with and without ethics may be attributable to the relatively small sample size (N = 52). Increasing the sample size would likely increase the probability of obtaining significance differences in ratings between participants with and without ethics class.

However, the issue of sample size may not address the reason why significance was not present. Both groups rated clinical behaviors most often as unethical which is consistent with the normative group. Thus, it seems plausible that the lack of significant difference between the two groups could be attributed to something else. Again, the issue of saliency needs to be considered. The ethical nature of the behaviors described on the TPS may have been obvious to most participants -- so obvious that not having the ethics class did not influence trainees to perceive the ethical nature of the clinical behaviors significantly differently than those trainees with the ethics class. Increasing the sample size may in fact demonstrate that ethics class or the lack thereof influences counselor trainees to rate clinical behaviors significantly more often as ethical or unethical.,However, the results of the current study suggest that the lack of variability in the frequency of ratings could be attributed to the saliency of issues presented on the TPS. In addition, participants in the current study are exposed to considerable "ethics" content in an introductory class early in their course work. Exposure to ethics early in their training may have lessened the differences between the participants with and without the formal class on ethics.

In summary, participants who had completed the ethics class were able to discern more ethical issues embedded in the counseling scenarios contained on the EDI than

participants who had not completed the ethics class. However, the more discerning participants still scored lower than doctoral participants in other studies. With respect to TPS scores, the difference in mean ratings between participants who had and had not completed the ethics class was not significant. A notable difference between these participants occurred whereby those who had completed the ethics class rated clinical behaviors less cautiously than those participants who had not completed the ethics class. Whether or not the lack of significance is attributed to sample size, the saliency of issues contained on the TPS, or prior exposure to ethical content needs to be further investigated.

Practicum Training

Practicum and performance on the EDI and the TPS

When participants' performance on the EDI and the TPS were evaluated with respect to whether or not they had completed a practicum class no significance was found. The main effect for practicum on both the EDI and the TPS was not significant. In other words, participants who completed a practicum class did not discern ethical issues nor rate clinical behaviors differently than those participants without practicum class.

The above outcome is interesting in lieu of Haas et al.'s (1986) finding that psychologists believed that the types of ethics education most helpful were graduate course work and collegial discussion. Practicum class tends to be oriented towards addressing specific clinical issues between the trainee and their clients. Trainees are encouraged to address clinical and ethical issues among their peers and instructor (i.e., collegial discussion). Moreover, it is common for practicum class to integrate the ethical nature of counseling into most if not all of the instruction delivered in class. In addition to practicum class, ethical issues are often the subject of trainees supervision at their

clinical site. And yet, participants' class experience and their involvement in supervision did not influence them to perform on the dependent measures significantly differently than those participants without the additional training received from practicum class.

Perhaps the above outcome is due in part to the small sample size. It seems that participants who had completed practicum would, for example, discern more ethical issues on the EDI than those without the same experience. Evaluating the relationship, or lack thereof, between practicum class and skill in discerning ethical issues and therapeutic behaviors needs to be further explored. If the outcome in this study is supported by other inquires, than serious consideration regarding practicum curriculum and training needs to occur among counselor educators.

In conclusion, the two training variables, practicum and ethics class, were evaluated as to their influence on participants' performance on the EDI and the TPS. Participants who had completed the required ethics class discerned more ethical issues on the EDI than participants without ethics. Yet, counselor trainees as a whole, failed on average to recognize approximately two-thirds of all ethical issues contained on the EDI. The differences between participants' performance on the EDI demonstrates both the importance of requiring counselor trainees to complete a class on ethics and the importance of counselor educators to evaluate how they may further equip or strengthen counselor trainees' skills in ethical decision-making. In addition, research investigating the influence of practicum on trainees' skill in discerning ethical issues needs to occur. In the current study, practicum did not significantly influence trainees' EDI performance. If future inquiry of practicum experience and ethical discernment among counselor trainees lead to results similar to the outcome of the current study, counselor educators will need to assess the objectives, curriculum and learning opportunities that practicum affords counselor trainees.

Unlike the above results, practicum experience did influence the frequency and degree of participants' ratings of clinical behaviors (i.e., the TPS). A significant interaction between practicum and treatment (i.e., placebo, Worksheet and Ethical Justification) occurred on the TPS. A discussion of the interaction follows.

Interaction

The MANCOVA procedure identified a significant interaction on participants' overall (i.e., total scores) performance on the TPS. Performance varied significantly depending on what treatment condition participants were assigned to and whether or not participants had practicum. The interaction of treatment by practicum was further evaluated by examining participants' performance on each of the three factors on the TPS: incidental involvements, social/financial involvements and dual role behaviors. The discussion that follows examines participants' total scores and performance on each factor. Suggestions regarding training in ethical-decision making and recommendations for future research are provided.

Total Scores

Different treatment conditions (i.e., placebo, Worksheet and EJ model) influenced participants' perceptions of unethical therapeutic behavior differently depending on trainees' practicum experience. In other words, the ethical decision-making models influenced participants differently depending if participants had practicum or did not have practicum. Specifically, the Worksheet model failed to equip participants without practicum to perceive the ethical nature of the therapeutic behaviors on the TPS more often than participants with practicum and within the same treatment condition. In other

words, the same model influenced participants significantly differently depending on their practicum experience.

Moreover, participants without practicum and in the Worksheet condition rated the ethicality of clinical behaviors (i.e., the TPS) significantly higher (more ethical) than participants without practicum experience and assigned to the other two treatment conditions (i.e., main effect for treatment). All participants with practicum rated clinical behaviors significantly lower (i.e., more cautiously) than the Worksheet no-practicum group. This was true even for those participants with practicum and assigned to the Worksheet condition. Participants in the Worksheet condition and who had practicum experience rated clinical behaviors similar to all other participants with practicum and assigned to the other two treatment conditions. Thus, it appears that practicum experience modified responses of participants assigned to the Worksheet condition to be more consistent with the other participants in this study.

