MORAL AND ETHICAL DECISION MAKING OF PHYSICIANS AND ATTORNEYS: THE INFLUENCE OF FAITH ACROSS THEIR CAREER LIFESPANS

by

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A DISSERTATION

IN

PSYCHOLOGY

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

DOCTOR OF PHILOSOPHY

Approved

August, 1999

ACKNOWLEDGMENTS

I wish to thank all of my committee members for agreeing to serve on my committee. It has been both an honor and a privilege to work with each and every one of them. Each one has contributed something very special to my career both professionally and personally. First, I wish to thank Dr. Jeffrey Elias, my major professor, who has served not only as my mentor, but as true example of what ethical behavior should be. I would also like to thank him for believing in me and taking me into his department at a time when he could not truly justify another student. I would also like to thank Dr. Thomas McGovern for his continual encouragement that this whole process was only a "hurdle to overcome," and for his never ending support of this project. To Timothy Floyd, adjunct professor of TTU Law School, I wish to thank him for agreeing to be on my committee, and for the many hours of time and advice he gave me before ever having met me in person. Last, but not least, I wish to thank Dr. Rhonda Brown for agreeing at the last minute to serve on my committee. Her input has been invaluable.

I would also like to thank all those agreeing to participate in this study.

This whole process would never have taken place without the love and support of many special people in my life. Each and every one of you have made this process bearable: Janie

Williams, Ronda Eade, Cathy Lindsay, Pam Patschke, Linda Knight, Marilyn Gillet, Clay Grizzle, Dr. James Gamble, and Dr. Truman Lewis and Mrs. Mona Lewis. A special thanks to my parents, Bill and Margaret Richardson, and my in-laws, Joe and Mary Parsons for enduring the trials and tribulations of my graduate career. I love all of you very much. In closing, I wish to thank my husband, Frank, for loving me and supporting me through an educational career that he knew little about, but never doubted that I could do it. Thank you, my dear husband! I wish to dedicate this dissertation to my children, Adam and Kaitlyn, without whom my life would never have been as complete as you have both made it.

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A review of the ethical and moral development literature suggested that specific factors, such as age, education, faith, and well-being may be determinants of moral development. The literature also showed that the ethical and moral judgment of professionals has rarely been examined. Nor has the literature examined extensively the role faith plays in the professional's process of ethical and moral decision making.

The present study surveyed a sample of adult professionals, physicians and attorneys to determine what factors were predictive of ethical and moral decision making. The specific role that faith plays was assessed. Physicians and attorneys were assessed to determine any differences that might exist in ethical and moral decision making or in the faith role between the professions. A demographic questionnaire and measures of moral development, faith development, general well-being, spiritual well-being, intrinsic and extrinsic faith, and the daily spiritual experience were used to obtain this information.

Results from this study revealed that age, education, well-being, and faith were not predictive of ethical and moral decision making. Surprisingly, physicians reported high in extrinsic faith and attorneys reported high intrinsic faith.

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A review of the ethical and moral development literature suggested that specific factors, such as age, education, faith, and well-being may be determinants of moral development. The literature also showed that the ethical and moral judgment of professionals has rarely been examined. Nor has the literature examined extensively the role faith plays in the professional's process of ethical and moral decision making.

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CHAPTER I

INTRODUCTION

Moral and Ethical Obligations Among Practicing Professionals

In the United States today, many individuals must rely on the expertise of trained professionals: specifically in our society people find that they need the services of attorneys, physicians, or psychologists to assist them in a process of decision making that will enhance the quality of their life. Frequently, this process encompasses caregivers as well as members of the extended family. Individuals rarely retain the services of the professional until a crisis situation arises. The emotional impact of a crisis can cause an otherwise competent and decisive person to engage in periods of indecisiveness and irrational decision making. As a result, the prospective client's (or patient's) ability to shop for and retain the services of a competent professional over an incompetent professional may decrease. In the end the quality of life for the client/patient may suffer greatly. (In the remainder of this document, "client" will refer to both client and patient.)

The initial responsibility of researching and choosing a qualified professional lies with the prospective client. Once services are retained, the professional's conduct toward his or her client should be based upon the highest ethical

and moral standards. The professional must adhere to ongoing ethical and moral behavior towards both the client and the professional organization he or she represents, such as the American Bar Association (ABA) (United States of America, 1995), American Medical Association (AMA) (Council on Ethical and Judicial Affairs, 1994), and the American Psychological Association (APA) (Stromberg et al., 1988). These professional organizations mandate the ethical and moral guidelines that professionals should incorporate into their private practices. Theoretically, the incorporation of these professional standards should protect both the client and the professional. However, as professionals respond to the onslaught of such day-to-day pressures as meeting time deadlines, retaining new clients, and attending to existing clients, ethical and moral behaviors may either fall to the wayside or be completely forgotten until the necessity of a situation demands that they be incorporated.

The professional's decision to practice within a moral and ethical framework stems from a self-regulated process. The professional, alone, gages the quantity and quality of ethical and moral autonomy to be implemented when he or she makes ethical and moral decisions. Likewise, only the professional can determine when to apply and when not to apply personal morals to a professional situation. A professional must decide whether to be governed by one's personal ethical and moral beliefs or to be governed by one's

professional code of ethics. For some professionals, the distinction between personal ethical and moral behavior and professional ethical and moral behavior is executed easily. However, other professionals believe that one cannot separate ethical and moral behavior according to personal and professional roles. The process of compartmentalizing ethical and moral behavior leads to the possibility of professional dissonance. Across the lifespan of the professional, a developmental process ensues as one's personal and professional experiences accumulate. The professional must repeatedly evaluate whether to implement moral and ethical decisions based upon one's personal experience, professional experience, or a combination of the two. The developmental process of faith across the lifespan also plays a role in the moral and ethical decision-making of professionals.

A review of the literature showed that the ethical and moral judgment of professionals rarely has been examined. Nor has the literature examined extensively the role faith plays in the professional's ethical and moral decision-making process. It is the purpose of this study to investigate the ethical and moral decision making perspectives of two specific groups of individuals--physicians and attorneys--and to determine if their level of faith can be a predictor of their level of ethical and moral decision making. The specific populations of physicians, and

attorneys were chosen based on their high levels of education; their ability to think abstractly, and their ability to implement high professional standards on specific issues of judgment. This study will also determine if educational level predicts the level of moral development. It also will be determined if age is a predictor of the level of moral development. The roles that intrinsic and extrinsic faith play in moral development will be assessed, as well as the role that spiritual well-being plays in moral development and faith development.

However, first, the theories pertaining to moral and ethical development will be discussed, and the instruments used to measure these areas of development will be discussed. Second, the theory of faith and instruments to measure it will be discussed. The next issues to be discussed will be factors, such as age education, socialization, spiritual faith, and well-being that are used to solve ethical and moral dilemmas. Finally, a brief overview of the professional organizations of physicians, attorneys, and psychologists will be introduced to assist in creating a better understanding of the ethical and moral guidelines that professionals are expected to show adherence. Although psychologists will not be included in this study, a brief overview of the APA will be discussed to create a more thorough picture of the realm of professional ethics among practicing professionals.

Morality

According to Rest, Thoma, and Edwards (1997), moral decision making is a process people use to determine which course of action is morally right or wrong in a particular situation. This decision-making process requires the individual to define the moral issues, determine how to settle any existing moral conflicts, and then implement the course of action. The moral decision making process can be broken down into two specific categories: personal morality and professional morality. Before discussing the development of personal morality and professional morality, a discussion of basic moral development itself will be presented.

Basic Moral Development

Research shows that basic moral development precedes higher level moral decision making (Grimley, 1991; Hanford, 1991; Kohlberg, 1981; Rest, 1979). One of the most noted authorities on moral development is Lawrence Kohlberg. Kohlberg (1981) modeled his stages of moral development after Piaget's paradigm of cognitive development. Miller (1989, p.46) summarizes Piaget's paradigm as follows:

> 1. Sensorimotor period (roughly birth to 2 years). The infant understands the world in terms of his overt, physical actions on that world. He moves from simple reflexes through several steps to an organized set of schemes (organized behaviors).
> 2. Preoperational period (roughly 2 to 7 years). No longer does the child simply make perceptual and motor

adjustments to objects and events. He can now use symbols (mental images, words, gestures) to represent these objects and events. He uses these symbols in an increasingly organized and logical fashion.
3. Concrete operational period (roughly 7 to 11 years). The child acquires certain logical structures that allow him to perform various mental operations, which are internalized actions that can be reversed.
4. Formal operational period (roughly 11 to 15 years). Mental operations are no longer limited to concrete objects; they can be applied to purely verbal or logical statements, to the possible as well as the real, to the future as well as the present.

Cognitive development pertains to the development of mental processes during such periods of development as the preoperational period, the concrete operational period, and the formal operational period. Piaget believed that once a person made the transition from concrete operational thought to formal operational thought, that person could begin the process of abstract thought. Kohlberg expanded upon Piaget's developmental paradigm and hypothesized that moral development began during the preoperational period. Kohlberg termed this first period of moral development as the preconventional level. Heilburn and Georges (1990, p. 181) succinctly summarized Kohlberg's (1981) stages of moral development and the process applied when a person determines "what is morally right":

Preconventional level
Stage 1 (heteronomous morality)... to avoid breaking rules that are backed by punishment
Stage 2 (individualism, instrumental purpose, and exchange)... following rules in order to receive rewards or fulfill needs

Conventional level

Stage 3 (mutual interpersonal expectations, relationships, and interpersonal conformity)...doing what is right because people expect it.

Stage 4 (social system and conscience)... conforming to laws of the broader group, institution, or society

Postconventional level

Stage 5 (social contact or utility and individual rights)...awareness of the relativity of group values but respect for certain nonrelative values *regardless of majority opinion.* (italics added)

Stage 6 (universal ethical principles)...willingness to follow *self-chosen principles despite violation of laws.* (italics added)

The first four stages deal with positive and negative external reinforcements (either/or decisions) and require little self control. Stages 5 and 6 deal with internal decisionmaking and require exceptional self-control. For example, individuals (in the postconventional level) may choose maintaining a personal principle despite any ensuing negative consequences.

Kohlberg (1973) hypothesized about two factors that contributed to the rate of moral development. The first hypothesis assumed that cognitive development must be a prerequisite for moral development. Kohlberg believed that an individual could advance more easily to a higher moral stage, if the individual had first advanced into a corresponding stage of cognitive development. For example, as one's educational level increases so should one's level of moral development. Walker (1986) supported Kohlberg's finding and showed cognitive development to be necessary, but

not sufficient. Walker also supported Kohlberg's hypothesis that the level of one's moral reasoning increases as one's educational level increases. Walker found that no one without post-secondary education ever attained stage four; yet he also found social experiences to be a greater predictor for the rate of moral development. However, Markoulis (1988) refuted Walker's findings and found that stage five occurred in educationally-advanced adults, but rarely.

Kohlberg's second hypothesis assumed that appropriate exposure to sociomoral experiences must occur before an individual can advance to a higher level of moral development. Sociomoral experiences expand based on one's educational level; one's occupational status, one's political and social activity, and one's living independently (Walker, 1986). Kohlberg believed that the appropriate sociomoral experiences involve decision making from both an emotional and moral level. Sociomoral experiences present an opportunity for an individual to be stimulated into making moral judgments when forced with a moral dilemma or when interacting in social relationships.

Although Kohlberg believed an increase in one's cognitive development and one's sociomoral experiences can increase one's level of moral development, he could not explain why so few people ever reached his sixth and final stage of moral development. If cognitive development ceased

and sociomoral experiences did not, then according to Kohlberg's hypothesis new sociomoral experiences should constitute ongoing moral development. Kohlberg (1981) proposed that the highest level of moral reasoning to be obtained by an individual was stage six of moral development--the universal ethical principle. This principle deals with mutual respect and dignity (Wygant, 1995). Kuhn, Langer, Kohlberg, and Haan (1977) argued that not every individual reaches stage six. They believed that individuals who never entered into stage six of moral development had never fully made the transition to formal operational thought, Piaget's stages five and six. They went on to suggest that life experiences may be the prerequisite to stage six of moral development.

Markoulis (1988) confirmed findings of both Kohlberg (1981) and Kuhn et al. (1977) that postformal operations, stage five and stage six of cognitive development, were a prerequisite for stage five and stage six of higher moral reasoning. Markoulis also found that cognitive development and moral development occurred in a synchronized manner; however, the synchronization occurred only up to stage four. Past this point, formal operational thinking no longer affected the rate of moral development. Markoulis also found that stage five of moral development was rare even among educationally-advanced adults. These studies indicate that

sociomoral experiences play a lesser role or no role at all if cognitive development ceases.

Frequently, the literature separates moral development into two categories: personal moral development and professional moral development.

Personal Morality: Developmental Process

Based on the literature, personal morality emerges from a collection of personal experiences that begin at birth, and it continues across the lifespan. These experiences serve as the foundation for both personal and professional decision making (Jack & Jack, 1989). These personal experiences develop over time due to the continual impact of such complex personal and social forces as family, friends, church, and school. These forces play a vital role in influencing and shaping personal experiences for individuals. According to Jack and Jack, every individual develops his or her own unique pattern of responses and assumptions to issues in life. These emerging patterns of responses and assumptions become a major part of the individual's personality, and the essence of who that individual is.

Professional Morality: Developmental Process

Jack and Jack (1989) described the professional morality process as beginning when the individual enrolls in the

chosen professional school of his or her choice (e.g., law school).

Professional schools endeavor to mold the students' professional ethical and moral decision making skills to the point that these students eventually fit into a pre-conceived mold of what best exemplifies their respective institution. Jack and Jack (1989, p. 31) refer to this molding process as "role-identification." Morgan and Rotunda (1995, p. 18) call it "role-differentiated behavior." Prilleltensky (1997, p. 531) refers to the professional as a "moral actor," and Friedrick and Douglass (1998, p. 549) label this molding process as "a process of persuasion." These terms imply that researchers view professional moral behavior as an assumed role, one that can be picked up or put down, purely at the discretion of the individual. The teaching of professional morality assists students in establishing the ethical and moral obligations they need to practice their profession. However, the continual process of deciding when to use personal morality versus professional morality can take a toll on the general well-being of professionals.

The Relationship of Personal Morality to Professional Morality

According to Jack and Jack (1989), morality does not have to be divided into two separate roles of personal morality and professional morality. For example, a

professional does not have to leave his or her personal moral beliefs at home and use only his or her professional morals while at work. They believe a professional continually acquires both personal morality and professional morality and can incorporate the two into their daily work as a professional. It is their belief that incorporating personal and professional morals will prevent moral tension. According to Jack and Jack, moral tension occurs when professional morality remains at odds with the morality of everyday life. According to Jack and Jack (1989), separating personal morality from professional morality ensures the preservation of the institution and prevents potential tyranny of the institution; however, this separation creates moral tension for many professionals. Each professional must determine to what degree he or she will willingly conform. The ideal situation occurs if an individual's personal morality coincides with his or her professional morality. The transition from personal to professional morality occurs without personal cost to an individual's moral structure. However, if that individual experiences difficulty in replacing personal morality with professional morality, moral tension results. Moral tension also results if personal morality overrides professional morality. Jack and Jack (1989) found that a gap between professional and personal morality not only creates moral tension, but it eventually

affects the professional's ability to effectively represent either the client or the institution.

Morgan and Rotunda (1995) showed that good moral decision making need not be a precursor to good professional ethics. They found that professionals could make ethical decisions without incorporating personal moral beliefs into the decision making process. They gave the following example: "It is not 'immoral' for a lawyer to form a law partnership with a non-lawyer...but it would violate current professional standards in almost every jurisdiction" (p.16). However, Morgan and Rotunda believed that dividing morality into the two roles of personal and professional and then assuming one role over the other role when the situation demanded was not a practical solution for the professional. If professionals attempt to "compartmentalize" their morality into either personal or professional morality, they run the risk of blocking the growth necessary on both a personal and a professional level. Morgan and Rotunda concluded that professionals can better serve their clients and their practice if they draw from a broad resource of personal and professional moral experiences. As a result, the professional will develop a fully integrated moral personality--he or she will continually draw upon the resources of both personal and professional moral experiences. In conclusion, both Morgan and Rotunda (1995) and Jack and Jack (1989) agreed that professionals should

incorporate degrees of personal morality into their professional roles. Moral tension is less likely to occur and the stage for practicing universal fairness can then be set.

A Professional's Ultimate Goal

"Universal Fairness". Universal fairness refers to Kohlberg's stage six of moral development, the universal ethical principle. Professional moral training centers on the idea that one should aspire to the level of treating every client with universal fairness (Morgan & Rotunda, 1995; Jack & Jack, 1989; Gilligan, 1982; Kohlberg, 1973 & 1981; Beauchamp & Childers, 1979). Not every person reaches this level of moral development (Colby & Kohlberg, 1987; Mwamwenda, 1992). However, individuals who reach this stage may be inclined to make moral decisions based on their own personal judgments and assessments of the rules and professional standards pertaining to each situation. According to Jack and Jack (1989), professionals at this level run the risk of no longer relying on either rules or professional standards to execute moral decisions. Corruption results if professionals misuse their authority in a system designed to work by the rules and regulations governing it. The sanctity of one's professional institution, such as the AMA, ABA, and APA, also becomes

threatened when absolute power lies in the hands of professionals.

To successfully implement the process of universal fairness, a professional must draw upon "sound practical judgments" and upon "the resources of broader moral experience" while always seeking to achieve "a fully integrated moral responsibility" (Morgan & Rotunda, 1995, p. 18).

The literature presents personal morality and professional morality as abstract principles; and therefore measuring a person's moral development can not be done in absolute terms. Rather, measurement is best addressed through the use of such things as production tasks or recognition tasks (Rest, Thoma, & Edwards, 1997).

Morality Measurements

A review of the literature showed that Colby and Kohlberg's (1987a, 1987b) Moral Judgment Interview (MJI), a technique of measuring an individual's level of moral judgment, pioneered the way for many researchers to assess moral decisionmaking. The Kholbergian format for collecting data from subjects has been to present a set of hypothetical moral dilemmas to each subject. Each subject is then asked what action ought to be done; then each subject justifies his or her course of action. The subject's responses are then

scored, and the stage of moral development is determined for each individual. This procedure is referred to as a production task. The Moral Judgment Interview has served as a preliminary model that other researchers could branch off of to measure moral development. Langford (1992) summarized the published methods of moral development performed by different researchers, and found that although the samples maintained the format of a production task, the method of scoring the samples would differ among the researchers. This led to a difference in the findings and an inconsistency in interpreting the data.

A solution to the inconsistent scoring techniques was the development of the Defining Issues Test (DIT)(Rest, Cooper, Masanz, & Anderson, 1974). The DIT differs from the MJI in that it is a recognition task versus a production task. A recognition task is administered in multiple-choice format versus the essay format of production tasks; thus scoring is made simple and consistent. The time taken to administer the test is reduced as a result. In a recognition task, such as the DIT, the subject is presented with a moral dilemma. Next, the subject is presented with a set of statements for the participant to evaluate. The subject then ranks or rates the provided statements according to the level of moral importance. The purpose of this procedure is to determine a subject's level of moral judgment, as it pertains to Kohlberg's six stages of moral development. According to

Rest, Thoma, Narvaez, and Bebeau (1997), where the DIT differs from the MJI is that the MJI assesses the stage of moral development the individual has reached, and the DIT assesses which stages the individual uses more. The assumption being that over time individuals will use higher stages of moral development more than they will use the lower stages. An individual never permanently closes the door between the stages of moral development.

Measurement of the DIT is best performed using indexes, such as the P index and the new index, N_2. The P index score represents the overall score assigned to an individual and is based on rankings. The N_2 index is based on ratings, rankings, or both. The DIT has consistently maintained internal reliability based on the P index and the N_2 index shows the potential of being just as reliable as the P index (Rest, Thoma, Narvaez, & Bebeau, 1997). Rest, Thoma, Narvaez, and Bebeau (1997) performed the P index and N_2 index on two composite samples. Based on Cronbach's alpha, internal reliability was found to be high in both indexes [1995 composite sample (n=932; P index r=.78 and N_2 index r=.83) and 1979 composite sample (n=994; P index r=.76 and N_2 index r=.80)]. Both composites were statistically significant, ($p<.001$).

The Moral Judgment Test (MJT) designed by Lind (1995) is a recognition task like the DIT. According to Rest, Thoma, and Edwards (1997) the MJT and DIT share the following

qualities: (1) Both purport to measure one's competence in moral decisionmaking; (2) both are based on Kohlberg's stages of moral development; (3) both produce ratings for analysis; and (4) both regard the algorithm as critical to combining the rating (or ranking) data into a general developmental score for the participant, such as the P index from the DIT or Lind's C index. (Each index will be discussed later.)

According to Lind (Rest, Thoma, & Edwards, 1997), the MJT outperforms the DIT because it can separate the affective aspects from the cognitive aspects of moral judgment. In other words, Lind proports that the MJT can measure the individual's pattern of response (stage consistency) versus the DIT that measures the individual's highest level of performance in a specific stage at that point of time (stage preference). Lind uses a consistency index, C index, to assess the individual's pattern of response. The C score is obtained by performing an ANOVA on each individual's pattern of response; and thus providing a way of characterizing the overall distribution of responses. Whereas, the DIT P score is obtained by weighting the sum of ranks for the principled items, or stages five and six. This means that the P score can be interpreted as to the degree which the individual thinks stages five and six are important in making moral decisions.

The MJT is used more widely in Europe than in the United States; however, recent controversy has risen as to whether

the MJT can outperform the DIT. Rest, Thoma, and Edwards (1997) performed a study to determine if the DIT was more consistent in the measurement of moral decision making than the MJT. They found that the DIT outperformed the MJT in such areas as stage consistency versus stage performance, construct validity, and internal validity. Rest, Thoma, and Edwards (1997) reanalyzed previous raw data that stemmed from classical studies of moral development. These classical studies had been cited in the literature as building construct validity for the DIT. Construct validity refers to the process of analyzing each individual item on the DIT and determining the items that test the highest for the stages of moral development. Rest, Thoma, and Edwards (1997) reanalyzed the data using Lind's C index procedure to determine if it outperformed the P index or if other newer indexes, such as the N_2 index outperformed it (Rest, Thoma, Narvaez, & Bebeau, 1997). Because the P index had been performed on all the classical studies, the researchers designated it as a benchmark for all other indexes. Rest, Thoma, and Edwards (1997) found that the P index maintained higher internal validity, or was more differentiating among subgroups (e.g., medical students, junior high students, moral philosophers) than the C index. For example, the correlation of P index with subgroup was .69 ($p<.001$); the correlation of the C index with subgroup was .38 ($p<.001$).

The P index indicated a stronger, more uniform growth pattern over time than did the C index (see Table 1).

However, when the C index was applied to the DIT data, it also exhibited an upward longitudinal trend. These new findings refuted Lind's hypothesis that people are exhibiting stage consistency versus stage preference. They had found that, over time, low stage scores go down and high stage scores go up. In other words, an individual ceases to use the previous stages of moral development; instead, he or she utilizes the current stage of moral development that has been attained.

Although the DIT outperformed the MJT, the MJT deserves recognition because it provides an alternate route to measuring moral development. Lind's C index also presented as another method of measuring stage preference. Perhaps indirectly, the most important contribution that Lind's MJT data and C index analysis made was that of supporting previous findings in the literature that the DIT is a reliable testing measure of moral development across the lifespan. After moral development has been measured, the remaining phase to be measured is ethical development.

Ethical-Decision Making

Definition

Frequently, the literature refers to ethical and moral as synonymous terms. However, this paper will separate the terms into two distinct categories. "Ethical" will pertain to a level of decision making that has been obtained only after the higher levels of moral development and cognitive formal operations have been established. Ethical decision making refers to a self-chosen process that appeals to logical comprehensiveness, universality, and consistency of the individual (Morgan & Rotunda, 1995, p. 17). Ethical decision making is a process that develops over the individual's lifespan.

Ethics itself requires that an individual understand a variety of rules, principles, relationships, and actions and consequences (Health Care Ethics Committees, 1993). According to Beauchamp and Childress (1979) ethical theories allow the individual to determine right and wrong in dilemmatic situations. They described ethical theories as working in a tier fashion of four levels of moral justification (p. 5):

4 Ethical Theories
↑
3 Principles
↑
2 Rules
↑
1 Judgments and Actions

First a judgment is decided for a particular dilemmatic situation, and then an action is taken based on a particular judgment. The second level requires that a decision be made as to what rules will apply. According to Beauchamp and Childress (1979), rules state what kind of actions ought to occur based on what is right or wrong. The third level is the foundation on which the rules are based. The fourth level pertains to the collective body of principles and rules that can be systematically related. For example, moral dilemmas require the application of moral rules. Moral rules can be justified by principles. A collection of these moral rules and principles compose the ethical theory that can justify the individual's right or wrong action.

Beauchamp and Childress'(1979) diagram of moral reasoning and justification has been criticized by the Health Care Ethics Committees (1993) as being misleading. Ethical dilemmas can not always be solved by one simple form of methodology. Ethical problems often encompass more than one person, and these problems can occur at the individual, institutional, or societal level.

Individual ethics pertain to the care of individuals. For example, which person should be recommended for a heart transplant. Whereas institutional ethics deal with the good of the institute. For example, only the patients who could pay would be considered for a heart transplant. Societal ethics deal with the good of society. For example, insurance

companies must decide whether or not to cover heart transplant procedures. It becomes a problem in and of itself for ethics committees to decide which ethical realm (individual, institutional, or societal) deserves priority.

Ethical Orientations

The literature also views ethical decision making as stemming from two distinct orientations: Ethical decision making may stem from that of a care-oriented approach (Gilligan, 1982), or it may stem from a justice-oriented approach (Kohlberg, 1981). Levine (1987) elaborates on the difference betwéen the two orientations. The care-oriented approach focuses on the importance of emotional attachment between individuals. Relationships must be preserved and maintained through such things as responsiveness, empathy, and unmediated personal interaction (Jack & Jack, 1989). The primary goal is to preserve existing relationships when solving ethical dilemmas, not to focus solely on the individual. The justice-oriented approach focuses on solving problems according to the rules. The rules are followed no matter what. An adherence to rules will guarantee a society composed of autonomous and separate individuals who strive to maintain independence(Jack & Jack, 1989).

Gilligan (1982) believes gender-linked moral differences exist. Women adhere more to the care-oriented approach, and

men adhere more to the justice-oriented approach. However, Jack and Jack (1989) performed a study among practicing attorneys to determine if gender differences existed among attorneys adhering to one of the two moral orientations. The attorneys responded to an interview format. The interview was divided into three sections. The first section was designed to determine their general moral orientation. The second section was designed to determine which moral orientation the attorneys would use in a real-life dilemma, and if that orientation differed from the one they would use in a hypothetical dilemma. The hypothetical dilemma composed the third section of the interview. Jack and Jack (1989) found that a gender difference existed in the area of general moral orientation. Women attorneys were 64% more likely to respond to a dilemma using the care-oriented approach, while men were 77% more likely to respond to the justice-oriented approach [$t(34)=-5.76$, $p < .00005$). However, as the attorneys were asked to respond to dilemmas requiring a more professional perspective the care-oriented approach was used less, and the justice-oriented approach was used more. The results are as follows: The first real-life dilemma found a significant difference between men and women's care-orientation means [$t(28)=-2.22$, $p < .03$]. For the second real-life dilemma [$t(150=-2.85$, $p < .01$]. Although women showed more care orientation than men in the first hypothetical-dilemma, no statistical difference was observed

(care orientation for women was 28% and men was 16%). Statistical significance was found for the second hypothetical-dilemma [$t(34)=-2.92$, $p < .006$]. Jack and Jack (1989)attributed these findings to the fact that as attorneys were directed more towards answering the dilemmas in a legal role, the less likely they were to respond within a care-oriented framework. Gender differences at this point held no bearing.

Ethical Measurements

Because ethical development is often used synonymously with moral development, the MJI (Kohlberg, 1981) is generally used to determine one's level of ethical reasoning. An exception to this is the Ethical Reasoning Inventory (ERI). A major drawback to the ERI is that it is lengthy to administer and procedurally complex (Gibbs et al., 1984). There is some question as to its validity being limited to only college-level subjects (Bode & Page 1979; Page & Bode, 1980).

Ethical and moral decision making is dependent upon an individual's level of moral development, however, a potential motivating factor that determines why an individual continually responds in either an ethical or moral manner across the lifespan is dependent upon that individual's level of faith.

Faith

Definition and Theory

Fowler (1981) defines faith in terms of a concept, not in terms of a simple definition. Fowler describes faith as being universal. Every human is born with the inherent capacity to develop his or her faith; therefore faith is not characteristic of religious people only. Tam (1996) summarizes Fowler's idea of faith in the following way:

> ...a human process by which one tries to integrate or order one's life towards the ultimate concern or transcendent values that one has appropriated. Different persons may perceive different values as their ultimate concern: for some their ultimate value(s) may be invested in family, university, politics; for others, perhaps church, God, religion; and for others, equality, love, justice, peace. (p. 252)

Fowler's faith theory is based upon the idea that faith is relational. A person performs faith as an act. For example, an individual who has faith in something or in someone is engaging in a relationship. It is a relationship built on such things as commitment to, trust in, or loyalty to something or someone. People can have faith in or belong to more than one type of faith relation (church, family, politics, professional organizations). No matter how many faith-relations a person belongs to each one is based on the sharing of a common faith and a common commitment with others who believe in that same shared image or belief system.

According to Fowler (1981), a component of faith is knowing. Knowing evolves from the images an individual

creates and stores to memory. As an individual matures across the lifespan so does his or her ability to know, see, and value things. Fowler (1981) describes a person's knowing ability as a transformation process that enables the person to change or strengthen his or her image of oneself, others, the world, and one's ultimate value(s). In other words, faith requires people to constantly evaluate such things as their direction in life, their relationships with others, and their ultimate life value(s). Tam (1996) stated that one's expression of faith occurs through one's commitment and loyalty to one's perceived value(s).

Developmental Process of Faith

Fowler (1981) based his theory of faith development upon the works of Piaget, Kohlberg, Erikson, and Levison. Piaget and Kohlberg adhered to structural development theories and Erikson and Levison adhered to life-span development theories (Tam, 1996). Fowler's theory develops across the lifespan in seven structural stages. Drawing from Fowler's (1981) work, entitled "The Vocation of Faith Development Theory," Tam (1996) succinctly summarizes the gist of each faith stage:

> Primal Faith (infancy): A prelanguage disposition of trust forms in the mutuality of one's relationships with parents and others to offset the anxiety that results from separations which occur during infant development.
>
> Intuitive-Projective Faith (Early Childhood): Imagination, stimulated by stories, gestures, and

symbols, and not yet controlled by logical thinking, combines with perception and feelings to create long-lasting images that represent both the protective and threatening powers surrounding one's life.

Mythic-Literal Faith (childhood and beyond): The developing ability to think logically helps one order the world with categories of causality, space, and time; to enter into the perspectives of others; and to capture life meaning in stories.

Synthetic-Conventional Faith (Adolescence and beyond): New cognitive abilities make mutual perspective taking possible and require one to integrate diverse self-images into a coherent identity. A personal and largely unreflective synthesis of beliefs and values evolves to support identity and to unite one in emotional solidarity with others.

Individuative-Reflective Faith (Young Adulthood and beyond): Critical reflection upon one's beliefs and values, utilizing third-person perspective taking; understanding of the self and others as part of a social system; the internalization of authority and the assumption of responsibility for making explicit choices of ideology and life-style; all open the way for critically self-aware commitments in relationships and vocation.

Conjunctive Faith (Mid-life and beyond): The embrace of polarities in one's life, an alertness to paradox, and the need for multiple interpretations of reality mark this stage. Symbol and story, metaphor and myth (from one's own traditions and others') are newly appreciated (second, or willed naiveté) as vehicles for expressing truth.

Universalizing Faith (Mid-life and beyond): Beyond paradox and polarities, persons in this stage are grounded in a oneness with the power of being. Their visions and commitments free them for a passionate yet detached spending of the self in love, devoted to overcoming division, oppression, and violence, and in effective anticipatory response to an inbreaking commonwealth of love and justice. (pp. 256-257)

Each one of the faith stages can present a different faith-pattern. According to Fowler, faith-patterns depend upon the interaction of the seven aspects of human faith and

one's level of faith development (Tam, 1996). The seven aspects are as follows: (a) form of logic, (b) role taking, (c) form of moral judgment, (d) bounds of social awareness, (e) locus of authority, (f) forms of world coherence, and (g) role of symbols. The aspects vary in intensity from stage to stage and from individual to individual. The structural change in each of these stages results from the changes in biological maturation and psychosocial, cognitive, and moral development. Stage transitions are unlikely to occur if a certain chronological age has not been reached. However, movement from one stage to the next does not automatically occur for each person. Transitions may occur at earlier stages for some people; whereas, other people may fixate at certain stages and never progress further. According to Tam, encountering crises, novelties, and specific experiences that threaten or challenge an individual's character constitute a change in one's faith pattern. The equilibrium of the individual's given stage becomes upset and transformation to the next one begins. Fowler notes that three specific things can either contribute or hinder one's transition to a new stage (Tam, 1996):

> (1) Developmental change:...change that results from the maturation and formation of the self.
> (2) Reconstructive change:...change as breakdown and rebuilding, restoration and healing, conversion and transformation.
> (3) Change as response to intrusive marker events: Intrusive marker events are those times in our lives when disruptive events happen to us that affect our

> lives pervasively. They alter the patterns of our lives fundamentally. A marker event is one after which in some significant sense one's life is never the same again. (pp. 255-256)

Gathman and Nessan (1997) discussed the parallels of cognitive development with faith development. The transition from one faith stage to the next could not occur until a certain level of cognitive development occurred. For example, advancing from stage 1 (Intuitive-Projective Faith) to stage 2 (Mythic-Literal Faith) depends upon the emergence of concrete operational thinking. The transition from stage 2 to stage 3 (Synthetic-Conventional Faith) occurs when formal operational thought begins. Transition from stage 3 to stage 4 (Individuative-Reflective Faith) results when the individual become more consciously aware of the complexities of life. The individual at this point also decides to search for a more dialectical approach to truth. In the transition from stage 4 to stage 5 (Conjunctive Faith), the individual acquires a new appreciation for the power of myth and symbols, a second-naiveté. The final transition, from stage 5 to stage 6 occurs when the individual becomes consciously aware of universal values such as justice, peace, and selfless concern. The individual also makes the decision to live a life committed to these ideals. Fowler (1981) noted that very few individuals ever leave stage 5, and if so, the transition occurs late in life. The individuals who reach stage 6 serve as the models for society.

Measuring an individual's level of faith has presented with some difficulty for researchers. Faith is an abstract concept that generally has been measured on a qualitative basis. However, attempts to measure faith on a quantitative scale have been designed.

Faith Measurements

Moseley, Jarvis, and Fowler (1986) designed the Faith Development Interview (FDI) as a means of measuring an individual's level of faith. The FDI evolved from Fowler and his associates interviewing over a 14-year period, 359 subjects ranging in age from 14 to 84 years (Das & Harries, 1996). The subjects responded to a four part interview. Part I, called life review, asked the subject to partition his or her life into segments that roughly corresponded to chapters in a book. Part II asked for life-shaping experiences and relationships. Part III elicited present values and commitments. Part IV specifically asked for the interviewee's religious beliefs, feelings, and practices. Particular passages of the interview were scored based on the dimension of one or more of the seven faith aspects (form of logic; role-taking; form of moral judgment; bounds of social awareness; locus of authority; forms of world coherence; and role of symbols) for which they were most relevant. Scores were assigned to each dimension and averaged. Next, scores

across dimensions were averaged to determine the faith stage for each subject. DeNicola (1992) found that interrater reliability increased if the seven faith aspects were given equal weight in the scoring process. DeNicola's scoring technique is now the accepted scoring technique for the Faith Development Interview.

Before the role faith plays in the ethical and moral decision making process can be discussed, the process of solving an ethical or moral dilemma must be discussed first.

Ethical and Moral Dilemmas

Process

A review of the literature showed that ethical and moral dilemmas lead to ethical and moral decision making. Rest, Thoma, and Edwards (1997) stated that moral judgments/moral decision making "involves defining what the moral issues are, how conflicts among parties are to be settled, and the rationale for deciding on a course of action" (p.5). As moral dilemmas accrue and are implemented, the images created by those experiences are recorded in a person's memory bank. Because the individual often has no time to plan and implement a higher level of moral reasoning when confronted with a new and challenging dilemma, applying one's current moral stage or reverting to an adjacent one commonly occurs. For example, the individual currently processes at Kohlberg's

stage 3, but can revert to stage 2 or stage 4, when necessary, (Colby & Kohlberg, 1987; Eisenberg, 1982; Langford, 1992; Rest, Turiel, & Kohlberg, 1969). For each individual, certain resources also exist that he or she can draw upon to assist in the solving of either an ethical or moral dilemma.

Factors to Solve Ethical and Moral Dilemmas

The resources a professional draws from to solve these dilemmas depends upon such factors as age, formal education, socialization, spiritual faith, and general well-being:

Age. Research performed on aging showed that age contributed to the process of moral decision making; however, controversy remains today as to the exact role it plays. Pratt, Golding, Hunter, and Norris (1988) found a significant effect for age on a moral stage, $F(4, 157)=8.10$, $p < .001$. They also found that an interaction between age and education approached significance, $F(4, 157)=2.14$, $p < .08$. Pratt, Golding, Hunter, and Norris had found that the elderly possessed a greater synthesis in moral judgment than younger adult groups. Their finding refuted earlier findings that with age, judgments of the elderly regress to earlier developmental stages (Denney, 1982; Salthouse, 1982). Nunn and Hazler (1990) hypothesized that moral development occurs as early as infancy and definitely before the age of four.

White (1988) found age to be significant in the moral decision making factor of only those individuals who had achieved eighteen or more years of education. A Moral Maturity Score (MMS) was obtained for each individual based on a summary score of his or her stage of moral reasoning. The correlation between age and the MMS within those having eighteen or more years of education was $r=.31$ ($p < .05$). Age did not significantly affect the decision making process among individuals with less than eighteen years of education ($r=.13$, $p < .05$).

Pratt, Golding, and Kerig (1987) found that the elderly produced significantly more varied reflections when solving personal dilemmas than did younger adult groups, yet the age effect was small and nonsignificant in regards to the stage levels of moral judgment, $F(2,53)$. In an earlier study performed by Pratt, Golding, and Hunter (1983), findings showed that age significantly affected moral development. However, in 1991, Pratt, Diessner, Hunsberger, Pancer, and Savoy found that no age-group differences existed. Controversy in the findings is apparent even among researchers who have performed ongoing studies in the area of ethical and moral research.

Level of Education. Gibson (1990) determined that the level of education directly affected moral decision making. There was a 79% correlation between the two. White (1988)

found that only individuals with eighteen years or more of education reasoned at higher moral levels. Rest and Thoma (1986) showed principled moral reasoning could be applied only by those with a college education. Walker (1986) also confirmed that educational level predicted moral maturity. Kohlberg (1981) found that the first four stages of moral development progressed as an individual's level of formal education progressed.

Even findings in the area of faith development, supported previous findings that the level of education directly effects faith development. Fowler (1981) found college students generally functioned at the fourth stage of faith development. Das and Harries' (1996) findings showed that college students functioned at stage 4 of faith development, while some functioned at stage 3 and even some at stage 2.

Level of Socialization. Hayes (1994) summarized Kohlberg's work on moral development and concluded that moral development occurred due to social interaction. For example, transactions result between the individual and the environment. The more transactions one engages in, the greater one's moral development. Meanwhile, advances in one's formal education enhances the socialization process and increases the overall moral development of the individual. Snell (1996) found that while social differences exist

between cultures, there exists very few differences within the cultures as to the process of ethical decision making.

Often, individuals base parts of their ethical decisions upon the views of their culture. Carpendale and Krebs (1992) showed people structure moral decisions according to their audiences' perceived expectations. Pulka (1991) and Nunn and Hazler (1990) introduced the concept that emotional development plays a role in moral development and assists in the development of prosocial behavior. Pratt and McLaughlin (1989a and 1989b) found college students' ethical beliefs and behaviors to be influenced by both peer groups and college professors. Walker (1986) found social experiences predictive of moral maturity.

Adherence to a Spiritual Faith. Fowler (1981) described faith stages and the dynamics of faith as a dual process of psychosocial development and structural development. Ideally, an individual strives towards each developmental stage, but the trials and tribulations of life may create periods of lag time in specific stages. Fowler (1981) stated that if the lagging faith stage fails to keep pace with the individual's psychosocial growth, the individual runs the risk of inadequate psychosocial functioning and a narrow range of faith. An opposing body of research (Ellison, 1991; Johnson, 1997) determined that the less formal education students had achieved the more religion they exhibited.

Heady et al. (1996) collected personal essays from attorneys who shared their beliefs and opinions on how one best reconciled one's professional life with one's spiritual faith when engaging in the process of ethical and moral decision making. Although this collection of essays presented no statistical information, they provided an inside glimpse into how professionals have learned to combine their spiritual faith with their career. Not one attorney discussed the option that faith should be abandoned. The underlying message was that faith across their career lifespan played a major role in the success of their careers.