The influence of practicum or the lack thereof on participants' assigned to the Worksheet condition demonstrate several important issues regarding the utility or usefulness and the effectiveness of practicum experience. Recall the previous discussion regarding the lack of effectiveness practicum had on participants' performance on the EDI and the TPS. Practicum experience was found not to significantly influence participants' performance on the dependent measures. Participants without practicum identified approximately the same number of ethical issues (i.e., the EDI) and rated clinical behaviors (i.e., the TPS) as unethical as frequently as did those with practicum experience. Consequently, practicum was not considered effective in influencing participants' performance on either dependent measure. However, the interaction that occurred between training and practicum demonstrates that practicum was useful to those participants in the Worksheet condition. Useful in the sense that their practicum

experience modified their ratings of clinical behaviors such that their ratings were approximately the same as all other participants with practicum experience. Thus, within the current study, practicum was useful in modifying participants' responses to be more cautious and similar to all other participants with practicum experience.

It appears that when operating from a perspective of beneficence (i.e., the Worksheet model) participants without practicum may have overestimated the value of the therapists' behavior depicted on the TPS items. Said differently, the lower frequency of unethical ratings by participants without practicum and trained in the beneficence model suggests that these participants did not discern the nuances of client welfare when rating clinical behaviors. Instead, they may have over generalized client welfare such that they did not discern as frequently the unethical nature of the clinical behaviors on the TPS.

Training programs and counselor educators that emphasize client welfare as a counselor's primary responsibility (as does the Ethical Standards of the American Counseling Associations, see Gladding, 1996) may need to evaluate if preparing trainees to operate from the principle of beneficence is in fact in the best interest of the trainees' future clients. The results of the current study suggest that trainees who are entering practicum for the first time may in fact underestimate the ethical nature of their behaviors toward clients. Ironically, the trainee who was prepared to promote client welfare may over generalize the value of their behavior and consequently may cause harm to their client(s). Given the small sample of the current study and the over representation of Caucasian participants, the analysis of the relationship between the Worksheet model and trainees discernment of ethical behaviors needs to occur. Repeating the analysis with a larger and more diverse population may lend credence to the aforementioned caution towards counselor educators and training programs.

In summary, the differences in frequency of ratings between participants within the Worksheet condition appears to be attributed to practicum. Participants with practicum rated the ethicality of clinical behaviors significantly lower more frequently than did those participants without practicum and in the same treatment condition. Training in ethical decision-making did not influence participants with practicum to rate clinical behaviors differently. Among participants without practicum, training significantly influenced them to rate clinical behaviors differently.

A plausible explanation of the performance of all participants within the Worksheet condition may be drawn from the supervision literature. Stoltenberg and Delworth (1987) identified counselor trainees who were entering supervision for the first time with little or no experience in delivering therapeutic services as "Level 1" counselors. Level 1 counselors simplistically conceptualize their clients' concerns and often prefer concrete therapeutic diagnostic plans be provided by their supervisor. Level 1 counselors are characterized as making "grand conclusions ... on rather discrete pieces of information, selected for their consistency with a particular theoretical orientation rather than for their salience to the client's presenting problem" (p. 56).

The characteristics of Level 1 counselors seem to arise in part from not having the benefit of a supervised therapeutic experience. Similarly, the participants in the current study without practicum experience lack the training, personal and professional development gleaned from providing therapeutic services. Assuming Stoltenberg and Delworth's description of beginning counselors is credible, it is likely that the participants without practicum are similar to Level 1 counselors. That is, they simplistically conceptualize their clients' presenting concerns and desire a pragmatic approach to evaluate ethical behaviors. The Worksheet provides such an approach. It is interesting that beginning counselor trainees who participated in a pilot study overwhelmingly

preferred the Worksheet model to the Ethical Justification model. Comments such as "Its easy to follow" and "I think this model [the Worksheet] would help a person be sure to cover all the bases when making a decision" are representative of pilot participants' remarks.

Sileo and Kopala (1994) suggest that the Worksheet makes abstract concepts of decision-making concrete and practical.,The Worksheet is intended to facilitate counselors who use the model apply key elements necessary to good ethical-decision making and think more critically about ethical dilemmas. However, the performance of the no-practicum trainees suggests that they did not think as critically as their peers who were assigned to the other treatment conditions. Perhaps the developmental level of the no-practicum trainees (i.e., Level 1) coupled with the pragmatic approach of the Worksheet model influenced trainees to rate clinical behaviors less cautiously frequently more often than their Level 1 peers assigned to the placebo and Ethical Justification models. The singular focus of the Worksheet model (i.e., promoting client welfare) coupled with Level 1 trainees' tendency to simplistically conceptualize clinical issues while possibly adhering to concrete therapeutic approaches to resolve ethical issues may have led trainees to underestimate the ethicality of clinical behaviors rather than think more critically of them.

These results suggest that counselor educators should not use ethical decision-making models indiscreetly. Care needs to be taken when incorporating an ethical decision-making model into a curriculum. Models influence participants perceptions of therapeutic behavior differently depending on their practicum experience. In fact, an educator who uses the Worksheet with beginning practicum students may not prepare the trainees to address clinical behaviors ethically appropriately.

However, it is interesting that the inexperienced trainees who were less cautious in their overall ratings (i.e., total scores) than all other participants in the current study were

actually most similar in their ratings to the experienced normative group's overall ratings. While the similarities between the normative group and the no-practicum Worksheet group appear to discredit the above explanation regarding Level 1 counselors and the no-practicum trainees' performance on the TPS, a review of the participants' and the normative groups' ratings on the individual factors of the TPS needs to be considered. The three factors of the TPS are: incidental involvements, social/financial involvements and dual role behaviors.