Kohlberg's theory of moral development is based on the premise that a spiritual foundation is not necessarily needed anywhere prior to the fifth stage of moral development. In his 1981 study, Kohlberg stated that reaching the first five stages of moral development did not require a religious foundation, but the sixth stage, universal fairness, required both adherence and movement towards a spiritual orientation. The first five stages rely on an individual's mastery of the concrete/formal operations (Piaget, 1924) and one's ability to obey laws and moral boundaries. However, the sixth stage, the universal ethical principal, requires abstract thought. Grimley (1991) also proposed that a theological foundation must exist before one can apply respect of human dignity (the basis of Kohlberg's sixth stage).

Level of Well-Being. Well-Being can be measured as a way to assess a person's quality of life (Paloutzian & Ellison, 1982). A review of the literature showed that an individual's well-being positively correlates with one's spiritual faith (Ellison, 1991; Genia, 1996; Slivinske, Fitch, & Morawski, 1996); thus enhancing decision making skills (Ellison, 1991). Ellison also found that intrinsic individuals were found to rely upon a divine other to solve problems. As a result, the problem-solving skills of intrinsics exceeded those of extrinsic individuals. The coping techniques of intrinsic individuals produced positive outcomes in their well-being.

The degree of intensity contributed by each factor to solve the dilemmas may vary according to the situation and the individual. The degree of intensity may also vary across the lifespan as a result of cognitive, moral, ethical, or spiritual development. However, the final summation remains: A professional solves moral dilemmas based upon the unique components of one's experience, whether it be on a personal or professional basis. Moreover, the amount of personal moral experience and professional moral experience professionals accumulates over a lifetime determines with what level of intensity they will adhere to the ethical/moral codes of their professional affiliation.

Professional Affiliations: Specifically the AMA, ABA, and the APA

The Ethical and Moral Codes of Each

According to Beauchamp and Childress (1979) a profession is composed of a cluster of occupational roles that members perform according to the functions that are requested and valued by society as a whole. Professions set strict criteria that must be met before accepting members into their organization. For example, new candidates must show that they have acquired the knowledge and skills necessary to perform the roles unique to that profession. There exists a certain degree of independence and autonomy for each professional when performing the functions valued by society; therefore, the professions attempt to ensure professional competence by specifying and enforcing certain responsibilities and obligations among their members. This allows the business relationship that develops between the client and professional to be one based on trust. The responsibilities and obligations mandated by each profession are recorded in the form of professional codes. Beauchamp and Childress describe professional codes as "articulated statements of role morality" (p. 10). Professional codes also set the standards for how professionals should interact between each other. Professional codes exist as a means of expressing moral principles and rules which in turn will

facilitate relationships of trust and confidence, thus encouraging certain activities be performed for socially valued ends. Beauchamp and Childress use the "promotion of health" as an example of socially valued ends being achieved. Stromberg et al. (1988) summarizes professional codes as serving many purposes such as:

> (1) helping to protect the public from misconduct;
> (2) stimulating demand for services by assuring consumers that they will be reasonably free of exploitation;
> (3) encouraging a high level of professional behavior;
> (4) protecting the prestige and therefore the economic standing of the profession;
> (5) binding professionals into a group by adherence to values;
> (6) regularizing practice and deterring innovation; and even
> (7) restraining trade by preventing certain methods of competition. (pp. 228-229)

Professional codes exist for physicians, attorneys, and psychologists (Gorlin, 1990). The professional organizations and the professional codes specific to each one will be discussed as follows:

Physicians of the American Medical Association (AMA)

The American Medical Association (AMA) was founded in May of 1847. It was founded to promote the science and art of medicine and the betterment of public health. Today, this goal still holds true. The AMA's activities strive towards improving physician competence, medical care for patients, and the use of medical science and knowledge. The AMA

requires their members to comply with the Principles of Medical Ethics (see Appendix A). If a member has sanctions brought against his or her self, the AMA may take disciplinary actions. If the member is found guilty, it can result in censure, suspension, or expulsion for that member. Sanctions imposed against members can be based upon unethical conduct.

According to the Principles of Medical Ethics, ethical behavior refers to a physician incorporating the following: (a) moral principles or practices, (b) customs and usages of the medical profession, and (c) policies that may or may not pertain to medical-moral issues. Unethical behavior refers to conduct failing to conform to these professional standards, customs and usages, or policies.

Professional Responsibility and Duty

Landmark Cases. It remains the responsibility and duty of the physician to maintain an ethical relationship in realms other than the AMA. The ethical codes of the American Psychiatric Association is an example (see Appendix B). The physician carries the responsibility for ethical decisionmaking in areas that pertain to the patient, the organization/ institution, society as a whole, and the self. This can be seen in the courts where they have on various occasions ruled on medical-moral issues pertaining to the patient, institution, society, or self.

Self. For example, physicians were supported by the court in executing ethical obligations towards the patient (The Council on Ethical and Judicial Affairs, 1994-1995):

> **Ill. App. 1986** Defense attorney in product liability suit was held in contempt of court for conducting ex parte discussions with plaintiff-patient's treating physician without patient's consent and contrary to authorized methods of discovery. The court held that the strong public policy favoring physician-patient confidentiality articulated in Principles II and IV and Opinions 5.05, 5.06, 5.07 and 5.08 justified a rule against such ex parte discussions. Further, the court held that the public has the right to rely on physicians to faithfully execute their ethical obligations. *Petrillo v. Syntex Laboratories, Inc., 148 Ill. App. 3d 581, 499 N.E.2d 952, 957, 958, 959.* (p. xvi)

Society. An example of a physician being ethically responsible for society as a whole was supported by the courts in the following case:

> **N.J. 1979** In wrongful death action against a psychiatrist whose patient murdered plaintiff's decedent, the court concluded, in accord with Principle 9 (1957) [now Principle IV}, that a psychiatrist may owe a duty to warn potential victims of possible danger from psychiatrist's patient despite the general emphasis on confidentiality. The court also noted the Preamble and Principles 1 and 3 (1957) [now revised Preamble, Principle I and Opinion 5.05] in discussing the psychiatrist-patient relationship. *McIntosh v. Milano, 168 N.J. Super. 466, 403 A.2d 500, 510, 512-13.* (p. xv)

Institution. The courts also supported the physician's ethical responsibility to an organization in the following case:

> **Mass. 1955** Plaintiff-physician was charged under state licensing statute by defendant-board with conspiracy and fee-splitting. Both parties sought a declaratory

judgment as to whether the defendant-board had jurisdiction to determine plaintiff's actions constituted "gross misconduct" under the statute, the court referred to Principles Ch. I, Secs. 1 and 6 (1947) [now Principle II and Opinion 6.02] delineating, in part, limitations on payment for medical services. These provisions, the court said, reflected the medical profession's understanding of its "peculiar obligations." *Forziati v. Board of Registration in Medicine, 333 Mass. 125, 128 N.E.2d 789, 791.* (p. xvii)

Self. Adhering to an ethical role towards the self was upheld by the courts in the case of Wood v. Upjohn Co (1984):

- **Wash. App. 1984** Plaintiff-pathologist sued his corporate employer and one of its subsidiaries for breach of his employment contract; defendants counterclaimed, alleging that plaintiff had tortuously interfered with defendants' business relationships. Plaintiff had discouraged the transfer of laboratory specimens for analysis at a distant lab because he allegedly believed that to do so would be a violation of medical ethics, particularly Principle 6 (1957) {now Principle VI]. In finding for plaintiff, the court acknowledged that a physician was bound to uphold duly prescribed medical ethical principles despite his employment status, especially where such a principle coincided with a public policy favoring acts that end to prevent "a deterioration of the quality of medical care. *Wood v. Upjohn Co., No. 6093-1-11 (Sept. 4, 1984) (LEXIS, States library, Wash. file).* (p. xxxi)

Attorneys

The American Bar Association (ABA) was founded in 1878. It is the national organization for the United States' attorney. Gorlin (1990) summarized the goals of the ABA as advancing the science of jurisprudence; promoting improvements in the justice system, adding and maintaining uniformity of legislation and judicial systems, delivering legal services; increasing public awareness of the legal system; assuring professional competency and ethical conduct

of its members; enhancing members' professional growth; encouraging cordial relations among lawyers; urging full and equal participation in the profession by minorities and women; and advancing the rule of law in the world. The ABA's activities consist of analyzing legal issues and developing effective remedial responses that range from policy positions to demonstration projects and conferences.

Unlike the AMA and the APA, the ABA does not have the power to discipline attorneys or enforce the rules it develops. The rules are designed by the ABA to serve as model legislation for the state and federal bars. In turn, the state and federal bars are to create their own rules of professional responsibility. Since 1995, over 35 states model their standards after the ABA's Model Rules. The remaining states base their standards on the older ABA Model Code of Professional Responsibility (Gorlin, 1990). However, the ABA does enforce a set of standards known as the Rules of Professional conduct (see Appendix C). Gorlin refers to them as the "black-letter" rules. The ABA intends for these rules to be enforceable and controlling. Enforcement of legal-ethics codes occurs by such disciplinary bodies as the Standing Committee on Ethics and Professional Responsibility. The Model Rules of Professional Conduct are written as rules of reason; however, they are not exhaustive of all ethical and moral considerations. It remains the responsibility of

the attorney to model his or her professional behavior into an exemplary framework that strives towards the ABA's model.

Disciplinary action occurs if an attorney fails to comply to the Rule's criteria. However, imposing discipline is difficult. The Rule states that the severity of a violation and the sanction imposed upon it may differ with every given set of circumstances. For example, how severe was the violation? Was it the attorney's first violation? How serious was the attorney's intent to commit the violation?

Despite the fact that imposing disciplinary action against attorneys for unethical conduct tends to be difficult, order and discipline must still be maintained in the realm of practicing universal ethical principles. Attorneys must decide on an individual basis what is appropriate ethical behavior and strive towards obtaining it.

Landmark Cases

An attorney who strives for the highest ethical and moral conduct will strive to protect the ethical realms of the client, the institution, society, and his or her self. The courts have provided support to attorneys in each of these ethical realms.

Client. The following case demonstrates how an attorney maintains ethical conduct with a client. In the case of In

re Ethics Advisory Panel Opinion (1993), the court concluded that if a lawyer learned from a client of another lawyer's misconduct, he must obtain the client's consent before reporting the other lawyer's misconduct. In this way, the client's confidences are preserved.

Institution. In the matter of Rowe (1992), the court ruled in favor of protecting the institution. A lawyer had killed his wife and three children. He was found not guilty by reason of mental disease. He later claimed to be "cured" and wanted to resume his law practice. The court ruled to not let him; stating that public confidence in the bar would be undermined if a killer was practicing law.

Society. The courts ruled in favor of society as a whole in the case of Frasher v. West Virginia Board of Law Examiners (1991). An applicant was denied admission to the bar as a result of having had three DUI convictions. The courts were safeguarding society from a supposedly tarnished moral character and safeguarding the professional image that should be characteristic of an ethical attorney.

Self. Attorneys have also benefited their own selves from the rulings of the courts. An example of this is in the case of In re Hiss (1975). If an attorney is disbarred, he or she can be reinstated after showing rehabilitation and present fitness.

Psychologists

Founded in 1892, the American Psychological Association (APA) "seeks to advance psychology as a science, profession, and means of promoting human welfare" (Gorlin, 1986, p.245). The APA's activities strive to maintain improvement and advancement in the areas of psychological knowledge, psychological research, and psychological expertise. Psychological expertise expands through standards of education, ethical conduct, and professional practice. The APA expects members to commit to the Ethical Principles of Psychologists, upon acceptance of one's membership. Allegations of unethical conduct will be investigated by the Governance Affairs Office/Ethics committee. Psychologists are to work promptly and thoroughly with the committee. Psychologists may have their license canceled, revoked, limited, or suspended if their state's disciplinary board deems it necessary (Stromberg et al., 1988). Stromberg et al. states that "about 30 states" have adopted the Ethical Principles of Psychologists directly into their laws of licensing and disciplining. Therefore, psychologists should become familiar with the licensing and disciplining procedures in the state where they are practicing.

The Ethical Principles of Psychologists' Preamble (Gorlin, 1990) (see Appendix D) is based on the assumption

that psychologists understand that their ethical conduct depends upon their ability to know when to detect, analyze, and respond to a potentially difficult situation (Stromberg et al., 1988). Psychologists must also understand that their ethical decisions may be composed of more perspectives than just the APA's Ethical Principles. Stromberg et al. listed seven possible perspectives: (1) professional ethics rules, (2) licensing/disciplinary rules, (3) general malpractice principles, (4) civil legal requirements, (5) criminal laws, (6) community standards of a good reputation, and (7) the psychologists' personal motivation to be "professional".

Landmark Cases

Psychologists must maintain responsibility and duty to the same ethical realms as the physician does-the client, the institution, the society, and the self. The psychologist is to maintain a relationship of confidentiality with his or her client. The court supported this in the case of State v. Miller (1985). The case was based on a man calling a state psychiatric hospital and telling the receptionist that he had just killed a man. He proceeded to give a false name and asked to speak to a psychiatrist. The psychiatrist had the call traced while speaking to the man. The police were able to apprehend the man. The courts ruled that the conversation that had ensued between the psychiatrist and the man would be

considered one of a "'therapeutic' quality" (Stromberg et al., 1988, p. 390). Therefore, the psychiatrist would not be allowed to testify and possibly incriminate the man for murder. The Psychologists who practice within an organization, such as a hospital, may face many ethical dilemmas. For example, if a patient is admitted on an involuntary basis, then the courts have ruled the patient has a right to treatment (Wyatt v. Stickney, 1971). The idea being that if the patient is in the hospital, then he should be provided with adequate treatment. Failure to do so violates his basic rights of due process.

As stated earlier a psychologist is to maintain patient confidentiality, but if the psychologist believes a client could be a threat to himself or others, then the psychologist has the right to waive patient confidentiality. The patient and or society would stand to benefit from this ethical decision. The courts supported the waiving of patient confidentiality in the landmark case of Tarasoff v. Regents of University of California (1976). The Supreme Court ruled the following decision in the Tarasoff case (Stromberg et al., 1988):

> When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another [person], he incurs an obligation to use reasonable care to protect the intended victim against such danger....[This duty] may call for [the therapist] to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or take

> whatever other steps are reasonably necessary under the circumstances. (p. 520)

The psychologist from time to time encounters the dilemma of having to commit a patient who is unwilling to be committed. This constitutes an involuntary commitment. The psychologist must perform an ethical duty to the welfare of the patient, but the psychologist must also protect his or herself from legal repercussions. The court protects the psychologist under the heading of civil commitment laws. Once such law is that found in Ariz. Rev. Stat Ann (1983): "'Any person acting in good faith upon either actual knowledge or reliable information who makes application for evaluation or treatment of another person....is not subject to civil or criminal liability for such act'" (Stromberg et al., 1988, p. 584).

Summary

Physicians, attorneys and psychologists must be continually aware of their vulnerability towards ethical and legal entanglements. They must also learn when and how to take a stand in issues pertaining to morality, ethics, and law. Moral and ethical dilemmas have become increasingly complex now that society has emerged into the areas of computer technology, radio and television talk shows, and dual relationships (Fretz & Simon, 1992). Moral and ethical boundaries are necessary for society as a whole. These

boundaries assist in creating structure and rule for individuals, institutions, and one's self. Developing ethical and moral character depends upon one's life experiences, habits and commitments (Willimon, 1997). Willimon concluded that if those in the higher education system are to contribute to the betterment of society, then the education system must begin to refocus on producing people of good moral and ethical character. The challenge for today's professional entails learning how to be a moral and ethical person in a society where moral and ethical behavior is too often ignored.

Purpose of Study

Based on the literature (Gibson, 1990; Kohlberg, 1981; Rest & Thoma, 1986; Walker, 1986; White, 1988), the greater one's level of education and one's level of formal operations, the greater one's moral development. However, Kohlberg (1981), Kuhn et al. (1977),and Markoulis, (1989) found that the 5th and 6th stages of moral development were rarely if ever obtained by most individuals. Those who did reach levels 5 and 6 were in mid to late adulthood and obtained those stages due to one's accumulation of life experiences or expertise (Kohlberg, 1969; Walker, 1986).

Today, in Western society, the highest level of formal education earned is the doctor of philosophy (Ph.D.), the

doctor of medicine (M.D.), or the doctor of jurisprudence (law). [Note that individuals choosing to specialize within their discipline may undergo further education.] Theoretically then, psychologists, physicians, and lawyers should be expected to function at the highest levels of moral reasoning.

If as Markoulis (1989) noted, the synchronicity of cognitive and moral development occurs only up to level four, what governs the rest of an individual's rate of moral development? Life experiences, specifically, sociomoral experiences, may be the major determinant for the rate of moral development or the level of moral decision making that occurs after level four of moral development has been reached.

Faith development may be another determinant of individuals advancing into higher stages of moral development. Fowler described faith as a developmental process across the lifespan that consists of an individual engaging in a relationship of loyalty; committing to that which is acknowledged or known; and specifically developing one's life and character around this commitment.

Until the research of Fowler (1981), the literature treated faith as an immeasurable concept. Fowler correlated faith development with Kohlberg's (1969) stages of moral development and Erikson and Levison's life-span development theories (Tam, 1996). Once Fowler put faith in the

perspective of a developmental process, it became measurable on a continuous scale. Faith has also been correlated with one's education level (Das & Harries, 1996; Fowler, 1981).

It is the purpose of this study to use a developmental perspective to investigate how faith effects the moral decision making of professionals, such as physicians, and attorneys. If education is a predictor of moral development, then these populations should be in the same or near the same stages of moral development. These populations also should adhere to some of society's strictest ethical and moral guidelines for professionals. Formal operations should be in levels of abstract thought with each of these individuals. This study will attempt to assess professionals who are currently in their respective fields of practice.

If socio-moral experiences determine moral development beyond level 4 as Kohlberg (1973) predicted, then age will be a predictor of faith development and a predictor of moral development. Intrinsic faith and extrinsic faith will be measured to determine if they are predictive of either moral development or faith development. Also, well-being will be measured to determine if it is predictive of moral development or faith development. In the current research, the following hypotheses were proposed:

1. If adherence to a spiritual faith must be obtained before an individual can advance into level five or level six of Kohlberg's moral development, then the level of faith will be

predictive of the levels of ethical and moral decision making. Level of education will be held as a constant.

2. Based on the previous findings that level of education positively correlates with level of moral development, professionals (e.g., physicians, and attorneys) should be functioning at Kohlberg's level 4 or higher.

3. Chronological age will be a predictor of levels of faith and levels of morality, but those professing a spiritual faith will account for more variance in moral development than those not professing to a spiritual faith.

4. Those professing to a spiritual faith will be functioning at higher levels of ethical and moral decision making versus those professing to a non-spiritual faith.

5. Those professing to an intrinsic faith will account for more variance in moral development than those professing to an extrinsic faith.

6. Spiritual well-being will be a predictor of levels of faith. It should also be a predictor of moral development.

CHAPTER II

METHODS

Subjects

Subjects recruited were 308 men and women from several sources in a large southwestern city and a medium sized communities: Women's Bar Association, Family Bar Association, Bankruptcy Bar Association, Board of District Judges, Texas Federal Judges, Legal-Ethical Conference, and a University Health Science Center comprised of practicing physicians . Sixty-eight subjects from five separate age categories participated in this study: less than 30 years; 30-39 years; 40-49 years; 50-59 years; and 60-69 years. Subjects were required to have been in practice a minimum of five years in order to participate in this study.

Instruments and Procedures

Subjects were given an introductory statement regarding the purpose of this investigation. Then a demographic inventory and six questionnaires were administered. The demographic inventory included items to ascertain age, education, socioeconomic status, race, sex, and religious affiliation, if any (see Appendix E).

Subjects were asked to indicate also the importance of their faith on a scale from 1 to 4: 1 = unimportant,

2 = somewhat important, 3 = important, 4 = very important. Subjects were also asked to rate their frequency of attendance in a worship service: 1 = at least twice weekly, 2 = at least once weekly, 3 = once a month, 4 = once a year, 5 = never. Subjects were asked to rate their prayer life based on the following scale: 1 = daily, 2 = once/week, 3 = once/month, 4 = religious holidays, 5 = rarely or never.

Daily Spiritual Experience

The firs questionnaire, the Daily Spiritual Experience (DSE), was developed by Underwood (in Press) to assess day-to-day spiritual experiences and attempt to measure the impact of both religion and spirituality on an individual's daily life. The short form which consisted of 6 items (see Appendix E) asked subjects to rate on a scale of 1 to 6 the frequency with which one might experience each item: 1 = many times a day, 2 = every day, 3 = most days, 4 = some days, 5 = once in a while, 6 = never or almost never.

Faith Development Interview

A second questionnaire consisted of 2 questions asking subjects to determine their level of faith (see Appendix E). Subjects were requested to write short descriptive answers to the following questions: (1) "What does it mean to be religious?" and (2) Do you regard yourself as religious?"

This questionnaire was based on the previous findings of Das and Harries (1996), whose findings supported Fowler's (1981) prediction that college students on average will be at Stage 4. Inter-rater reliability for Fowler's Faith Development Interview has produced a 93% mean correlation among experienced raters, while new raters produced a mean correlation of 88%. According to DeNicola (1993), experienced raters differ from new raters based on how familiar they are with the faith theory and administering and scoring the faith interview. For example experienced raters averaged eight years experience versus new raters who averaged 1.5 years of experience. The current study's aim was to determine if practicing professionals will be at Stage 4 or already have progressed to a higher level of faith development.

Wellness-Index

A third questionnaire, the Wellness-Index (Slivinske, Fitch, & Morawski, 1996) was administered to determine each subject's level of personal well-being (see Appendix E). This questionnaire was also used to determine if a positive correlation exists between an individual's level of moral development, level of faith development, level of personal well-being. Only four of the six scales were administered: physical health, morale, economic resources, and religiosity.

The Wellness-Index was chosen due to its ability to be self-administered. Also, this Index was chosen due to the fact that it maintains high reliability and validity among the subscales and the Index itself. Slivinske, Fitch, and Morawski found that each subscale had acceptable reliability (alpha = .80 - .94) and validity (r = .10 to .38, p <.05, p <.01, p < .001).

Religious Life Inventory:
External, Internal, & Quest Scale

A fourth questionnaire consisted of three subscales: (1) the External scale, (2) the Internal scale, and (3)the Quest scale. These were administered to determine if subject's reporting a spiritual faith differ among each other in their spiritual orientation (see Appendix E). For example, do subjects report higher in intrinsic faith than in extrinsic faith, or do they report highest on the Quest scale? The Quest scale was designed to assess individuals who fall into the category of possessing a more open-minded, non-discriminatory attitude toward religious beliefs. These three subscales (External scale, Internal scale, and the Quest scale) were based on the work of Batson, Schoenrade, and Ventis (1993) and Genia (1996). Genia's study found internal reliability, using alpha coefficients, at .54 (Ep) and .66 (Es) for the External scale, .86 for the Internal scale, and .82 to .84 for the Quest scale.

These scales were chosen for this study based on their ability to measure an individual's dimension of faith and thus determine a potential pattern of behavior. For example, the internal scale measures an individual's intrinsic faith (Allport & Ross, 1967) or the degree to which one's religion is based on internal needs such as "certainty", "strength", and "direction" (Batson, Schoenrade, & Ventis, 1993). The external scale measures one's extrinsic faith (Allport & Ross, 1967), or rather the dimension one's religion is based upon one's desire to gain social acceptance and also increase social bonds (Batson, Schoenrade, & Ventis, 1993). The Quest scale designed by Batson, Schoenrade, and Ventis (1993) measures a third dimension of faith. It measures the degree to which an individual understands that one's basic faith structure may change across the lifespan as a result of experiencing the tribulations of life itself. The Quest scale also was chosen as a follow-up to Genia's (1996) work that the Quest had never been studied as to its effects on spiritual well-being.

Spiritual Well-Being Scale

A fifth questionnaire designed by Paloutzian and Ellison (1982) was implemented to measure spiritual well-being (see Appendix E). Based on 20 questions, it measured Religious Well-Being (RWB) and Existential Well-Being (EWB). It was

chosen to assist in determining if spiritual well-being would correlate positively with the Quest scale (Genia, 1996) and the well-being index used in this study. Paloutzian and Ellison reported test-retest reliability coefficients were .93, and internal consistency reflected a high magnitude of .89.

Defining Issues Test

The sixth and final questionnaire, the Defining Issues Test (DIT), was administered to determine each individual's level of moral development (Rest, Cooper, Masanz, & Anderson, 1974). The DIT was chosen for this study based on it's multiple-choice format and the ease with which it could be administered (see Appendix E).

The short 3-story form DIT was administered versus the 6-story form DIT. The shorter form produces a statistically significant result for both the P and N2 indexes ($n=502$, $p < .001$). However, the shorter form N2 (matched $t=10.36$) outperformed the short form P index (matched $t=7.99$) and was found to produce greater sensitivity in measuring moral development. The N2 index also produced an internal validity superior to that of the P index (Cronbach alpha for N2 is .74 and for P is .65).

The subjects were asked to read one of three moral dilemmas. Each dilemma was followed by 12 queries. The

subjects were asked to evaluate a dilemma based on the 12 statements that follow each dilemma. The responses are designed so that the individual must make a choice and justify why that was the choice he or she made. Subjects will be asked then to rate the relative importance of each query on a 5-point Likert-type scale ranging from "Great Importance" to "No Importance.". As a final part of the DIT, subjects were asked to rank, in descending order, the four most important queries of the twelve. Each subject's evaluating of queries will be ranked, and then each individual's level of moral development will be determined.

An experimenter will provide subjects with an information page for completing the background inventory and the series of questionnaires. The assurance of complete anonymity will be included in this information.

CHAPTER III

RESULTS

To reveal the possible age differences among attorneys and physicians, the means and standard deviations were generated for each group (see Table 1). As can be seen in Figure 1, age was reported on four separate groups: 1 = 30-39 groups; 2 = 40-49 groups; 3 = 50-59 years; 4 = 60-69 years. Results showed that attorneys and physicians reported primarily in the third age group of 50-59 years. Out of a group of 68 subjects, a total of 48 attorneys and physicians reported their socioeconomic status (SES) as exceeding 60 thousand dollars a year (see Figure 2). The number of years working in their respective fields was broken down into six categories: 1 = less than 1 year; 2 = 1-5 years; 3 = 5-10 years; 4 = 11-15 years; 5 = 16-20 years; 6 = greater than 21 years. Figure 2 shows that attorneys retained an average of 11-15 years experience while physicians retained an average of 1-5 years experience. As seen in Table 1, the reported means and standard deviations for age, SES, and work experience suggested that the SES of attorneys increases at a slower rate over time than does that of the physicians.

Attorneys and physicians were asked to rate the percent of daily time spent in the role of administering to the patient, education, research, administration, or other job

related duties. They were also asked to rate the percent of time ethically spent in each of these roles. The subjects chose from the following categories to rate these questions: 1 = 0%; 2 = 1-25%; 3 = 26-50%; 4 = 51-75%; 5 = 76-100%. After the means and standard deviations were calculated, the results indicated that the majority of the professional's work day is spent in the patient client role (see Table 2). Table 3 showed that 26-50% of the attorney's time is spent in an ethical role with their client and as little as 1-25% of an ethical role with the patient is practiced by physicians. Interestingly, the results indicated that the physicians spent no time in practicing an ethical role in the areas of administration or other job related roles. The attorneys reported higher than the physicians in these areas, but still reported as low as 1-25% of an ethical role. When the categories for the amount of time spent in an ethical role were compared between attorneys and physicians no significance was found (client: F (3, 40) = 1.19, p = .32; education: F (3, 45) = 1.22, p = .31; research: F (2, 40) = .87; p = .43; administration: F (3, 38) = 1.68, p = .19; other role: F = 3.48, p = .03).

For comparison between groups and scales, all scales were converted to standardized z-score values. The sample means and standard deviations were obtained for the frequency of prayer; the importance of religion; the importance of

faith; and the frequency of church attendance (see Table 4). It can be seen that the physicians scores tended to fall below the standardized mean; whereas the attorneys' scores were above the standardized mean.

As seen in Table 5, F-tests were performed on various scales to determine homogeneity of variance among attorneys and physicians, and to determine how their responses differed in the issues of faith, spiritual well-being; faith development; general well-being; and moral development. The F-test revealed no significance for homogeneity between attorneys and physicians for prayer (F = 1.28, p = .5); importance of faith (F = 1.22, p = .55); well-being health scale (F = 1.21, p = .61); well-being morale scale (F= 1.07, p = .88); faith development scale (F = 1.27, p= .57); and DIT's stage-P (F = 1.15, p = .73). A 2-tailed t-test was performed on the scales to determine if significant difference could be detected among physicians and attorneys. As seen in Table 6, a 2-tailed t-test revealed that the importance of religion (t = .68, p = .50) and the DSE (t = .004, p = .996) were not significantly different among physicians and attorneys. This suggested that attorneys and physicians presented with little to no difference in their frequency of prayer and daily level of spiritual faith. The RWB scale and EWB scale maintained significance after the

2-tailed t-tests were performed (RWB: t = -4.31, p = 0; EWB: t = -5.54, p = 0). This suggested that difference did exist among the attorneys and physicians' response to spiritual items on these scales. For example, the attorneys showed a greater tendency of intrinsic faith, and the physicians showed a greater tendency of extrinsic faith.

Hypothesis 1: Faith As a Predictor

Correlations between items pertaining to faith and ethical-moral development were generated to determine if any relationships could be detected. Table 7 shows that based on the combined responses of attorneys and physicians the faith items have no significant relationships with the principled moral development score (a.k.a. DIT's stage-P). Although it be modest, there was a significant negative correlation between the importance of faith and stage-P (r = -.29, p<.05). There was not a significant correlation between the faith development scale and stage-P (r = -.21, p<.05). This finding does not support the hypothesis that one's level of faith development is predictive of one's level of ethical-moral development. Correlations between faith items and stage-P were then performed on the responses of attorneys only (see Table 8) and physicians only (see Table 9). As can be seen in Table 8, the attorney correlations between prayer,

importance of religion, importance of faith, attendance, DSE, and Well-Being scale of Religion were r = .40 or greater. The faith items were significantly correlated with each other. These findings did not differ greatly from the pattern of correlations for physicians on Table 7. The attorneys showed no indication that their response to the items pertaining to faith were significantly correlated with their level of moral development. However, in Table 8, the attorneys showed a significant, albeit modest, correlation between prayer and the Internal scale of the RLI (r = -.36, p<.05) indicating prayer showed a modest correlation with an individual's intrinsic faith. It should be noted that the prayer variable is based on a reverse scoring technique and is inversely related to the RLI Internal scale. The attorneys also reported a small, but modest, correlation between the importance of religion and the RLI Internal scale (r =-.34, p<.05). This finding suggested that as an attorney's intrinsic faith increased, his or her belief in religion decreased. The attorneys reported no correlation between any of the faith scales and the DIT's stage-P (see Table 8). As can be seen in Table 9, the physicians showed highly significant correlations among the faith scales similar to the attorneys (see Table 8). However, unlike the attorneys, the physicians showed a high correlation between the RLI External scale and

the items of prayer (r = .69, p<.05); importance of religion (r =-.63, p<.05); importance of faith (r = -.69, p<.05), attendance (r = .86, p<.05); and the DSE (r = .56, p<.05). The physicians also showed a high correlation between the RLI Quest scale and the items of prayer (r = .73, p<.05); importance of religion (r =-.67, p<.05); importance of faith (r = -.72, p<.05), attendance (r = .82, p<.05); and the DSE (r = .70, p<.05). These findings suggest that the physicians are reporting at different levels of faith than the attorneys. The physicians show a greater tendency to be extrinsic in their faith than do the attorneys. Their performance on the Quest scale suggests that they are less rigid in their religious beliefs than the attorneys. The physicians also showed a modest, but significant, correlation between attendance and stage-P moral development (r = .44, p<.05). These findings imply that physicians appear to be drawing from their external environment in such a way that their personal religion is being influenced (Batson, Schoenrade, & Ventis, 1993). Based on the physicians response to the RLI Quest scale, also it can be implied that physicians are very responsive to spiritual dialogue and maintain an open mind to existential questions. Batson, Schoenrade, and Ventis (1993) suggest this open-minded approach can be contributed to questions that are raised by the trials, tribulations, and tragedies of life. The fact

that the physicians showed significant correlation between the frequency of attendance and stage-P (r = .44) suggests that their faith may be predictive of their level of principled moral development. Further testing needs to be implemented to determine if RLI Internal and External scale are predictors of stage-P.

The DSE showed significant correlation with the faith scales between both attorneys and physicians (see Table 10). Correlations between the six items on the DSE (God's presence; strength and comfort; inner peace; God's love; touched) and the faith items (prayer, importance of religion, importance of faith; attendance; RLI External scale; RLI Internal scale; RLI Quest scale; SWB Religious scale; SWB Existential scale) were performed to determine where any difference might exist. The results can be seen in Table 11 for the combined groups. These results indicate that the internal scale on the RLI does not correlate with the DSE except for one item, touched (r = .63, p<.05). The touched item reads as "I am spiritually touched by the beauty of creation". This item was the only one that correlated with the EWB scale (r = .61, p<.05). The RLI External scale and the RLI Quest scale showed significant correlations with the first 5 DSE items, but they were modest in size. That is the RLI External scale correlated with the DSE items as follows: God's presence (r = .37, p<.05); strength/comfort (r = .34,

$p<.05$), inner peace (r = .32, $p<.05$); God's love (r = .41, $p<.05$). The RLI Quest scale correlated with the DSE items as follows: God's presence (r = .36, $p<.05$); strength/comfort (r = .37, $p<.05$), inner peace (r = .31, $p<.05$); God's love (r = .37, $p<.05$). These findings suggest that since the RLI and EWB scales show the smallest correlation with the DSE, the DSE does not measure accurately items pertaining to internal faith on the RLI, or items pertaining to eternal faith on the SWB scale.

Hypothesis 2: Moral Development At Level 4 or Higher

According to a secondary analysis performed by Rest (1986), the following stage-P mean scores were representative of the following age/education groups: Jr. high school (μ = 21.9, sd = 8.5); high school (μ = 31.8, sd = 13.5); college (μ = 42.3, sd = 13.2); graduate school (μ = 53.3, sd = 10.9); adults (μ = 40, sd = 16.7). Based on the findings in Table 12, the attorneys reported in the range of high school students and college students (valid scores only μ = 38.28, sd = 18.13), and the physicians fell within the high school, college, and adult range (valid scores only μ = 40.07). Figure 5 shows that age did not appear to correlate with stage-P moral development; thus an individual's level of moral development is not dependent upon age. Kohlberg's

theory that age and education are predictors of moral development was not supported by the findings in this study.

Hypothesis 3: Faith Greater Predictor of Moral Development Than Age

To determine if age was predictive of Kohlberg's Level 4 moral development or any levels greater than Level 4, an F-test was performed between age groups. The test revealed that there was no significant relationship between age and the DIT stage-P scale (F (3,58) = .128, p = .94). An F-test was also performed to determine if different homogeneity of variance existed between physicians and attorneys (F = 1.15, p = .73). There was no significance and no differences between attorneys and physicians' range of response to the stage-P scale.

An F-test was also performed to determine if gender showed a significant relationship to stage-P. The F-test was not significant; therefore, gender was not predictive of stage-P [F (1, 58) = 1.05, p = .31].

Rest (1986) recommends reporting how many subjects were declared invalid due to the DIT scoring criteria; however, based on the small sample size in this study, analyses were performed on valid and invalid as one composite group, then further analyses were performed on valid and invalid responders as two distinct groups. Invalid cases were determined based on one or more of the following criteria

being met: A) The M score exceeded a score of 4; B) more than 8 inconsistencies in a story were recorded; or C) one of the three moral dilemmas had more than 9 items rated the same.

There was a total of 8 invalid cases (physicians: 5, attorneys: 3) and 52 valid cases (physicians: 23, attorneys: 32). The reason that invalid cases were kept for analyses is due to the fact that 6 of the 8 cases were declared invalid due to M scores that exceeded a score of 4. The M score is based on nonsensical items designed to sound pretentious and contain no meaning what so ever. According to the findings in this study, there appears to be a tendency for the attorneys and physicians to lean towards pretentious statements versus statements with simplistic meaning.

The DIT defines the cutoff ranges of ethical-moral development as follows: (1) Low Third: scores up to 27; (2) Middle Third: 28-41; (3) High Third: 42 and higher. As can be seen in Table 13, despite the tendency to endorse pretentious statements, the invalid endorsers still maintained ethical decision making. The results showed that 44.1% of the attorneys (both valid and invalid responders) were in the high range of moral development. The group of valid responding attorneys consisted of a 45.2% group response in the high range of moral development. This percentage differed little from the valid and invalid responding attorneys. The group response of the physicians in the high range of moral development was as follows: valid

and invalid responders (39.3%) and valid only responders (39.1%).

Figure 3 illustrates the range of valid and invalid responses among both physicians and attorneys (μ = 38.5, sd = 17.9).

Figure 4 illustrates the valid and invalid responses by attorneys and physicians respectively.

Table 13 shows that 42% of the attorneys and physicians fell into the high range of moral development. The attorneys responded as a group more often in the High Third range (Valid and Invalid at 44.1% and Valid Only at 45.2%) than did the physicians (Valid and Invalid at 39.3% and Valid Only at 39.1%); however, the physicians were at a higher range of moral development (Valid and Invalid μ = 57.3, sd = 10.4; Valid Only at μ = 54.9, sd = 10.6).

Figure 6 shows that there is no relationship between the development of faith and age. Therefore, it can not be assumed that faith develops as a result of age. The majority of subjects responded in the range of stage 3 to stage 4. This would suggest that those at stage 3 of faith development are concerned with social acceptance and social approval. They seek approval in order that they can have a sense of personal identity. Stage 4 characterizes the individuals who are in the process of incorporating their personal identity into their evolving lifestyle. They have begun to join social groups based on their own personal belief system. The

groups they join will assist them in generating their belief system. Subjects who responded in the area between stage 3 and stage 4 of faith development are in the transition from one stage to the next.

Hypothesis 4: Spiritual Faith Versus Non-Spiritual Faith

To determine if those professing to a spiritual faith functioned at a higher level of ethical and moral decision making than those professing to a non-spiritual faith, a comparison of the groups was performed on 2 items: religious affiliation and DIT's stage-P of ethical and moral development. To determine the average p-score for religious and non-religious attorneys and physicians, the means and standard deviations were determined. The results in Table 14 indicate that those professing to have no religious affiliation (attorneys: μ = 45, sd = 7.1, N=2; physicians: μ = 51.3, sd = 14.2, N=5) rated at a higher level of moral development than those professing to have a religious affiliation (attorneys: μ = 37.3, sd = 18.5, N=33; physicians: μ = 38.3, sd = 16.5, N=23). The small sample size among those professing to a non-religious affiliation (N=7) needs to be taken into account when considering this finding. A scatterplot (see Figure 7) was implemented to reveal any relationships that might exist for faith

development and stage-P of moral development. The findings revealed nothing specific except that 6 of the subjects reporting as level 3 faith development reported a higher level of moral development than those at level 4 of faith development. A larger sample size and further analyses are recommended to determine if this finding holds any significance.

Hypothesis 5: Intrinsic Versus Extrinsic Faith

The measurement of intrinsic and extrinsic faith was obtained through the SWB scales (RWB & EWB) and the RLI scales (Internal, External, & Quest). The RWB and the RLI-Internal were designed to measure intrinsic faith, or rather one's internal need for strength and direction--A "one-on-one" relationship with God. The EWB and RLI-External scale were designed to measure an individual's external need for social acceptance and social approval. The Quest scale measured an individual's ability to look objectively at one's self and the trials of life and maintain an open attitude of change when the opportunity presented itself. The Quest scale combined aspects of intrinsic and extrinsic faith. The findings in this study showed that physicians and attorneys were found to be significantly different from attorneys in their response to the SWB scales (RWB: F (1, 63) = 18.5, p = 0 and EWB: F (1, 63) = 30.7, p = 0). A significant

difference was found for the attorneys and physicians on the RLI Internal Scale (F (1,63) = .20, p = .65). As was shown in Table 9, physicians showed high correlations between faith items and the External and Quest scales of the RLI. It can be seen in Table 8 that the attorneys did not show any significant correlation with faith and the External and Quest scales. Interestingly, neither attorneys or physicians showed significant correlations between faith items and the SWB Existential scale. This would imply that the EWB is not a valid measurement of attorneys and physicians' responses to extrinsic faith. The physicians showed higher correlation of faith items with the RWB (see Table 9) than the attorneys. These findings suggest that the physicians are more extrinsic in their level of faith than attorneys. It should be noted that only the physicians showed a significant correlation between attendance and stage-P (see Table 9). This would suggest that their extrinsic faith is reinforced by their church attendance; and their moral development correlates positively with their church attendance.

Hypothesis 6: Spiritual Well-Being Predictive of Faith and Moral Development

As faith was not found to be a predictor of moral development in this study, the hypothesis that spiritual well-being would be a predictor of moral development could

not be supported. However, based on the finding that attorneys and physicians responded on average differently to spiritual items, as was reported in Table 13, a comparison of valid and invalid responders' level of faith development was generated. Figure 8 shows that valid responders (both attorneys and physicians) were at higher levels of faith development than invalid responders. A larger sample size is recommended to determine if these findings could be validated further. As seen in Figure 9, valid responders who reported faith as being a very important role in their life were at higher levels of moral development than were the invalid responders. Valid responders reporting religion as playing an important role in their life also reported at higher levels of moral development (see Figure 10).