Incidental Involvements

Counselor trainees did not vary significantly in the frequency of their ratings of incidental involvements. Furthermore, no interaction occurred between type of treatment condition and practicum experience. Participants rated incidental involvements as unethical with the same frequency in spite of the treatment condition (i.e., placebo, Worksheet and Ethical Justification model) they were assigned to and their practicum experience.

The lack of variation in frequency of ratings of incidental involvements indicates that participants perceived the degree of ethicality of these behaviors similarly Unlike participants performance on total scores, treatment condition nor practicum experience influenced participants to rate incidental involvements significantly differently Participants rated incidental involvements most often as unethical as did the normative group.

The lack of significant differences in frequency of ratings between participants may be attributed to the saliency of the incidental involvements. Gookin (1989) found that the less salient ethical issues were the greater variability between individual evaluations of ethical issues occurred. Thus, when evaluating the outcome of the current study in light of

Gookin's research, the lack of significant variation in participants' ratings may be attributed to the prominence of the ethicality of incidental involvements. The ethical nature of the incidental involvements may have been so obvious to participants that training in ethical-decision making and practicum experience were not necessary in order to evaluate the ethicality of incidental involvements.

When the differences in frequency of ratings between participants with and without practicum and assigned to different treatment conditions is inspected visually (i.e., figure4.5) an interaction effect between treatment and practicum appears to have occurred. However, an inspection of mean differences indicates that participants' ratings did not significantly vary in frequency as a function of training and practicum. Evaluating the influence of treatment and practicum on participants' ratings of incidental involvements with a larger sample size would likely accomplish one of two things. First, using a larger sample size may bolster the finding that an interaction between treatment and practicum does not operate so as to influence trainees' ratings of incidental involvements. Secondly, increasing the sample size may clarify if the "interaction" figuratively illustrated between treatment and practicum does in fact represent a statistically significant interaction between treatment and practicum and ratings of incidental involvements.

Social/financial Involvements

Participants' ratings of social/financial involvements (i.e., factor two) were similar in frequency to participants' ratings of incidental involvements. Assignment to treatment condition and practicum did not significantly influence participants' frequency of ratings of social/financial involvements. However, two observations of participants ratings' need to be made. First, the critical value reached by the tests for a treatment and practicum main effect were below an alpha level of .05. Secondly, although significant differences were

not reached between participants within the current study, the no-practicum participants assigned to the Worksheet condition did rate the ethicality of social/financial involvements higher (i.e., more ethical) than did the normative group. Both of these observations are discussed below.

Because of the multiple tests conducted in this study, a family wise error rate of .0167 was set a priori. The mean differences between participants with and without practicum experience and assigned to the different treatment conditions failed to reach the critical value. However, tests for evaluating the influence of treatment and of practicum or the lack thereof on participants' ratings of social/financial involvements did reach an alpha level of less than .05. Although the critical value of .0167 was not reached, it is possible that the differences that did occur were not by chance alone. As in the previous discussion regarding incidental involvements, issues of power and specifically sample size need to be considered. The small sample size in the current study likely contributed to the lack of significance measured between participants. Increasing the number of counselor trainees in a future analysis would likely clarify if training in ethical decision-making and or practicum would significantly influence trainees' perceptions of social/financial involvements.

Secondly, although significant differences were not reached between participants on factor two, the no-practicum participants assigned to the Worksheet condition did rate the ethicality of social/financial involvements higher more often than did the normative group. All other participants rated social/financial involvements more cautiously (i.e., lower) than did the normative group. Because no significant main effect was found for practicum or treatment condition, inferences explaining why participants without practicum and assigned to the Worksheet condition performed as they did are at best speculative. If differences between participants with and without practicum and assigned

to the different treatment groups occurred solely by chance than the performance of the no-practicum participants in the Worksheet condition can only be attributed to chance factors. Consequently, the need to replicate the current study with a larger sample is further strengthened.

If future inquiry substantiates that trainees without practicum and trained in using the Worksheet model of ethical-decision making underestimate the ethical nature of social/financial involvements, than counselor educators need to consider if the Worksheet model is appropriate for preparing trainees. Trainees who do not discern the ethical nature of social/financial involvements may begin their practicum training less prepared to appropriately work with clients who present social and financial issues in therapy. Future research may clarify the relationship between training in the Worksheet model and beginning counselor trainees' perceptions of social/financial involvements.

Dual Professional Roles

Unlike participants' ratings on factors one and two, participants did rate the ethicality of dual professional roles (factor three) significantly differently. More specifically, the no-practicum participants assigned to the Worksheet condition rated dual role behaviors less cautiously significantly more often than the other participants without practicum and assigned to the other two treatment conditions. The no-practicum participants trained in the beneficence model also rated dual professional roles less cautiously than the normative group. Participants in the current study and assigned to the Ethical Justification treatment condition, the placebo condition and the normative group rated dual professional roles as unethical more frequently than did the no-practicum participants assigned to the Worksheet condition.

The no-practicum participants assigned to the Worksheet condition performed on factor three similar to their overall or total score performance. When participants without practicum were trained in the Worksheet model they rated the ethicality of dual professional roles higher significantly more often than all other participants in the current study and higher than the normative group. This suggests that clinically inexperienced trainees that were trained in promoting client welfare (i.e., the Worksheet model) failed to discern the nuances of client welfare and over generalized the benefit a client would receive from the counselors' behaviors depicted on the TPS. For example, the following item was rated most frequently as "Ethical under most conditions" by the no-practicum participants trained in the Worksheet model: "Providing individual therapy to a relative, friend or lover of an ongoing client." The above rating of this item suggests that the participants in question considered the potential benefit of therapy more than the prospect of exploiting the trust or dependency of the client (Ethical Standards of the American Counseling Association, 1995).