Table 1

Sample Means and Standard Deviations
for Age, SES, and Work Experience

	Age	SES	Work Yrs.
Attorneys			
M	3.25	5.21	3.95
SD	1.08	1.09	1.67
N	39	38	39
Physicians			
M	3.46	5.90	2.88
SD	0.88	0.41	1.18
N	29	29	26

$p<.05$.

Note:

Age Groups:	SES Groups:	# Work Years
1= 30-39 years	1=21k-30k	1=5-10 years
2= 40-49 years	2=31k-40k	2=11-15 years
3= 50-59 years	3=41k-50k	3=16-20 years
4= 60-69 years	4=51k-60k	4=22 years plus
	5=61k plus	

Table 2

Sample Means and Standard Deviations
for Occupational Role

	Daily Time Spent With...				
	Client	Ed	Research	Admin.	Other
Attorneys					
M	3.88	1.97	2.00	2.15	2.30
SD	1.37	0.50	0.58	0.61	1.24
N	35	28	31	34	31
%	51-75%	1-25%	1-25%	1-25%	1-25%
Physicians					
M	3.90	2.62	1.92	1.84	1.18
SD	0.68	0.63	0.56	0.55	0.40
N	28	29	26	25	11
%	51-75%	26-50%	1-25%	1-25%	0%

$p<.05$

Note: Percentages represent percent to respond in that group.

Table 3

Sample Means and Standard Deviations
for Ethical Role

	Daily Time Spent With...				
	Client	Ed	Research	Admin.	Other
Attorneys					
M	3.11	2.06	1.86	2.25	2.11
SD	1.47	0.91	0.83	1.11	1.34
N	35	32	29	28	27
%	26-50%	1-25%	1-25%	1-25%	1-25%
Physicians					
M	2.85	2.20	1.86	1.73	1.36
SD	1.26	0.65	0.85	0.55	0.50
N	26	25	21	22	11
%	1-25%	1-25%	1-25%	0%	0%

$p<.05$

Note: Percentages represent percent to respond in that group.

Table 4

Standardized Sample Means and Standard Deviations
Prayer, Religion, Faith, and Attendance

	Pray	Relig.	Faith	Attendance
Attorney				
M	0.01	0.07	0.05	0.12
SD	1.06	0.93	0.96	1.08
N	39	39	39	39
Physicians				
M	-.008	-.098	-.068	-.165
SD	0.93	1.10	1.07	0.87
N	29	29	29	29

$p<.05$.

Raw Scores

Prayer		Religion		Faith		Attendance	
Attys	Drs.	Attys.	Drs.	Attys.	Drs.	Attys.	Drs.
μ=2.13	μ=2.28	μ=3.85	μ=3.45	μ=3.18	μ=2.93	μ=2.82	μ=2.62
sd=1.6	sd=1.5	sd=1.3	sd=1.6	sd=1.0	sd=1.2	sd=1.2	sd=1.1
N=39	N=29	N=39	N=29	N=39	N=29	N=38	N=29

Note: The items pertaining to prayer, religion, faith, and attendance were rated according to the level of importance given by each subject:

Frequency of prayer: 1 = daily; 2 = once/wk; 3 = once/month; 4 = religious holidays; 5 = rarely or never

Importance of Religion: Rate from 1-5 with 1 being "religion is not important to me" and 5 being "religion is very important to me".

Importance of Faith: 1 = unimportant; 2 = somewhat important; 3 = important; 4 = very important.

Frequency of Church Attendance: 1 = at least twice weekly; 2 = at least once weekly; 3 = once a month; 4 = once a year; 5

Table 5

F-Test To Determine Differing Responses Among Physicians and Attorneys for Faith Scales and Stage-P_

	F-value	p-value
prayer	1.28	.5
import. of faith	1.22	.55
well-being health	1.21	.61
well-being morale	1.07	.88
faith development	1.27	.57
DIT Stage-P	1.15	.73

p<.05.

Table 6

2 Population T-test

FAITH Items	2-tailed t-test	p-level	Attorney N	Doctors N	Attorney Mean	Doctors Mean
Prayer	.06	.96	40	28	.01	-.01
ImporRelig	.68	.50	40	28	.07	-.10
ImporFaith	.47	.64	40	28	.05	-.07
Attendance	1.15	.26	39	28	.12	-.16
DSE	.004	1.00	40	28	.00	-.00
RLI-Ext	1.11	.27	39	26	.11	-.17
RLI-Int	-.45	.65	39	26	-.05	.07
RLI-Quest	1.11	.27	39	26	.11	-.17
SWB Scales						
RWB	-4.31	.00	39	26	-.39	.58
EWB	-5.54	.00	39	26	-.46	.70
Faith Development						
FDS	1.54	.13	32	22	.17	-.25
Well-Being Scales						
Wellhealth	1.51	.14	39	28	.16	-.22
WellMorale	1.31	.19	39	27	.13	-.19
WellEconom	1.69	.10	39	27	.17	-.25
WellRelig	.02	.99	39	27	.00	-.002
Moral Development						
DIT Stg-P	-.75	.45	36	26	-.08	.11

$p<.05$

Abbreviations	Expanded Terms
Prayer	Frequency of Prayer
ImporRelig	Importance of Religion
ImporFaith	Importance of Faith
Attendance	Frequency of Church Attendance
DSE	Daily Spiritual Experience
RLI-Ext	Religious Life Inventory External Scale
RLI-Int	Religious Life Inventory Internal Scale
RLI-Quest	Religious Life Inventory Quest Scale
RWB	Spiritual Well-Being Religious Scale
EWB	Spiritual Well-Being Existential Scale
FDS	Faith Development Scale
Wellhealth	Well-Being Health Scale
WellMorale	Well-Being Morale Scale
WellEconom	Well-Being Economic Scale
WellRelig	Well-Being Religious Scale
DIT Stg-P	Defining Issues Test Stage-P

Table 7

Correlations Among Items Pertaining to Faith and Stage-P of Ethical/Moral Development (Attorneys and Physicians)

	Pray	Impo Rel	Impo Fai	Attn dnc	DSE	Well Rel	RLI EXT	RLI INT	RLI Ques	RWB	EWB	FDS	Stg -P
Pray		-.74	-.72	72	.64	.76	33			.39			
Impo Rel			.83	-.60	-.69	-.85	-.40			-.41			
Impo Fai				-.59	-.71	-.80	-.40			-.37			-.29
Attn dnc					.46	.68	.33					-.36	
DSE						.69	.41			.39		-.21	
Well Rel							.52			.38			

p<.05.

Note: Reverse Scoring was implemented for prayer, attendance, and the DSE.

Abbreviations	Expanded Terms
Prayer	Frequency of Prayer
ImporRelig	Importance of Religion
ImporFaith	Importance of Faith
Attendance	Frequency of Church Attendance
DSE	Daily Spiritual Experience
RLI-Ext	Religious Life Inventory External Scale
RLI-Int	Religious Life Inventory Internal Scale
RLI-Quest	Religious Life Inventory Quest Scale
RWB	Spiritual Well-Being Religious Scale
EWB	Spiritual Well-Being Existential Scale
FDS	Faith Development Scale
Wellhealth	Well-Being Health Scale
WellMorale	Well-Being Morale Scale
WellEconom	Well-Being Economic Scale
WellRelig	Well-Being Religious Scale
DIT Stg-P	Defining Issues Test Stage-P

Table 8

Correlations Among Items Pertaining to Faith and Stage-P of Ethical/Moral Development (Attorneys)

	Pray	Impo Rel	Impo Fai	Attn dnc	DSE	Well Rel	RLI EXT	RLI INT	RLI Ques	RWB	EWB	FDS	Stg-P
Pray		-.66	-.61	.71	.54	.70		-.36		.39			
Impo Rel			.72	-.57	-.58	-.83		-.34		-.39			
Impo Fai				-.56	-.64	-.77				.34			
Attn dnc					.40	.68				.44		-.37	
DSE						.67				.36			
Well Rel										.42			

p<.05.

Note: Reverse Scoring was implemented for prayer, attendance, and the DSE.

Abbreviations	Expanded Terms
Prayer	Frequency of Prayer
ImporRelig	Importance of Religion
ImporFaith	Importance of Faith
Attendance	Frequency of Church Attendance
DSE	Daily Spiritual Experience
RLI-Ext	Religious Life Inventory External Scale
RLI-Int	Religious Life Inventory Internal Scale
RLI-Quest	Religious Life Inventory Quest Scale
RWB	Spiritual Well-Being Religious Scale
EWB	Spiritual Well-Being Existential Scale
FDS	Faith Development Scale
Wellhealth	Well-Being Health Scale
WellMorale	Well-Being Morale Scale
WellEconom	Well-Being Economic Scale
WellRelig	Well-Being Religious Scale
DIT Stg-P	Defining Issues Test Stage-P

Table 9

Correlations Among Items Pertaining to Faith and Stage-P of Ethical/Moral Development (Physicians)

	Pray	Impo Rel	Impo Fai	Attn dnc	DSE	Well Rel	RLI EXT	RLI INT	RLI Ques	RWB	EWB	FDS	Stg-P
Pray		-.88	-.88	.74	.79	.87	.69		.73	.79			
Impo Rel			.94	-.70	-.80	-.89	.63		-.67	-.72			
Impo Fai				-.68	-.79	- 83	-.69		-.72	-.71			
Attn dnc					.58	.74	86		.82	.61			44
DSE						.71	.56		.70	.87			
Well Rel													

p<.05.

Note: Reverse Scoring was implemented for prayer, attendance, and the DSE.

Abbreviations	Expanded Terms
Prayer	Frequency of Prayer
ImporRelig	Importance of Religion
ImporFaith	Importance of Faith
Attendance	Frequency of Church Attendance
DSE	Daily Spiritual Experience
RLI-Ext	Religious Life Inventory External Scale
RLI-Int	Religious Life Inventory Internal Scale
RLI-Quest	Religious Life Inventory Quest Scale
RWB	Spiritual Well-Being Religious Scale
EWB	Spiritual Well-Being Existential Scale
FDS	Faith Development Scale
Wellhealth	Well-Being Health Scale
WellMorale	Well-Being Morale Scale
WellEconom	Well-Being Economic Scale
WellRelig	Well-Being Religious Scale
DIT Stg-P	Defining Issues Test Stage-P

Table 10

Significant Correlations of DSE Items With Faith Scales Between Attorneys and Physicians

	DSE Attorneys	DSE Physicians	DSE Attorneys & Physicians
Prayer	.54	.79	.64
Imporrel	-.58	-.80	-.69
Imporfai	-.64	-.79	-.71
Attndnc	.40	.58	.46
Wellrel	.67	.71	.69
RLI-Ext		.56	.41
RLI-Int			
RLI-Quest		.70	
RWB	.36	.87	.39
EWB			
FDS			-.21
DIT Stg-P		.44	

p<.05.

Note: Reverse Scoring was implemented for prayer, attendance, and the DSE

Abbreviations	Expanded Terms
DSE	Daily Spiritual Experience
RLI-Ext	Religious Life Inventory External Scale
RLI-Int	Religious Life Inventory Internal Scale
RLI-Quest	Religious Life Inventory Quest Scale
RWB	Spiritual Well-Being Religious Scale
EWB	Spiritual Well-Being Existential Scale
FDS	Faith Development Scale
DIT Stg-P	Defining Issues Test Stage-P

Table 11

DSE Items Correlated with Faith Items

	God's Pres	Str/Comf	Inner Peace	God's Love	Touched
Prayer	.67	.62	.47	.57	.40
Imporrel	-.68	-.72	-.51	-.64	-.38
Imporfai	-.48	-.50	-.35	-.43	-.34
Attndnc	.62	.63	.44	.62	.32
RLI-Ext	.37	.34	.32	.41	.78
RLI-Int					.63
RLI-Quest	.29	.31		.30	.57
RWB	.36	.37	.31	.37	.63
EWB					.61

p<.05.

Note: Reverse Scoring was implemented for all items on the DSE.

Abbreviations:

God's Pres

StrComf

InnerPeace

God's Love

Touched

Expanded Terms:

1. I feel God's presence.
2. I find strength and comfort in my religion.
3. I feel deep inner peace or harmony.
4. I feel God's love for me directly or through others.
5. I am spiritually touched by the beauty of creation.

Table 12

Principled Morality (P-Scores) of
Physicians and Attorneys (Valid and Invalid)

	Physicians		Attorneys	
	Valid	nvalid	Valid	Invalid
Mean	38.28	32.23	40.07	43.36
SD	18.13	19.54	17.25	14.91
N	32	3	23	5

p<.05.

Table 13

P-score Cutoff Points for Attorneys and Physicians (Valid and Invalid)

Attorneys & Physicians	Low Third (up to 27)	Mid Third (28-41)	High Third (42 & up)
	Low Third (up to 27)	Mid. Third (28-41)	High Third (42 & up)
Mean	17.74	35.44	55.6
SD	6.6	3.6	10.3
N	17	19	26
Group Response	27.4%	30.6%	42%

p<.05.

Attorneys						
	Low Third (up to 27)		Mid Third (28-41)		High Third (42 & up)	
	Valid & Invalid	Valid	Valid & Invalid	Valid	Valid & Invalid	Valid
Mean	17	17.7	35	34.3	54.3	54.9
SD	7.1	7.0	3.8	3.5	10.4	10.6
N	11	10	8	7	15	14
Group Response	32.4%	32.3%	23.5%	22.3%	44.1%	45.2%

p<.05.

Physicians						
	Low Third (up to 27)		Mid Third (28-41)		High Third (42 & up)	
	Valid & Invalid	Valid	Valid & Invalid	Valid	Valid & Invalid	Valid
Mean	19.2	17.6	35.8	35.2	57.3	57.4
SD	6.	5.2	3.7	3.8	10.4	10.5
N	6	5	11	9	11	9
Group Response	21.4%	21.7%	39.3%	39.1%	39.3%	39.1%

p<.05.

Table 14

Reported P-scores for Religious and Non-religious(Attorneys and Physicians)

	Religious		Non-Religious	
	Attorneys	Physicians	Attorneys	Physicians
Mean	37.3	38.3	45	51.3
SD	18.5	16.5	7.1	14.2
N	33	23	2	5

$p<.05$.

Age Ranges of Attorneys and Physicians

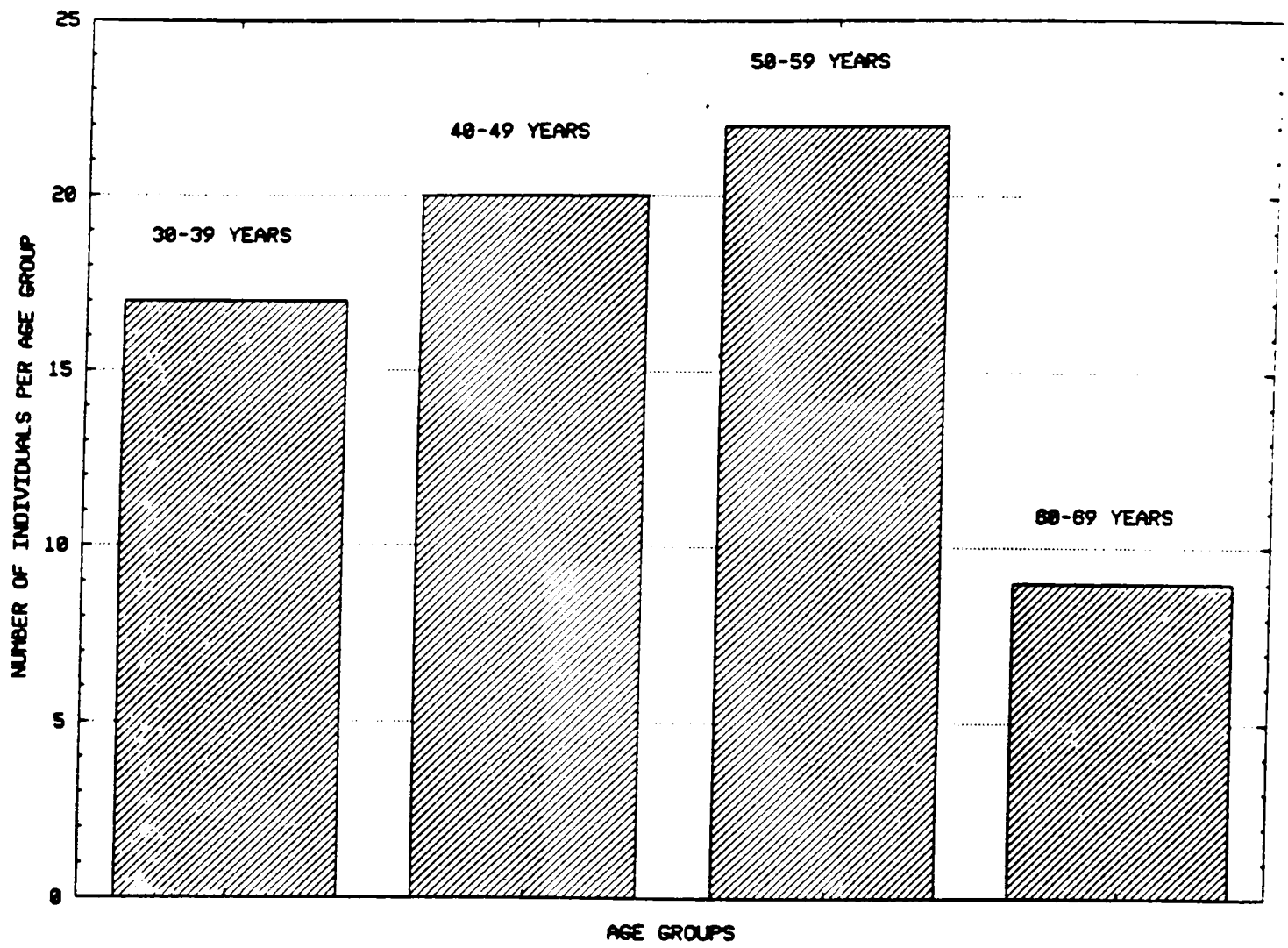
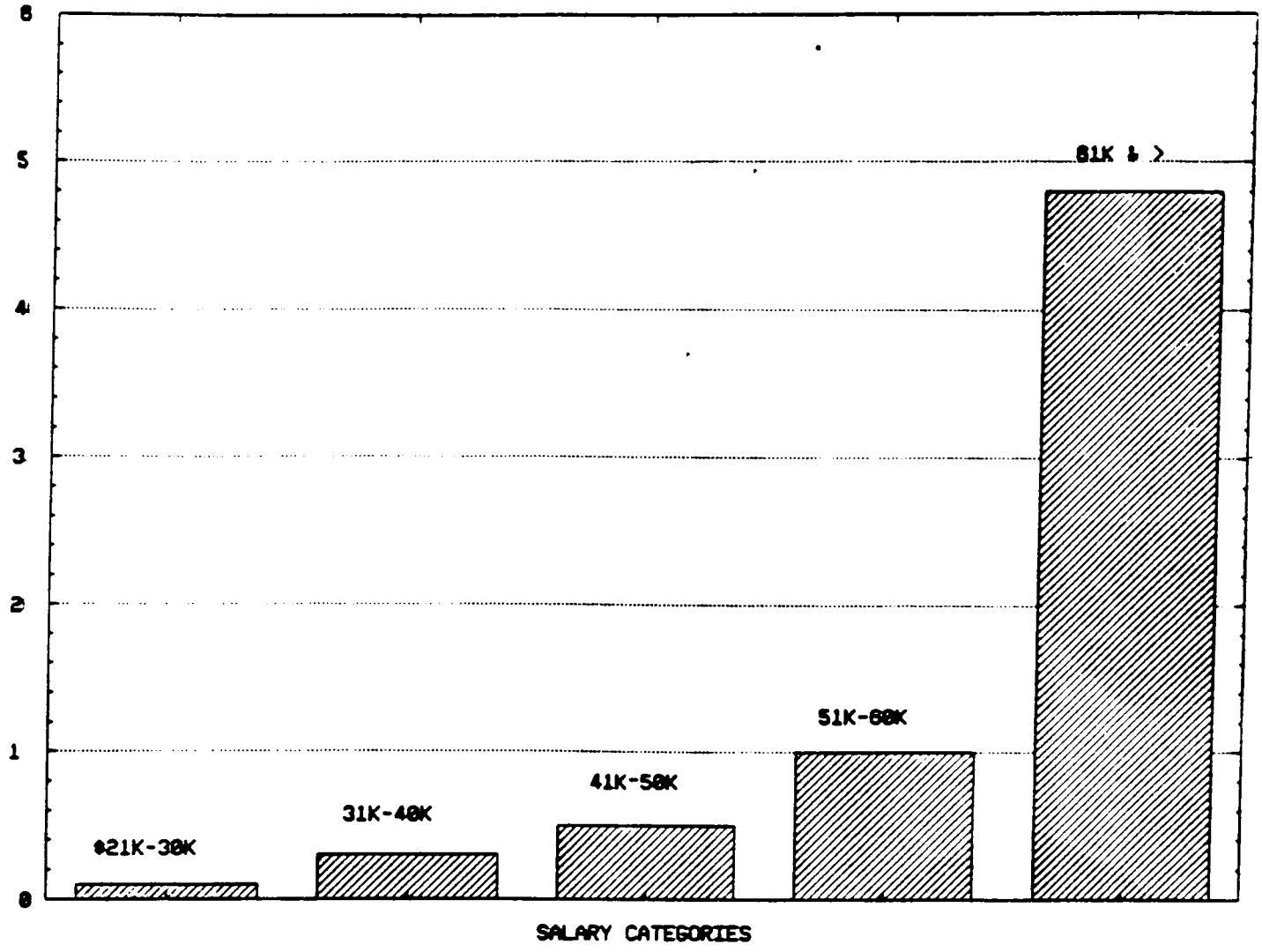