Borys (1988) and Gladding (1996) identify dual role behaviors occurring between a therapist and client when the therapist seeks to gratify their own needs at the expense of the client. It is interesting that the no-practicum participants in the Worksheet condition perceived dual role behaviors from the perspective of client welfare and not from the perspective of getting their own needs met. The combination of the Worksheet condition and no practicum experience led participants to perceive behaviors as beneficial that are normally perceived as exploitive. Hence, it appears that the Worksheet model influenced clinically inexperienced participants to confuse the value of dual role behaviors. Rather than perceiving such behaviors as harmful they perceived them as beneficial.,

The explanation of the participants without practicum and assigned to the Worksheet condition suggested above could be further evaluated if participants had been

given the opportunity to state the reasons for their ratings. Ratings indicate how a participant perceived the clinical behavior. Yet the rating does not indicate why it was chosen. In other words, what a participant perceived as salient is not indicated by their rating. If participants without practicum and assigned to the Worksheet condition are similar to Level 1 counselors (as already suggested) then they would likely provide simplistic statements that fail to identify the salient issues of the clinical behavior in question. Researchers who are interested in exploring the rationale of trainees' perceptions of clinical behavior could pursue this in a future study.

In addition to the no-practicum participants assigned to the Worksheet condition rating dual role behaviors less cautiously than all other participants, the MANCOVA procedure identified two significant interaction effects between treatment and practicum on factor three. However, when each interaction was evaluated separately, neither reached significance. The failure of each interaction to be significant is likely attributed to the relatively small sample size. A future study with a larger sample should explore the relationship between training in ethical-decision making and practicum experience among participants' ratings of dual professional roles. Understanding how training in ethical decision-making and practicum experience influence participants' ability to evaluate dual professional roles would help counselor educators equip future counselors to more thoroughly evaluate clinical behaviors.

In summary, participants without practicum and assigned to the Worksheet condition rated the ethicality of dual professional behaviors and social/financial involvements more ethical than did the normative group. In addition, dual professional roles were perceived as ethical significantly more often than participants without practicum and assigned to the placebo and Ethical Justification model. No significant differences occurred in the frequency of ratings of social/financial or incidental

involvements among all participants. The no practicum participants assigned to the Worksheet condition performed overall (i.e., total scores) similar to the normative group. However, when performance of these two groups were evaluated by each factor, the no practicum participants rated dual role behaviors and social/financial involvements more ethical significantly more often than the normative group. This suggests that the Worksheet model influenced participants without practicum to underestimate the ethical nature of certain clinical behaviors. Accordingly, similarities between the no-practicum participants and the normative group cannot be interpreted as though the Worksheet condition prepared trainees to perceive clinical behaviors similar to seasoned therapists (i.e., the normative group).

In conclusion, an interaction occurred between treatment and practicum on the TPS. Participants assigned to the Worksheet condition varied in their perceptions of therapeutic behaviors significantly more often if they did not have practicum. Among all participants without practicum, training in the Worksheet condition influenced participants' ratings significantly more often than did training in either the Ethical Justification model or the placebo model. Each factor of the TPS was considered when comparing the differences among participants' ratings and in comparison to the normative group.

Conceptualizing the Utility of Ethical Decision-Making Models

The utility of ethical decision-making models is endorsed throughout the literature. For example, Neukrug, Lovell, and Parker (1996) state that ethical decision-making models provide a "flexible and comprehensive approach for resolving ethical dilemmas." The outcome of the present study would argue that such broad based endorsements over generalize the effectiveness of models. Such a generalization may

mislead counselor educators and practitioners to believe that incorporating any decision-making model into their training and practice would facilitate the resolution of ethical dilemmas.

The results from this study suggest at least two issues regarding the utility of ethical decision-making models: (1) models be scrutinized prior to assigning them merit and (2) that the term "ethical appraisal model" (not decision-making) more accurately describes the function of ethical decision-making models. Both of these issues are discussed below.

This study evaluated the influence of the A-B-C-D-E Worksheet model and the Ethical Justification model on trainees' ability to discern ethical issues embedded in counseling situations and their perceptions of therapeutic behavior. This study did not evaluate whether or not the above decision-making models influenced trainees to make ethically sound decisions. The focus of this study was not to judge if trainees resolved ethical dilemmas but if models were effective in helping trainees evaluate dilemmas and influence their perceptions of unethical behavior. Both of these factors, i.e., evaluating ethical dilemmas and perceiving ethically appropriate behavior, are critical to the process arriving at ethically appropriate decisions.

In order for an individual to make an ethically appropriate decision he or she must evaluate the issues involved and discern what actions would likely lead to the most "just" outcome for the persons involved. According to Tarvydas (1987), this process is largely skill and knowledge based. The results of this study demonstrated that individuals trained in the Ethical Justification (EJ) model were better equipped with the necessary skills and knowledge to discern ethical dilemmas. Likewise, individuals trained in the Worksheet model were not equipped as well to discern the ethical issues as evidenced by their EDI performance. Furthermore, participants assigned to the Worksheet condition not only

identified significantly fewer ethical issues than participants assigned to the EJ condition but they performed as poorly as those participants assigned to the placebo training. In other words, the Worksheet model of ethical decision-making did not improve participants' skill nor provide a process whereby they discerned any more ethical issues than did participants trained not in a model.