Figure 1

Socioeconomic Status of Physicians and Attorneys



Note: X-axis pertains to the number of years working in their respective field
1= less than one year
2= 1-5 years
3= 5-10 years
4= 11-15 years
5= 16-20 years
6= greater than 21 years

Figure 2

Attorneys and Physicians' Valid and
Invalid Responses Combined

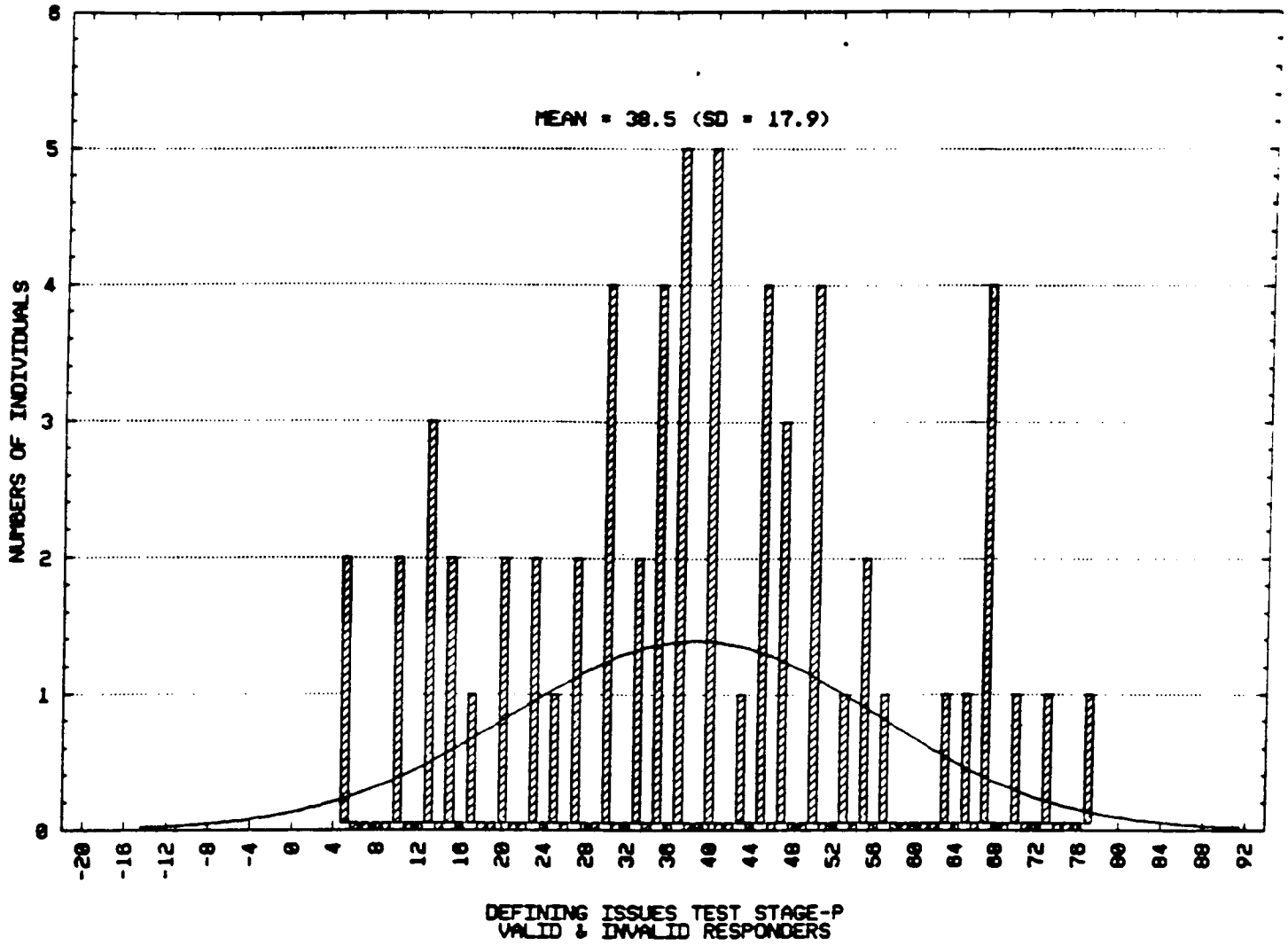


Figure 3

Attorneys and Physicians' Valid and Invalid Responses Respectively

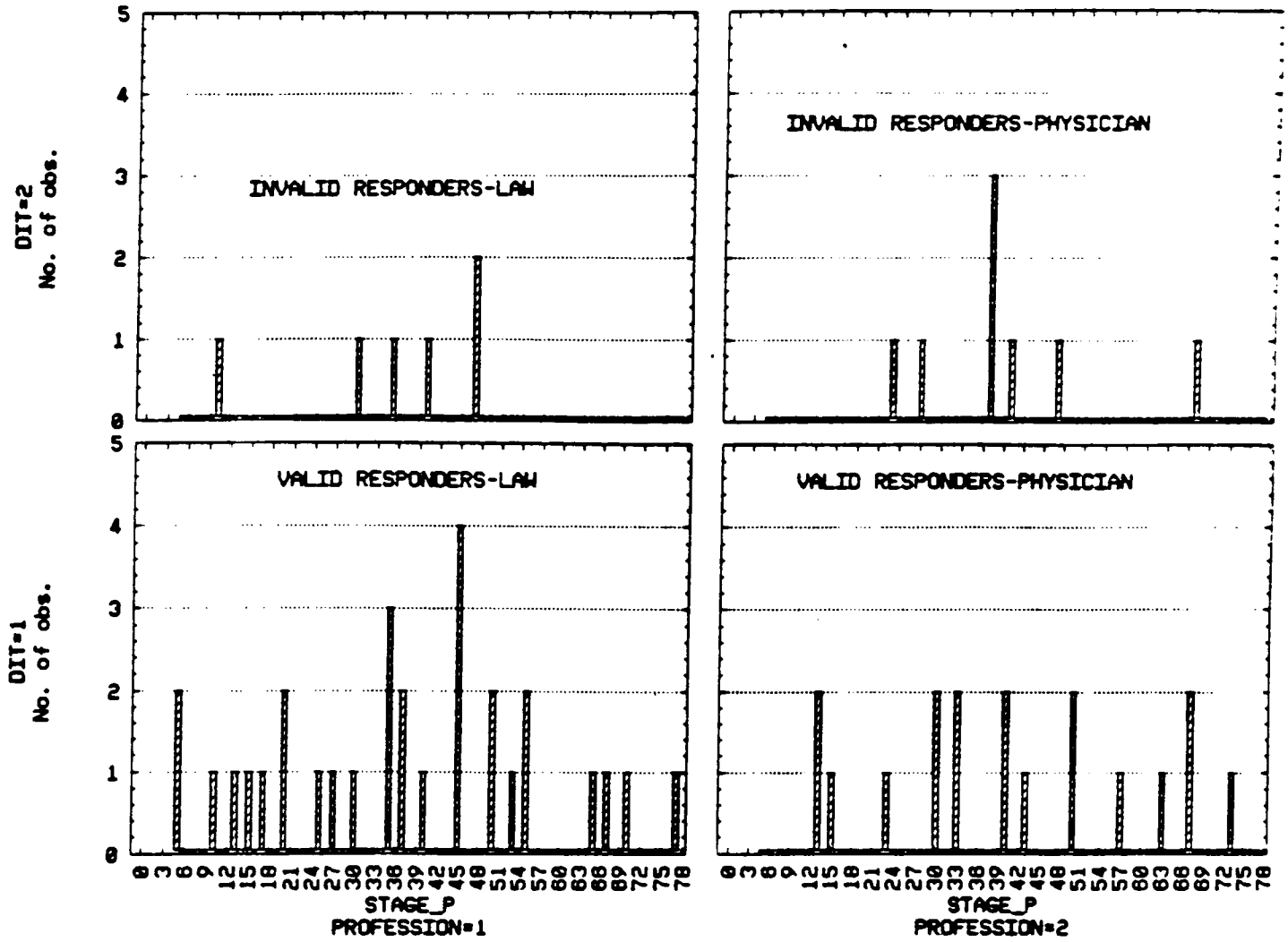
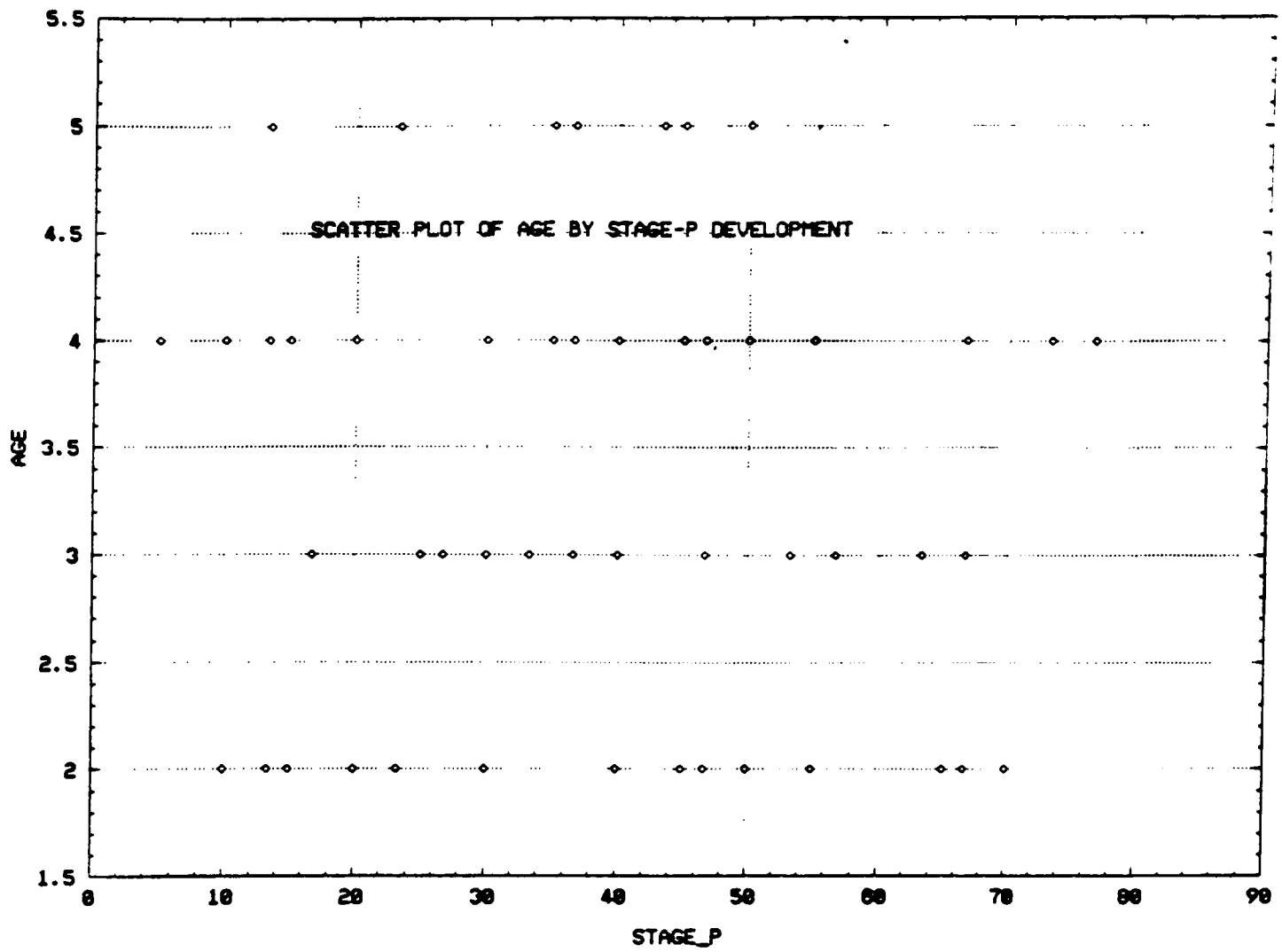


Figure 4

Age Correlated with Stage-P Moral Development

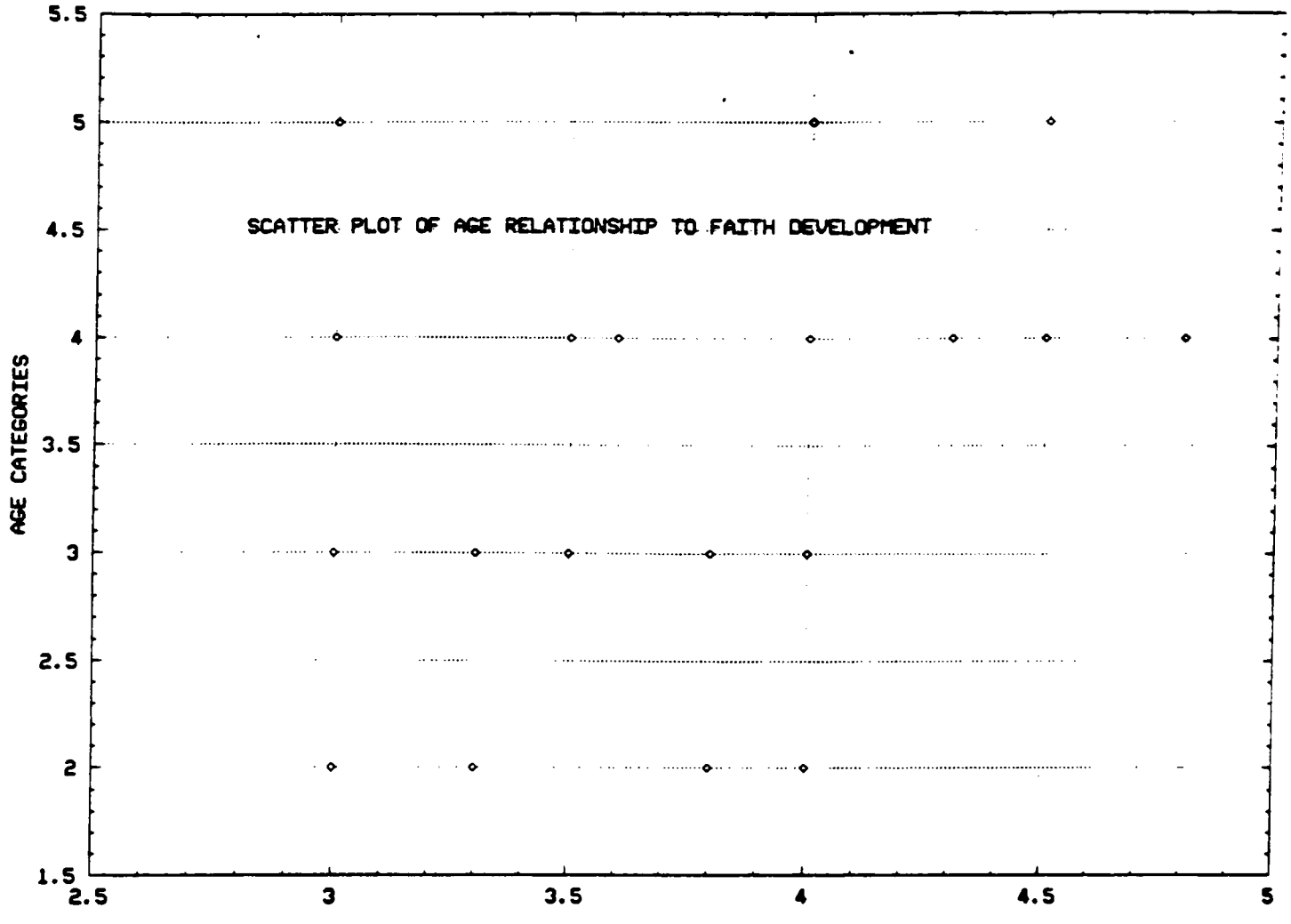


Note: X-axis pertains to the age range of attorneys & physicians

2= 30-39 years of age
3= 40-49 years of age
4= 50-59 years of age
5= 60-69 years of age

Figure 5

Age Correlated with Level of Faith Development



Note: X-axis pertains to the age range of attorneys & physicians

2= 30-39 years of age
3= 40-49 years of age
4= 50-59 years of age
5= 60-69 years of age

Figure 6

Stage-P Correlated with Level of Faith Development

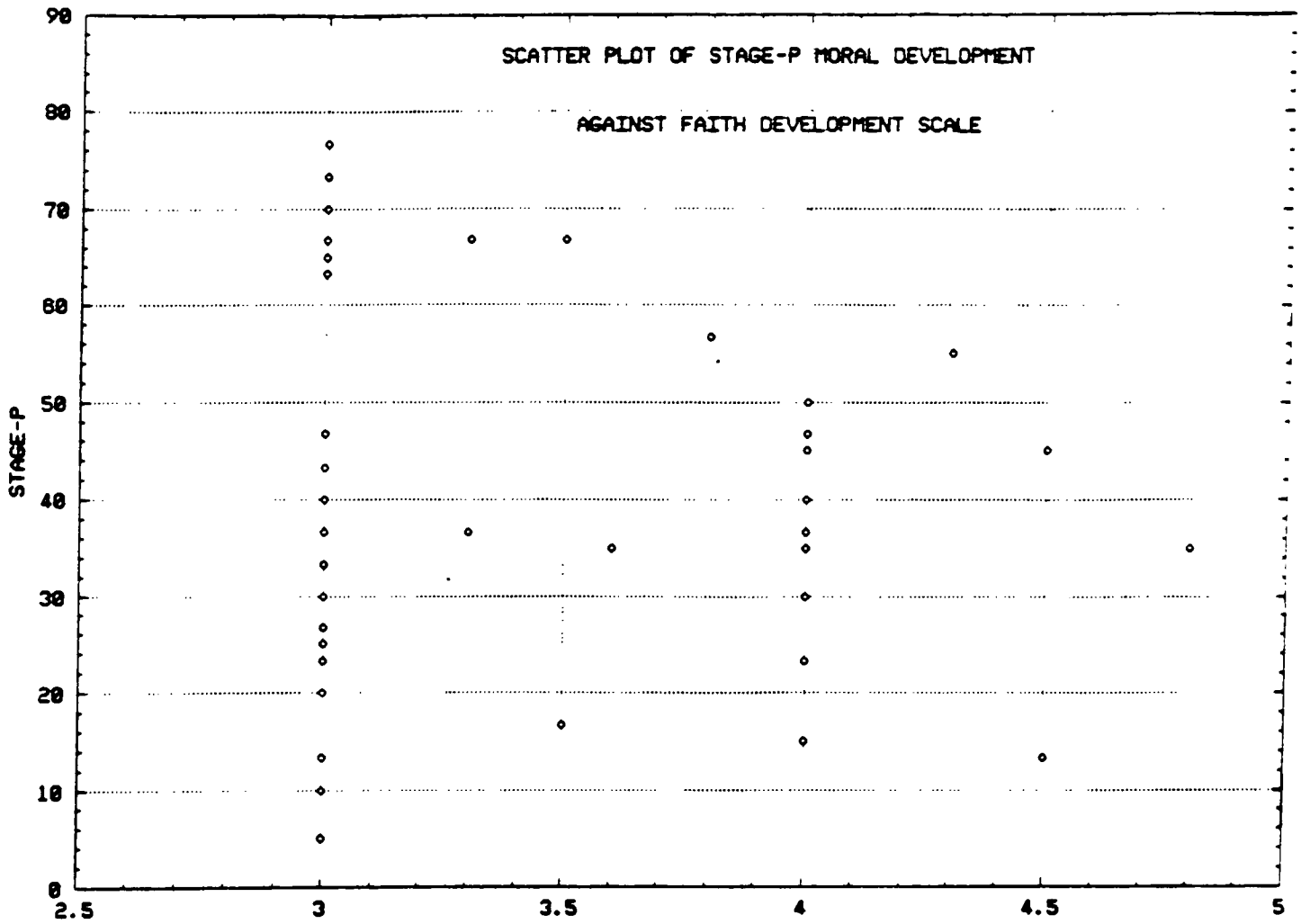


Figure 7

Level of Faith as Pertained to Valid and Invalid Responders

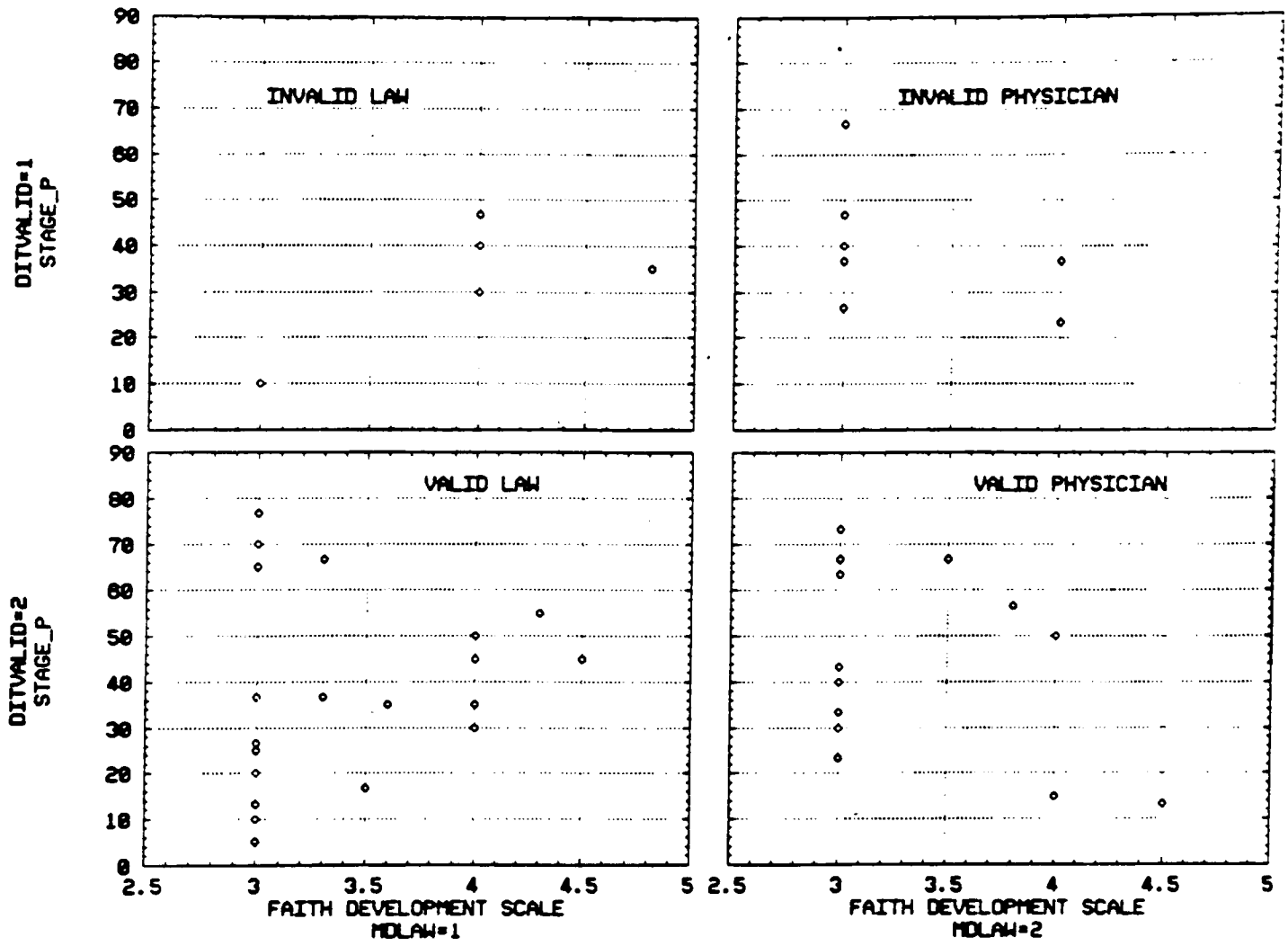


Figure 8

Importance of Faith as Pertained to
Valid and Invalid Responders

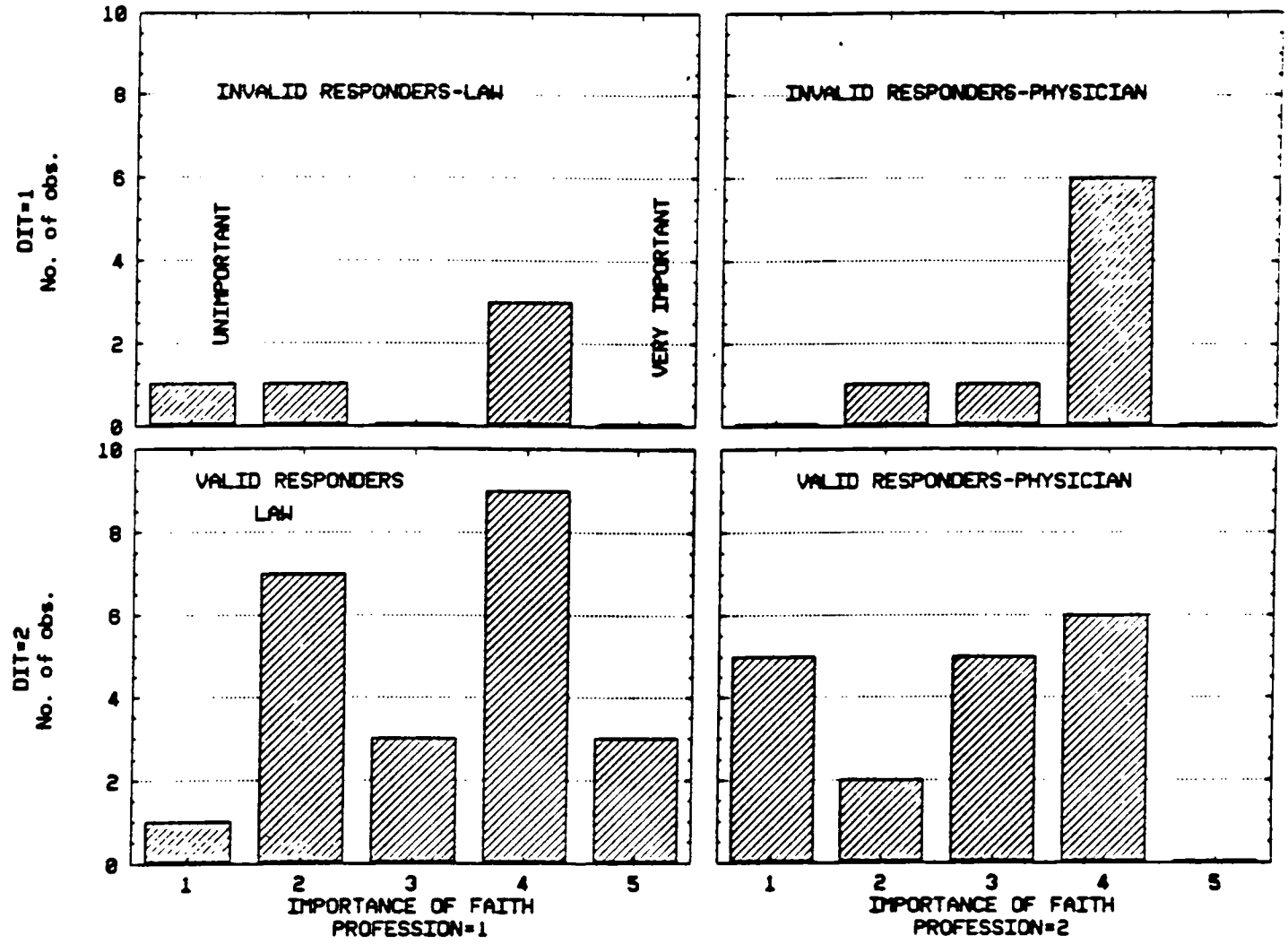


Figure 9

CHAPTER IV

DISCUSSION

Ethical and Moral Decision-Making

The primary focus of this study was to better understand the relationship of faith and ethical and moral decision making among professionals. The previous literature had focused primarily on the relationship between level of education and level of ethical-moral decision making; while faith generally was examined through the relationship of age and one's level of faith. There was a tendency for the literature to focus on the ethical decision making of graduate students, law students, and medical students only prior to their graduating. It is difficult to predict one's ability to make ethical decisions in the work place until one is submitted to that environment. Based on this line of reasoning, the present study was designed to look at the ethical decision making of practicing professionals only, and if faith played a role in this process.

To provide a sample representative of the population in general subjects were gathered from several sources: various bar associations, district and federal judges, attorneys attending an area-wide ethical conference, and physicians practicing in a university health science center. No specific religious organizations were chosen so that the

questions pertaining to one's individual faith potentially could be answered in the professional's work environment. This also allowed this sample to be somewhat extended from those in the literature.

The age ranges of our subjects provided for comparisons between seasoned professionals and young professionals. This allowed for the possibility of identifying when during the aging process that changes of faith and moral development might be most prevalent.

Gender differences were not detected in this study. That could be due to the small sample size and even smaller sample of women that responded to this study.

The questionnaire administered to the subjects was designed in such a manner that individuals could respond in both an objective and subjective way. This would ensure that subjects' responses were based on their own individual responses and not responses that could be generalized to individuals other than themselves.

Six hypotheses were presented in order to identify some of the changes that might occur with respect to ethical and moral development and faith development. The first hypothesis attempted to examine the relationship between faith and ethical and moral decision making. This hypothesis was based on the assumption that spiritual faith must be obtained before an individual could advance into level 5 or level 6 of Kohlberg's moral development.

Faith as a Predictor

Level of faith was not found predictive of ethical-moral development for either physicians or attorneys. This finding is surprising due to the fact that faith is based on the premise of "being good and doing good". The importance of faith showed a modest, but significant, negative correlation with moral development indicating that as faith increases moral development has a tendency to decrease. A larger sample size is recommended to determine if the importance of faith would still show a negative correlation with moral development. There is the possibility that if these findings were supported in future studies that the literature reporting faith and moral development to not be related would be supported (Hanford, 1991; Johnson, 1997).

The faith scales all correlated highly with each other. These scales appeared to be specific in what they were measuring and could be considered both reliable and valid in the measurement of an individual's level of faith.

The DSE was found to not correlate well with the items pertaining to intrinsic faith. This is surprising considering the DSE was designed to measure one's daily relationship with God (Underwood, in Press). Given the short form of the DSE was used in this study, future studies should use the long form of the DSE to determine the validity of the scale to measure intrinsic faith. However, the results of

the current study suggest further study is needed of the faith and relationship to God constructs. Perhaps in different educational and professional groups the relationships would differ.

The faith development scale (FDS) was implemented to provide the subjects with the opportunity of responding with an individual response of what faith was. The overall response from the subjects was discouraging. The second question which asked, "Are you religious" was often responded to with a "yes" or "no" response, despite them being instructed to give a short, but descriptive response. It is recommended that the question be re-designed in such a manner that a yes or no response is not possible. A few of the subjects professing to be atheist or agnostic refused to even answer the faith questions stating that "questions did not apply to them, as they did not believe in God". An additional statement in the questionnaire should be added. It should instruct those professing to be atheist or agnostic to answer why they are or are not religious. This would increase the reliability of the scale.

Age and Education Predictors of Moral Development

Kohlberg's contention that age and education are predictors of moral development was not supported in this study. This is also surprising, along with the finding that faith was not a predictor of moral development. It would be erroneous and premature to conclude that based on these findings age, education , or faith are not predictors of moral development. There is a large body of literature over the years that has shown just the opposite to be true (Kohlberg, 1981, 1982; Fowler, 1981; Rest, 1979) What should be concluded instead is that further research is needed among highly educated professionals to determine if these findings can be reproduced. It may be that given the daily decisions that must be dealt with in physicians and attorneys that relationships found in the general population relating to moral development do not hold. The items used to develop the constructs may be viewed very differently by individuals trained to pick constructs apart or look at them from all angles.

DIT Stage-P Predictor of Moral Development

When the correlational patterns were examined to determine if any major differences existed among attorneys and physicians, none were found. Correlational analyses were

then performed to determine if stage-P correlated with any of the faith items, or the faith development scale. Stage-P was found to correlate with only one item, frequency of church attendance. This suggests that stage-P is not sensitive to issues outside of moral development. Richards and Davison (1992) and Holley (1991) also found that the DIT is not as sensitive to conservative Christians as it is liberal Christians. Those scoring high on the Quest scale should be considered the most open-minded or liberal in our study. If this is the case then stage-P should show some level of correlation with the Quest scale. This was not the case.

Although stage-P showed no relationship to the faith items or the faith scale, it did show 42% of the attorneys and physicians reported at the high range of moral development. The valid and invalid responders on the DIT differed little in their level of ethical decision making. The attorneys (valid and invalid: 44.1%) were found to endorse the third group, high level of moral development, more often than did the physicians (valid and invalid: 39.3%). However, the physicians' mean level of moral development was found to be descriptively higher than that of the attorneys. The attorneys in this study appeared in many cases to be in the transition stage from level 3 to level 4 of moral development. The fact that, as a group, the physicians responded at a lower level on the DIT than the

attorneys could be due to the fact that they were conservative in their responses.

The finding that non-religious responders were found to have a higher level of moral development than religious responders needs to be accepted with caution. The non-religious sample size consisted of only seven. Although statistically significant, further research is needed before this finding can be validated.

Intrinsic Versus Extrinsic Faith

The measurement of intrinsic and extrinsic faith was obtained through the SWB scales (RWB & EWB) and the RLI scales (Internal, External, & Quest). The RWB and RLI-Internal measure intrinsic faith. The EWB and RLI-external measured extrinsic faith. The Quest scale measured a person's search for the truth.

Interestingly, the physicians and attorneys were found to be reporting at different levels of faith. The physicians reported to be high in the area of extrinsic faith, and they also reported high on the Quest scale. Physicians reporting high in the area of extrinsic faith could be described as people who use religion only in a self serving manner (Genia, 1996). People professing to an extrinsic faith were described by Genia as being less spiritual than those professing to an intrinsic faith. The Quest scale has been

referred to as the scale that is measuring a person's search for the truth. Altemeyer and Hunsberger's (1992) findings that searching for the truth did not end in the early college years or just with people searching for religious sentiment were supported in this study. Interestingly, Altemeyer and Hunsberger referred to people who scored high on the Quest scale as maintaining qualities of being tolerant, accepting, and nonprejudiced. Genia (1996) described Quest seekers as people who were open-minded and had an inquisitive approach about their faith. The fact that the physicians reported higher on these scales than the attorneys should be pursued in further research with specific emphasis put on personality testing to determine if certain personality traits are predictive of certain professions and potentially predictive of certain roles in spiritual faith. Certainly the day-to-day professional demands of physicians and attorneys would differentially support open-mindedness. The legal process is not designed to be open-minded and is an advocacy system. It would also be interesting to determine in future studies if the day-to-day roles of attorneys and physicians assists in molding their faith into either intrinsic, extrinsic, or quest roles. For example, if physicians deal with healing, death, and dying on a daily basis would their spiritual outlook not differ from the professional who never saw these processes.

Based on significant correlation between attendance and stage-P of moral development for physicians, it can be suggested that their tendency to gravitate towards religious-social interactions possibly exposes physicians to more situations that are less well defined in terms of moral and ethical issues.

The attorneys reported high on the intrinsic scale (RWB), and their frequency of prayer correlated high with the intrinsic scale. According to Batson, Schoenrade, and Ventis (1993) individuals with an intrinsic faith have an internal need for certainty, strength, and direction. Genia (1996) states that intrinsic faith is based on a personal relationship with God. The findings in this study that attorneys display intrinsic faith and active prayer lives supports the literature that faith and prayer share positive relationship with each other (Ellison, 1991). There is also the possibility that the literature is further supported by the finding in this study that as intrinsic faith increases religious belief decreases (Fowler, 1981). In other words, as intrinsic faith develops, there is less of a need to draw upon religious social functions as a source of spiritual strength.

Although the findings in this study suggest attorneys and physicians are on differing levels of faith development, these findings do not suggest that one form of faith is better than the other, or that physicians as a group lack

intrinsic faith development. What they do suggest is that professionals exhibiting an extrinsic faith may be exposed to more situations that require ethical and moral decision making. If this is true, from a professional standpoint then, the professional exhibiting extrinsic faith or a Questing faith would be the most beneficial to a client or patient. This appears to contradict the definition of extrinsic faith as being based on a self-serving attitude. However, perhaps it is the drive for religious social interaction that is serving as the avenue for physicians to experience a greater number of ethical and moral dilemmas as compared to attorneys who are professing to intrinsic faith. Further research is suggested.

Summary, Conclusions and Future Studies

This study was designed on the premise that high levels of education would lead to high levels of moral development. That was not proven true in this study. The range of moral development was from stage 3 to stage 4 of moral development. According to the literature (Kohlberg, 1982), stage 3 and stage 4 of moral development pertain to external reinforcement, and stage 5 and 6 pertain to internal decision making. External reinforcement for moral and ethical decision making occurs as a result of external authority, such as society's views of right and wrong. Internal

decision making occurs as a result of self-control and a willingness to do what is right, no matter the negative consequences that might ensue. Based on the literature it can be suggested that attorneys and physicians are not relying on independent thoughts, but rather preconceived ideas of what society thinks is right and wrong.

Another premise of this study was that advanced levels of faith development would lead to advanced levels of moral development even if education did not. This premise was not supported either. The final premise was that as age increased so would one's level of faith and level of moral development. This relationship was not supported.

It would appear that either the constructs for these special populations are not valid in the form that elicits a response, or the constructs do not hold for highly educated professionals who are constantly faced with the rules and regulations that they may find go against personal ethics. This issue was not approached in this study and offers an avenue of further investigation. Moral and ethical constructs specific to professions have not been developed. The results of the study suggest more effort should be directed toward this end. It is important that laymen be able to place their trust into the hands of a professional such as an attorney or physician. In turn it is important that the attorneys and physicians understand that their career is based on the foundation of duty-to-the-client and

the institution which the professionals represent. Attorneys and physicians are viewed as leaders and role-models in society, both from an educational perspective and an ethical perspective. The importance of maintaining an ethical and moral perspective in their career should not be lost in the process of building their career. We need to know more about those perspectives.

. It is important to note the response of the subjects to this study. The questionnaire was administered to 308 subjects and only 22% responded (39 attorneys and 29 physicians). Unfortunately, this question was not asked-but might not be responded to freely. Simply, how often does one find oneself in ethical challenge or turmoil? The non-responders may score in the frequent range on this question. The failure of many attorneys to respond was often based on the same response: "Why should I take time out of a busy workday to fill out a questionnaire that I can not bill for?" The physicians failure to respond was unknown. It can only be assumed that they had a similar view with respect to time pressures. Alternatively, the respondents may have faced uncertainty in answering the questions which cause one to look deeply at personal values. The questionnaires were anonymous but required exploration of personal values. This may be a difficult topic as the professionals often find themselves in ethical dilemmas or ethical challenges. The questionnaire required 30 minutes to complete.

An additional population that would be recommended for further study of ethical and moral development is the population of practicing psychologists. They often work with issues that combine both law and medicine into the work with their client. Psychologists are ethically bound to their client as well as the professional organization they represent.

The faith development scale that was implemented in this study would be utilized better, if in future studies it was administered separate from the rest of the questionnaire. This would ensure that the responses be more descriptive and allow the researcher to develop a better profile of what the subject's level of faith is. Faith is not based on rules and regulations, but on a knowledge and acceptance of a belief or system of belief. Faith in this sense becomes a motivating factor for how an individual responds to the trials and tribulations of life.

Future research is essential for several reasons. It is important that professionals be exposed to the importance of ethical behavior and to understand how to best implement ethical decision making. Before the educational process of ethics and morality can be implemented successfully, a better understanding of what predicts or drives ethical and moral behavior must be obtained. This can occur only through further research.

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APPENDIX A

PRINCIPLES OF MEDICAL ETHICS

Preamble

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibilities not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community. (Gorlin, 1990, pp. 191)

APPENDIX B

PRINCIPLES OF MEDICAL ETHICS
(FOR PSYCHIATRISTS)

Preamble

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibilities not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

1. The patient may place his/her trust in his her psychiatrist knowing that the psychiatrist's ethics and professional responsibilities preclude him/her gratifying his/her own needs by exploiting the patient. This becomes particularly important because of the essentially private, highly personal, and sometimes intensely emotional nature of the relationship established with the psychiatrist.