Sileo and Kopala (1993) developed the Worksheet in an attempt to facilitate counselors in weighing and considering ethical dilemmas in a systematic fashion. They proposed that such a systematic approach to resolve ethical dilemmas would ensure that good standards of practice would be upheld and the best possible solution would be chosen. However systematic the Worksheet may be, it did not adequately equip individuals in this study to weigh and consider ethical issues. The influence of the Worksheet condition on participants' EDI performance suggests that neither good standards of practice nor the best possible solution would be chosen by individuals of similar training and clinical experience. The Worksheet's failure to provide trainees with an effective approach to evaluate ethical issues does not affirm Sileo and Kopala's claim stated above. The Worksheet did not equip trainees with the necessary skills to discern the ethical issues used in this study.

Accordingly, the results of this study question the utility of the Worksheet model and affirm the merit of the Ethical Justification model. However, the relatively small and ethically homogeneous sample size, the possible violation of the independence of replica assumption are limitations of this study. It is important that the utility of the Worksheet model continue to be evaluated in future research that controls for the limitations and delimitations in the current study.

The second issue regarding the utility of the ethical decision-making models addresses the influence the decision-making models had on participants' performance on

the two dependent measures. The utility of the two ethical decision-making models were not measured by the types of ethical decisions trainees made but by the ethical evaluations participants made and the perceptions participants had. Researchers agree (and consistent with ethical hierarchialism theory) that ethically appropriate decisions follow from a thorough evaluation or appraisal of ethical issues. Accordingly, poor or inadequate appraisal leads to unethical practice (cf. Drane 1982; Tarvydas, 1987; Giesler, 1971; Kitchener, 1984, 1988; Rest, 1984; Sileo & Kopala, 1993; and others). However, the reverse is not always true (i.e., thorough evaluation does not always lead to ethical behavior). For example, Kitchener (1988) outlines a four step psychological process underlying responsible ethical action. The ability to reason about ethical issues is the second step in the process. Developing moral responsibility and the ego strength to take action and the ability to tolerate the ambiguity of ethical decision-making are the third and fourth steps respectively. In other words, Kitchener believes that practicing ethically responsible behavior must include all steps and not just the ability to reason about ethical issues.

The decision-making models evaluated in this study provide a structure to evaluate ethical issues. Whether or not ethical decision-making models provide individuals with the necessary skills to resolving ethical dilemmas needs to be investigated. The outcome of the current study and the research cited above suggests that ethical decision-making models are more accurately described as models that appraise ethical situations than they are models that resolve ethical dilemmas.

Future research of the utility of the models used in this study as well as other ethical decision-making models needs to continue. If the results in the current study are consistent with future inquiry with larger and more diverse populations, then counselor

educators will need to continue to develop models and curriculums that prepare trainees to practice ethically appropriate behavior.

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APPENDIX A: INSTRUMENTS

Demographic Questionnaire

Please respond with an "X" in the spaces below that best describe yourself.

==========

1. Gender: ___(1) female ___(2) male.

2. Age _____

3. Highest academic degree completed:

___ (1) bachelors

___ (2) masters

___ (3) Ph.D./Ed.D.

___ (4) other.

4. Current academic degree pursuing: ___(1) M.Ed. ___ (2) Ed.D. ___ (3) other.

5. Counseling track enrolled in:

___ (1) Community Counseling

___ (2) School Counseling

___ (3) Non-Degree Professional Certification in School Counseling.

6. Ethnic Origin:

___ (1) African-American

___ (2)American-Indian

___ (3) Asian

___ (4) Asian-American

___ (5) Caucasian

___ (6) Hispanic

___ (7) Other.

7 Relationship Status:

___ (1) single
___ (2) married
___ (3) divorced
___ (4) partnered
___ (5) separated
___ (6) widowed.

8. Career Goals: (please check only one of the following)

___ (1) school counselor
___ (2) licensed professional counselor
___ (3) other.

9. Please check each class that you **have completed and are currently enrolled in**

___ (1) EPSY 5001 Advanced Workshop in Counseling
___ (2) EPSY 5334 Rehabilitation of Neurological and Sensory Deficits
___ (3) EPSY 5323 Cultural Foundations of Education
___ (4) EPSY 5331 Human Development
___ (5) EPSY 5350 Introduction to the Counseling Profession
___ (6) EPSY 5352 Child Counseling
___ (7) EPSY 5354 Group Counseling
___ (8) EPSY 5356 Principles of Ed. & Psych. Measurement
___ (9) EPSY 5355 Introduction to Career Counseling
___ (10) EPSY 5357 Techniques of Counseling
___ (11) EPSY 5358 Organization and Administration of Counseling Services
___ (12) EPSY 5360 Practicum in Counseling
___ (13) EPSY 5360 Practicum in Counseling
___ (14) EPSY 5361 Practicum in Consulting Techniques

___ (15) EPSY 5362 Practicum in Group Counseling

___ (16) EPSY 5363 Practicum in Counseling with School Families

___ (17) EPSY 5364 Theories of Counseling

___ (18) EPSY 5365 Adlerian Life-Style Analysis

___ (19) EPSY 5366 Dysfunctional Behavior

___ (20) EPSY 5367 Family Counseling Applied to School Settings

___ (21) EPSY 5369 Seminar in Counseling: Addictions

___ (22) EPSY 5369 Seminar in Counseling: Cognitive and Behavioral Approaches to Therapy

___ (23) EPSY 5369 Seminar in Counseling: Ethics (or EPSY 5370 Legal & Ethical Issues)

___ (24) EPSY 5380 Introduction to Statistics

___ (25) EPSY 5394 Internship in Counseling

___ (26) EPSY 6335 Advanced Counseling Techniques

___ (27) EPSY 6336 Personality and Motivation in the Learning Process

___ (28) EPSY 6337 Personality Assessment in Educational Psychology

___ (29) EPSY 6354 Practicum in Group Leadership Techniques

___ (30) EPSY 6360 Advanced Practicum in Counseling

___ (31) EPSY 6366 Advanced Practicum in Counselor Education and Supervision.

10. I have **completed** _____ hours in the counselor education program.

11. I am **currently** enrolled in _____ hours in the counselor education program.

12. In addition to the above courses, have you received formal training in ethics?

___ (1) Yes ___(2) No

13. If you answered yes to the above question, please indicate the settings in which you received the additional training in ethics otherwise skip to the next question.

___ (1) A class (not including the course offered in the educational psychology counselor education program).

___ (2) workshop

___ (3) seminar

___ (4) other.

14. Below is a list of practicum settings. In addition, several types of supervision are listed after each practicum setting. Indicate what setting(s) you have worked at (or are currently working at) then mark the type of supervision that best describes your experience at that setting. Only choose one form of supervision for every setting that you mark.

___ (0) I have not taken a practicum class. (Skip to the next question).

___ (1) College counseling center

___ (a) No supervision ___ (b) Individual supervision ___(c) Group supervision

___ (d) Both individual and group supervision ___ (e) Other

___ (2) Counselor education dept. (Group practicum)

___ (a) No supervision ___ (b) Individual supervision ___(c) Group supervision

___ (d) Both individual and group supervision ___ (e) Other.

___ (3) Counselor education dept. (Consulting techniques)

___ (a) No supervision ___ (b) Individual supervision ___(c) Group supervision

___ (d) Both individual and group supervision ___ (e) Other.

___ (4) Elementary School

___ (a) No supervision ___ (b) Individual supervision ___(c) Group supervision

___ (d) Both individual and group supervision ___ (e) Other.

___ (5) Junior High School

___ (a) No supervision ___ (b) Individual supervision ___(c) Group supervision

___ (d) Both individual and group supervision ___ (e) Other

___ (6) Sr. High School

___ (a) No supervision ___ (b) Individual supervision ___(c) Group supervision

___(d) Both individual and group supervision ___ (e) Other.

___ (7) State Agency

___ (a) No supervision ___ (b) Individual supervision ___(c) Group supervision

___ (d) Both individual and group supervision ___ (e) Other.

___ (8) Private Agency

___ (a) No supervision ___ (b) Individual supervision ___(c) Group supervision

___ (d) Both individual and group supervision ___ (e) Other.

___ (9) Private Practice.

___ (a) No supervision ___ (b) Individual supervision ___(c) Group supervision

___ (d) Both individual and group supervision ___ (e) Other.

___ (10) Other.

___ (a) No supervision ___ (b) Individual supervision ___(c) Group supervision

___ (d) Both individual and group supervision ___ (e) Other.

15 Please indicate below the two most convenient times for you to participate in a 3 hour training experience. Please place a **"1"** by your most convenient time and a **"2"** by your second most convenient time.

___ **(1)** Wednesday (4/10/96) 6:00 to 9:00 p.m.

___ **(2)** Thursday (4/11/96) 6:00 to 9:00 p.m.

___ **(3)** Saturday (4/13/96) 9:00a.m. to 12:00 noon.

___ **(4)** Saturday (4/13/96) 2:00 to 5:00 p.m.

___ **(5)** Sunday (4/14/96) 9:00a.m. to 12:00 noon.

___ **(6)** Sunday (4/14/96) 2:00 to 5:00 p.m.

___ **(7)** Monday (4/15/96) 6:00 to 9:00 p.m.

Ethical Attitudes Survey

Dinger, T. J. & Dawson, J. M. (1996)

The ability to make ethical decisions is crucial for professional counselors. However, the research on the effectiveness of ethics education for professional counselors is mixed. For example, professional counselors often report feelings that their training in ethical decision making was inadequate. Although, there is agreement that ethics education is essential to counselors, there is little consensus within the literature on ethics education and among counselor educators on how to improve training in ethical decision making.

The following questionnaire is designed to help researchers as well as professionals that teach courses in ethics to understand the perspective of Counselor Education students regarding the content and process of ethical decision making. The questions are open-ended and are designed to be discussed. All responses will be kept strictly confidential. Please use the back side of this sheet if you need more space to complete your answer.

1. When you think of the term "ethics" what words come to mind?

2. Do you feel that training in ethical decision making can make a difference? For example, can it improve a person's ability to recognize an ethical dilemma? Can it change a person's understanding of an ethical dilemma? Can it influence their response to ethical dilemmas?

3. Should training in ethical decision making be different for Counselor Education students than for students in other professional fields? Why or Why not?

4. Can ethical decision making be taught without bias? Why or why not?

5 Compared to other facets of counselor training, how important is training in ethics?

6. What should be the goal of training and or course work in ethical decision making?

7 In your opinion which is more important, understanding the theoretical and philosophical frameworks that guide ethical decision making, or understanding the specific code of ethics for counselors? Please explain.

8. In your opinion, what aspect of ethical decision making would be the most difficult to learn?

9. What learning activities do you think would facilitate students' ability to make ethical decisions?

10. What character qualities should an effective teacher or trainer of ethical decision possess?

Ethical Discrimination Inventory

Baldick, T. L. (1980) and N. E. Lipsitz, (1985)

This questionnaire consists of 12 ethical problem situations, in which you as a counselor might find yourself. For each situation, please indicate in a two to five word phrase, the possible ethical problem or problems involved in each situation. It is not intended for you to resolve the posed ethical dilemma, or to make judgments about whether behaviors presented in each dilemma are right or wrong, but to recognize what the problems or considerations are in each situation. The example below illustrates the test procedure and indicates that more than one problem may be involved in each case.

Example: A graduate student in counseling is in the midst of his dissertation. He is mailing a questionnaire to two groups of licensed professional counselors. Because it might interfere with his results he gives misleading reasons for their cooperation. In addition, he disguises a recently published questionnaire as his own in an effort to evaluate professional reaction to student efforts.

1. Problem of appropriate publication credit.

2. Possible misuse of research participants.

3. Question of appropriate supervision.

1. A client informs his therapist that he plans to murder his girlfriend due to her unfaithfulness to him. He is extremely angry The therapist later contacts both the girl and the local authorities explaining the situation.

2. While running a weekend encounter group, where the rule is that "each member is totally responsible for him or herself and what he or she does", the therapist has sexual intercourse with one of the group members. This is described as a "deeply moving and releasing experience" for both of them, and was "healthy and therapeutic since it was thoroughly discussed with the other group members"

3 A psychologist serving a small city was consulted by the local high school guidance counselor and asked if he would "look over" M.M.P.I. profiles of certain students from time to time and write a "rough" interpretation so that the counselor can help the students better understand themselves.

4. As a professional counselor you receive an announcement from a licensed colleague inviting you to a nude marathon weekend. the literature states that the "the effectiveness of the nude marathon has been proven... unquestionable superior to clothed marathons in fostering self-actualization"

5. During a cross-country flight, the passenger sitting next to a counselor begins to unfold his many troubles. The counselor feels he can help the passenger so he encourages him to talk, and is able to make several interpretations and interventions. When they reach their destination the passenger says, "I don't know whether I feel better or worse after talking with you." Then they go their separate ways.

6. A mother of a teenage son consults with a counselor about the conflicts that she is confronting at home and further arranges for her son to see the therapist the following week. The day following his appointment the mother comes into the office to pay her bill and asks, "What did he say to you?"

7. A claustrophobic patient contracts with a therapist to be treated by flooding technique, involving continued exposure to the conditioned stimulus until extinction. The therapist carefully explains the procedure and its theoretical justifications. Accordingly the patient is placed in a confined space with avoidance blocked by locking the door. After a time, she panics and pleads with the therapist to be released. He refuses, based on the fact that this panic must be overcome in order for extinction to take place.

8. A counselor has been counseling with a young married female for about a year. Her husband becomes quite psychologically dysfunctional and is a suicide risk. He is hospitalized and treated by a local psychiatrist and his staff. In the course of his treatment, the psychiatrist working with the husband meets with the wife to discuss her therapy and suggests she terminate therapy with her counselor and begin treatment with him. During her next session she reveals this to her counselor.

9. A 45 year old psychologist is consulted by a young man who appears anxious about his homosexual orientation. The psychologist discloses to the client that he is himself a homosexual, and that he is willing to counsel the client toward understanding and accepting his homosexual desires.

10. After several sessions with a married, 32 year old female, who is requesting therapy due to "mood changes", the counselor notes increased agitation, excitability and hyperactivity being manifested in session. She is unable to concentrate on any one particular subject and is quite distractible. The therapist calls the client's husband, who states that this is not uncommon behavior for her and that her mother and brothers have this problem. The counselor arranges for sessions to be three times per week, and sets up a home token economy to help the client develop more stable and appropriate behavior.

11. During the initial group session the group leader discusses the value of group, how "it" works and some of the techniques which may be used. About 3 weeks later a member exits from the group because a friend of his, who was taking a course from the group leader at a local college, saw him on a video tape of group process, shown in class.

12. A busy psychologist makes it a practice to give a prescribed battery of psychological tests to all new clients. Because of his busy schedule and the lack of space in his office, he will send the M.M.P.I. and the Edwards Personal Preference Schedule home with the client to be completed there.

The Ethics Position Questionnaire

Forsyth, D. R. (1980)

Instructions. You will find a series of general statements listed below. Each represents a commonly held opinion and there are no right or wrong answers. You will probably disagree with some items and agree with others. The researcher is interested in the extent to which you agree or disagree with such matters of opinion. Please read each statement carefully Then indicate the extent to which you agree or disagree to the statement by placing on the provided answer sheet the number corresponding to your feelings, where:

1 = Completely disagree	4 = Slightly disagree	7 = Moderately agree
2 = Largely disagree	5 = Neither agree or disagree	8 = Largely agree
3 = Moderately disagree	6 = Slightly agree	9 = Completely agree

---

1. A person should make certain that their actions never intentionally harm another even to a small degree.

2. Risks to another should never be tolerated, irrespective of how small the risks might be.

3. The existence of potential harm to others is always wrong, , irrespective of the benefits to be gained.

4. One should never psychologically or physically harm another person.

5. One should not perform an action which might in any way threaten the dignity and welfare of another individual.

6. If an action could harm an innocent other, then it should not be done.

1 = Completely disagree 4 = Slightly disagree 7 = Moderately agree

2 = Largely disagree 5 = Neither agree or disagree 8 = Largely agree

3 = Moderately disagree 6 = Slightly agree 9 = Completely agree

---

7. Deciding whether or not to perform an act by balancing the positive consequences of the act against the negative consequences of the act is immoral.

8. The dignity and welfare of people should be the most important concern in any society

9. It is never necessary to sacrifice the welfare of others.

10. Moral actions are those which closely match ideals of the most "perfect" action.

11 There are no ethical principles that are so important that they should be a part of any code of ethics.

12. What is ethical varies from on situation and society to another.

13. Moral standards should be seen as being individualistic; what one person considers to be moral may be judged to be immoral by another person.

14. Different types of moralities cannot be compared as to "rightness"

15. Questions of what is ethical for everyone can never be resolved since what is moral or immoral is up to the individual.

16. Moral standards are simply personal rules which indicate how a person should behave, and are not to be applied in making judgments of others.

17. Ethical considerations in interpersonal relations are so complex that individuals should be allowed to formulate their own individual codes.

18. Rigidly codifying an ethical position that prevents certain types of actions could stand in the way of better human relations and adjustment.

19. No rule concerning lying can be formulated; whether a lie is permissible or not permissible totally depends upon the situation.

20. Whether a lie is judged to be moral or immoral depends upon the circumstances surrounding the action.

Therapeutic Practices Survey

Boyrs, D. S. (1988)

Please complete both sides of this form regardless of whether you have ever provided psychotherapy services. Below are listed a number of behaviors which therapists may engage in as part of their clinical practice For each behavior, please indicate, by circling the appropriate number, whether you consider it: ALWAYS ETHICAL (5), ETHICAL UNDER MOST CONDITIONS (4), ETHICAL UNDER SOME CONDITIONS (3), ETHICAL UNDER RARE CONDITIONS (2), NEVER ETHICAL (1) or if you are NOT SURE (0).

In responding to each item, please consider only psychotherapy with adult clients (including family therapy and parent guidance). Unless otherwise indicated, items refer to a therapist's behavior with clients he or she is currently treating.

Behavior	Always Ethical	Ethical Under Most Conditions	Ethical Under Some Conditions	Ethical Under Rare Conditions	Never Ethical	Not Sure
Accepting a gift worth under $10 from a client	5	4	3	2	1	0
Accepting a client's invitation to a special occasion (e.g. his/her wedding)	5	4	3	2	1	0
Accepting a service or product as payment for therapy	5	4	3	2	1	0
Becoming friends with a client after therapy	5	4	3	2	1	0
Selling a product to a client	5	4	3	2	1	0
Accepting a gift worth over $50 from a client	5	4	3	2	1	0
Providing therapy to a then-current employee	5	4	3	2	1	0

Behavior	Always Ethical	Ethical Under Most Conditions	Ethical Under Some Conditions	Ethical Under Rare Conditions	Never Ethical	Not Sure
Engaging in sexual activity with a client after termination	5	4	3	2	1	0
Accepting a handshake offered by a client	5	4	3	2	1	0
Feeling sexually attracted to a client	5	4	3	2	1	0
Disclosing details of one's current personal stresses to a client	5	4	3	2	1	0
Inviting clients to an office/clinic open house	5	4	3	2	1	0
Employing a client	5	4	3	2	1	0
Going out to eat with a client after a session	5	4	3	2	1	0
Buying goods or services from a client	5	4	3	2	1	0
Engaging in sexual activity with a current client	5	4	3	2	1	0
Inviting clients to a personal or social event	5	4	3	2	1	0
Providing individual therapy to a relative, friend or lover of an ongoing client	5	4	3	2	1	0
Providing therapy to a current student or supervisor	5	4	3	2	1	0
Allowing a client to enroll in one's class for a grade	5	4	3	2	1	0

APPENDIX B: CASE STUDIES

Instructions to Group Exercise

For each situation, indicate in a two to five word phrase, the possible ethical problem or problems involved in each situation. It is not intended for you to resolve the posed ethical dilemma, or to make judgments about whether behaviors presented in each dilemma are right or wrong, but to recognize what the problems or considerations are in each situation.

The Case of Brenda

(Gookin, K. D., 1989)

Case Summary

Brenda is a 28-year-old student at a large university. She is attempting to complete her degree and is invested in finishing. She is paying her own educational expenses and one-half of household expenses. She has been married for 8 years to a man who is not supportive of her academic goals. She recently lost her job and may have to leave school if she does not find another job soon. She has recently become convinced that her husband is having an affair with one of her friends and feeling betrayed and angry at them. She found a romantic letter written by the friend to her husband and assuming it was for her as well, read it.

In the course of the interaction with a counselor, Brenda expresses her shock and anger at her husband and her friend. She is determined that the woman will pay for what she has done to her and states, "This will never happen again to anyone." She indicates she knows where the woman works. She also indicates she has a tendency to eventually "blow up" when things become intolerable, and she states she will no longer be passive about things that bother her.

Instututionalized Adult

Kitchener, K. S. (1984)

Case Summary

A 52-year-old mentally handicapped adult has been institutionalized since birth. After a recent testing by a psychologist, it appears that the disability is not as severe as previously thought. The psychologist recommends moving the person to a community care home where hem may become more independent. This will save the agency about $10,000 a year and relieve overcrowding on the ward. In a preplacement interview, the client tells the psychologist that the institution is his home and he doesn't want to leave it. Furthermore, the client exhibits symptoms of severe depression.

The Case of Sheri

(Gookin, K. D., 1989)

Case Summary

Sheri is an 18-year-old female freshman at a large university. She is living in a rooming house near the campus in order to reduce living expenses. She is interested in moving out of the rooming house and into an apartment with a woman whom she has just met. Sheri's presenting concern in therapy involved feeling lonely and unmotivated in school.

In the course of the interaction with the counselor during her third session, Sheri indicates that she wants to move out of the rooming house because she is frightened and disgusted by what is happening there. The woman who owns the house lives there with her boyfriend and her 14-year-old daughter, Jennifer. Jennifer recently told Sheri that her mother's boyfriend has exposed himself to her (Jennifer) on several occasions.

The Case of Ms. B

(Gookin, K. D., 1989)

Case Summary

Ms. B., a 30-year-old single woman, comes to Dr. Jones asking for counseling. She says that she has had chronic fears of getting close to men and has been too anxious to ever date. She had consulted Dr. Smith for the same problem 1 year previously. she began seeing him for regular sessions. She reports that Dr. Smith told her that she would learn to trust other men by learning to trust him. this initially involved embracing each other and progressed to sexual intercourse, which Ms. B. says continued for several months. Ms. B. became increasingly uncomfortable about her sessions with Dr. Smith and recently discontinued seeing him.