2. A psychiatrist should not be a party to any type of policy that excludes, segregates, or demeans the dignity of any patient because of ethnic origin, race, sex, creed, age, socioeconomic status, or sexual orientation.

3. In accord with the requirements of law and accepted medical practice, it is ethical for a physician to submit his/her work to peer review and to the ultimate authority of the medical staff executive body and the hospital administration and its governing body. In case of dispute, the ethical psychiatrist has the following steps available:

   a. Seek appeal from the medical staff decision to a joint conference committee, including members of the medical staff executive committee and the executive committee of the governing board. At this appeal, the ethical psychiatrist could request that outside opinions be considered.
   b. Appeal to the governing body itself.
   c. Appeal to state agencies regulating licensure of hospitals if, in the particular state, they concern themselves with matters of professional competency and quality of care.
   d. Attempt to educate colleagues through development of research projects and data and presentations at professional meetings and in professional journals.
   e. Seek redress in local courts, perhaps through an enjoining injunction against the governing

body.

f. Public education as carried out by an ethical psychiatrist would not utilize appeals based solely upon emotion, but would be presented in a professional way and without any potential exploitation of a patients through testimonials.

4. A psychiatrist should not be a participant in a legally authorized execution.

II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

1. The requirement that the physician conduct himself with propriety in his/her profession and in all the actions of his/her life is especially important in the case of the psychiatrist because the patient tends to model his/her behavior after that of his/her therapist by identification. Further, the necessary intensity of the therapeutic relationship may tend to activate sexual and other needs and fantasies on the part of both patient and therapist, while weakening the objectivity necessary for control. Sexual activity with a patient is unethical.

2. The psychiatrist should diligently guard against exploiting information furnished by the patient and should not use the unique position of power afforded him/her by the psychotherapeutic situation to influence the patient in any way not directly relevant to the treatment goals.

3. A psychiatrist who regularly practices outside his/her area of professional competence should be considered unethical. Determination of professional competence should be made by peer review boards or other appropriate bodies.

4. Special consideration should be given to those psychiatrists who, because of mental illness, jeopardize the welfare of their patients and their own reputations and practices. It is ethical, even encouraged, for another psychiatrist to intercede in such situations.

5. Psychiatric services, like all medical services, are dispensed in the context of a contractual arrangement between the patient and the treating physician. The provisions of the contractual arrangement, which are binding on the physician as well as on the patient, should be explicitly established.

6. It is ethical for the psychiatrist to make a charge for a missed appointment when this falls within the terms of the specific contractual agreement with the patient. Charging for a missed appointment or for one not canceled 24 hours in advance need not, in itself, be considered unethical if a patient is fully advised that the physician will make such a charge. The practice, however, should be resorted to

infrequently and always with the utmost consideration for the patient and his/her circumstances.

7. An arrangement in which a psychiatrist provides supervision or administration to other physicians or nonmedical persons for a percentage of their fees or gross income is not acceptable; this would constitute fee-splitting. In a team of practitioners, or a multidisciplinary team, it is ethical for the psychiatrist to receive income for administration, research, education, or consultation. This should be based upon a mutually agreed upon and set fee or salary, open to renegotiation when a change in the time demand occurs. (See also Section 5, Annotations 2,3, and 4).

8. When a member has been found to have behaved unethically by the American Psychiatric Association or one of its constituent district branches, there should not be automatic reporting to the local authorities responsible for medical licensure, but the decision to report should be decided upon the merits of the case.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to .the best interests of the patient.

1. It would seem self-evident that a psychiatrist who is a law-breaker might be ethically unsuited to practice his/her profession. When such illegal activities bear directly upon his/her practice, this would obviously be the case. However, in other instances, illegal activities such as those concerning the right to protest social injustices might not bear on either the image of the psychiatrist or the ability of the specific psychiatrist to treat his/her patient ethically and well. While no committee or board could offer prior assurance that any illegal activity would not be considered unethical, it is conceivable that an individual could violate a law without being guilty of professionally unethical behavior. Physicians lose no right of citizenship on entry into the profession of medicine.

2. Where not specifically prohibited by local laws governing medical practice, the practice of acupuncture by a psychiatrist is not unethical per se. The psychiatrist should have professional competence in the use of acupuncture. Or, if he/she is supervising the use of acupuncture by nonmedical individuals, he/she should provide proper medical supervision. (See also Section 5, Annotations 3 and 4).

IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

1. Psychiatric records, including even the identification of a person as a patient, must be protected with extreme care. Confidentiality is essential to psychiatric treatment. This is based in part on the special nature of psychiatric therapy as well as on the traditional ethical relationship between physician and patient. Growing concern regarding the civil rights of patients and the possible adverse effects of computerization, duplication equipment, and data banks makes the dissemination of confidential information an increasing hazard. Because of the sensitive and private nature of the information with which the psychiatrist deals, he/she must be circumspect in the information that he/she chooses to disclose to others about a patient. The welfare of the patient must be a continuing consideration.

2. A psychiatrist may release confidential only with the authorization of the patient or under proper legal compulsion. The continuing duty of the psychiatrist to protect the patient includes fully apprising him/her of the connotations of waiving the privilege of privacy. This may become an issue when the patient is being investigated by a government agency, is applying for a position, or is involved in legal action. The same principles apply to the release of information concerning treatment to medical departments of government agencies, business organizations, labor unions, and insurance companies. Information gained in confidence about patients seen in student health services should not be released without the student's explicit permission.

3. Clinical and other materials used in teaching and writing must be adequately disguised in order to preserve the anonymity of the individuals involved.

4. The ethical responsibility of maintaining confidentiality holds equally for the consultations in which the patient may not have been present and in which the consultee was not a physician. In such instances, the physician consultant should alert the consultee to his/her duty of confidentiality.

5. Ethically the psychiatrist may disclose only that information which is relevant to a given situation. He/she should avoid offering speculation as fact. Sensitive information such as an individual's sexual orientation or fantasy material is usually unnecessary.

6. Psychiatrists are often asked to examine individuals for security purposes, to determine suitability for various jobs, and to determine legal competence. The psychiatrist must fully describe the nature and purpose and lack of confidentiality of the examination to the examinee at the beginning of the examination.

7. Careful judgment must be exercised by the psychiatrist in order to include, when appropriate, the parents or guardian in the treatment of a minor. At the same

time the psychiatrist must assure the minor proper confidentiality.

8. Psychiatrists at times may find it necessary, in order to protect the patient or the community from imminent danger, to reveal confidential information disclosed by the patient.

9. When the psychiatrist is ordered by the court to reveal the confidences entrusted to him/her by patients he/she may comply or he/she may ethically hold the right to dissent within the framework of the law. When the psychiatrist is in doubt, the right of the patient to confidentiality and, by extension, to unimpaired treatment, should be given priority. The psychiatrist should reserve the right to raise the question of adequate need for disclosure. In the event that the necessity for legal disclosure is demonstrated by the court, the psychiatrist may request the right to disclosure of only that information which is relevant to the legal question at hand.

10. With regard for the person's dignity and privacy and with truly informed consent, it is ethical to present a patient to a scientific gathering, if the confidentiality of the presentation is understood and accepted by the audience.

11. It is ethical to present a patient or former patient to a public gathering or to the news media only if the patient is fully informed of enduring loss of confidentiality, is competent, and consents in writing without coercion.

12. When involved in funded research, the ethical psychiatrist will advise human subjects of the funding source, retain his/her freedom to reveal data and results, and follow all appropriate and current guidelines relative to human subject protection.

13. Ethical considerations in medical practice preclude the psychiatric evaluation of any adult charged with criminal acts prior to access, or availability of, legal counsel. The only exception is the rendering of care to the person for the sole purpose of medical treatment.

V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

1. Psychiatrists are responsible for their own continuing education and should be mindful of the fact that theirs must be a lifetime of learning.

2. In the practice of his/her specialty, the psychiatrist consults, associates, collaborates, or integrates his/her work with that of many professionals, including psychologists, psychometricians, social workers, alcoholism counselors, marriage counselors, public health

nurses, etc. Furthermore, the nature of modern psychiatric practice extends his/her contacts to such people as teachers, juvenile and adult probation officers, attorneys, welfare workers, agency volunteers, and neighborhood aides. In referring patients for treatment, counseling, or rehabilitation to any of these practitioners, the psychiatrist should ensure that the allied professional or paraprofessional with whom he/she is dealing is a recognized member of his/her own discipline and is competent to carry out the therapeutic task required. The psychiatrist should have the same attitude toward members of the medical profession to whom he/she refers patients. Whenever he/she has reason to doubt the training, skill, or ethical qualifications of the allied professional, the psychiatrist should not refer cases to him/her.

3. When the psychiatrist assumes a collaborative or supervisory role with another mental health worker, he/she must expend sufficient time to assure that proper care is given. It is contrary to the interests of the patient and to patient care if he/she allows himself/herself to be used as a figurehead.

4. In relationships between psychiatrists and practicing licensed psychologists, the physician should not delegate to the psychologist or, in fact, to any nonmedical person any matter requiring the exercise of professional medical judgment.

5. The psychiatrist should agree to the request of a patient for consultation or to such a request from the family of an incompetent or minor patient. The psychiatrist may suggest possible consultants, but the patient or family should be given free choice of the consultant. If the psychiatrist disapproves of the professional qualifications of the consultant. If the psychiatrist disapproves of the professional qualifications of the consultant or if there is a difference of opinion that the primary therapist cannot resolve, he/she may, after suitable notice, withdraw from the case. If this disagreement occurs within an institution or agency framework, the differences should be resolved by the mediation or arbitration of higher professional authority within the institution or agency.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

1. Physicians generally agree that the doctor-patient relationship is such a vital factor in effective treatment of the patient that preservation of optimal conditions for development of a sound working relationship between a doctor and his/her patient should take precedence over all other considerations. Professional courtesy may lead to poor

psychiatric care for physicians and their families because of embarrassment over the lack of a complete give-and-take contract.

2. An ethical psychiatrist may refuse to provide psychiatric treatment to a person who, in the psychiatrist's opinion, cannot be diagnosed as having a mental illness amenable to psychiatric treatment.

VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

1. Psychiatrists should foster the cooperation of those legitimately concerned with the medical, psychological, social, and legal aspects of mental health and illness. Psychiatrists are encouraged to serve society by advising and consulting with the executive, legislative, and judiciary branches of the government. A psychiatrist should clarify whether he/she speaks as an individual or as a representative of an organization. Furthermore, psychiatrists should avoid cloaking their public statements with the authority of the profession (e.g., "Psychiatrists know that...")

2. Psychiatrists may interpret and share with the public their expertise in the various psychosocial issues that may affect mental health and illness. Psychiatrists should always be mindful of their separate roles as dedicated citizens and as experts in psychological medicine.

3. On occasion psychiatrists are asked for an opinion about an individual who is in the light of public attention, or who has disclosed information about himself/herself through public media. It is unethical for a psychiatrist to offer a professional opinion unless he/she has conducted an examination and has been granted proper authorization for such a statement.

4. The psychiatrist may permit his/her certification to be used for the involuntary treatment of any person only following his/her personal examination of that person. To do so, he/she must find that the person, because of mental illness, cannot form a judgment as to what is in his/her own best interests and that, without such treatment, substantial impairment is likely to occur to the person or others. (Gorlin, 1990, pp. 239-244)

APPENDIX C

A LAWYER'S RESPONSIBILITIES

Preamble

A lawyer is a representative of clients, an officer of the legal system and a public citizen having special responsibility for the quality of justice.

As a representative of clients, a lawyer performs various functions. As advisor, a lawyer provides a client with an informal understanding of the client's legal rights and obligations and explains their practical implications. As advocate, a lawyer zealously asserts the client's position under the rules of the adversary system. As negotiator, a lawyer seeks a result advantageous to the client but consistent with requirements of honest dealing with others. As intermediary between clients, a lawyer seeks to reconcile their divergent interests as an advisor and, to a limited extent, as a spokesperson for each client. A lawyer acts as evaluator by examining a client's legal affairs and reporting about them to the client or to others.

In all professional functions a lawyer should be competent, prompt and diligent. A lawyer should maintain communication with a client concerning the representation. A lawyer should maintain communication with a client concerning the representation. A lawyer should keep in confidence information relating to representation of a client except so far as disclosure is required or permitted by the Rules of Professional Conduct or other law.

A lawyer's conduct should conform to the requirements of the law, both in professional service to clients and in the lawyer's business and personal affairs. A lawyer should use the law's procedures only for legitimate purposes and not to harass or intimidate others. A lawyer should demonstrate respect for the legal system and for those who serve it, including judges, other lawyers and public officials. While it is a lawyer's duty to uphold legal process.

As a public citizen, a lawyer should seek improvement of the law, the administration of justice and the quality of service rendered by the legal profession. As a member of a learned profession, a lawyer should cultivate knowledge of the law beyond its use for clients, employ that knowledge in reform of the law and work to strengthen legal education. A lawyer should be mindful of deficiencies in the administration of justice and of the fact that the poor, and sometimes persons who are not poor, cannot afford adequate legal assistance, and should therefore devote professional time and civil influence in their behalf. A lawyer should aid the legal profession in pursuing these objectives and should help the bar regulate itself in the public interest.

Many of a lawyer's professional responsibilities are prescribed in the Rules of Professional Conduct, as well as substantive and procedural law. However, a lawyer is also

guided by personal conscience and the approbation of professional peers. A lawyer should strive to attain the highest level of skill, to improve the law and the legal profession and to exemplify the legal profession's ideals of public service.

A lawyer's responsibilities as a representative of clients, an officer of the legal system and a public citizen are usually harmonious. Thus, when an opposing party is well represented, a lawyer can be a zealous advocate on behalf of a client and at the same time assume that justice is being done. So also, a lawyer can be sure that preserving client confidences ordinarily serves the public interest because people are more likely to seek legal advice, and thereby heed their legal obligations, when they know their communications will be private.

In the nature of law practice, however, conflicting responsibilities are encountered. Virtually all difficult ethical problems arise from conflict between a lawyer's responsibilities to clients, to the legal system and to the lawyer's own interest in remaining an upright person while earning a satisfactory living. The Rules of Professional Conduct prescribe terms for resolving such conflicts. Within the framework of these Rules many difficult issues of professional discretion can arise. Such issues must be resolved through the exercise of sensitive professional and moral judgment guided by the basic principles underlying the Rules.

The legal profession is largely self-governing. Although other professions also have been granted powers of self-government, the legal profession is unique in this respect because of the close relationship between the profession and the process of government and law enforcement. This connection is manifested in the fact that ultimate authority over the legal profession is vested largely in the courts.

To the extent that lawyers meet the obligations of their professional calling, the occasion for government regulation is obviated. Self-regulation also helps maintain the legal profession's independence from government domination. An independent legal profession is an important force in preserving government under law, for abuse of legal authority is more readily challenged by a profession whose members are not dependent on government for the right to practice.

The legal profession's relative autonomy carries with it special responsibilities of self-government. The profession has a responsibility to assure that its regulations are conceived in the public interest and not in furtherance of parochial or self-interested concerns of the bar. Every lawyer is responsible for observance of the Rules of Professional Conduct. A lawyer should also aid in securing their observance by other lawyers. Neglect of these

responsibilities compromises the independence of the profession and the public interest which it serves.

Lawyers play a vital role in the preservation of society. The fulfillment of this role requires an understanding by lawyers of their relationship to our legal system. The Rules of Professional Conduct, when properly applied, serve to define that relationship. (Gorlin, 1990, pp. 335-336)

APPENDIX D

ETHICAL PRINCIPLES OF PSYCHOLOGISTS

Preamble

Psychologists respect the dignity and worth of the individual and strive for the preservation and protection of fundamental human rights. They are committed to increasing knowledge of human behavior and of people's understanding of themselves and others and to the utilization of such knowledge for the promotion of human welfare. While pursuing these objectives, they make every effort to protect the welfare of those who seek their services and of the research participants that may be the objective of study. They use their skills only for purposes consistent with these values and do not knowingly permit their misuse by others. While demanding for themselves freedom of inquiry and communication, psychologists accept the responsibility this freedom requires: competence, objectivity in the application of skills, and concern for the best interests of clients, colleagues, students, research participants, and society. In the pursuit of these ideals, psychologists subscribe to principles in the following areas: 1. Responsibility, 2. Competence, 3. Moral and Legal Standards, 4. Public Statements, 5. Confidentiality, 6. Welfare of the Consumer, 7. Professional Relationships, 8. Assessment Techniques, 9. Research With Human Participants, and 10. Care and Use of Animals.

Acceptance of membership in the American Psychological Association commits the member to adherence to these principles.

Psychologists cooperate with duly constituted committees of the American Psychological Association in particular, the Committee on Scientific and Professional Ethics and Conduct, by responding to inquiries from duly constituted state association ethics committees and professional standards review committees. (Gorlin, 1990, pp. 247)

APPENDIX E

QUESTIONNAIRE

Demographic Information

01. What is your current age?
    a. <30 years b. 30-49 c. 40-49 d. 50-59 e. 60-69
    f. >70 years

02. What is your sex?
    a. female
    b. male

03. What is the current range of your annual salary? (Do not include your spouse or significant other).
    a. <20,000 b. 21-30,000 c. 31-40,000 d. 41-50,000
    e. 51-60,000 f. >61,000

04. What is your ethnic race?
    a. Caucasian b. Hispanic c. Black d. Asian
    e. Native American f. Indian g. other

05. Which postgraduate degrees do you hold? (Check all that apply.)
    a. PhD of Psychology
    b. PhD
    c. J.D.
    d. M.D. of Psychiatry
    e. M.D./D.O.
    f. R.N./M.S.N.
    g. M.A./M.S.
    h. other grad degree (Please specify)_____

What percentage of your occupational role is typically expended in each of the following areas?

06. patient/client care
    a. 0% b. 01-25% c. 26-50% d. 51-75% e. 76-100%
07. education
    a. 0% b. 01-25% c. 26-50% d. 51-75% e. 76-100%
08. research
    a. 0% b. 01-25% c. 26-50% d. 51-75% e. 76-100%
09. administration
    a. 0% b. 01-25% c. 26-50% d. 51-75% e. 76-100%
10. other
    a. 0% b. 01-25% c. 26-50% d. 51-75% e. 76-100%

What percentage of your occupational role related to ethics is typically expended in each of the following areas?

11. case consultation
    a. 0% b. 01-25% c. 26-50% d. 51-75% e. 76-100%
12. education
    a. 0% b. 01-25% c. 26-50% d. 51-75% e. 76-100%
13. research
    a. 0% b. 01-25% c. 26-50% d. 51-75% e. 76-100%
14. administration
    a. 0% b. 01-25% c. 26-50% d. 51-75% e. 76-100%
15. other
    a. 0% b. 01-25% c. 26-50% d. 51-75% e. 76-100%

How long have you been professionally engaged in our current profession? (Choose only the one that applies to your current profession.)

16. attorney
    a. <1 year b. 1-5 years c. 6-10 years d. 11-15 years
    e. 16-20 years f. >21 years

17. psychiatrist
    a. <1 year b. 1-5 years c. 6-10 years d. 11-15 years
    e. 16-20 years f. >21 years

18. other physician
    a. <1 year b. 1-5 years c. 6-10 years d. 11-15 years
    e. 16-20 years f. >21 years

19. What is your personal religious affiliation now?
    a. Catholic
    b. Protestant
    c. other Christian (specify)_____
    d. Jewish
    e. Buddhist
    f. Islamic
    g. atheist
    h. other (specify)_____
    i. none

20. How often do you currently meditate, pray, or otherwise observe religious rituals and services?
    a. daily
    b. once/wk
    c. once/month
    d. religious holidays
    e. rarely or never

21. Please rate the personal importance of religion in your life now, with 1 being "religion is not important to me" and 5 being "religion is very important to me".
    a. 1
    b. 2
    c. 3
    d. 4
    e. 5

22. How important a role does spiritual faith play in your life?
    a. unimportant
    b. somewhat important
    c. important
    d. very important

23. How often do you attend a worship service?
    a. at least twice weekly
    b. at least once weekly
    c. once a month
    d. once a year
    e. never

Daily Spiritual Experience

The following items deal with possible spiritual experiences. To what extent can you say you experience the following? Circle the appropriate one.

1. I feel God's presence.
   1-Many times a day 2-Every day 3-Most days
   4-Some days 5-Once in awhile
   6-Never or almost never

2. I find strength and comfort in my religion.
   1-Many times a day 2-Every day 3-Most days
   4-Some days 5-Once in awhile
   6-Never or almost never

3. I feel deep inner peace or harmony.
   1-Many times a day 2-Every day 3-Most days
   4-Some days 5-Once in awhile
   6-Never or almost never

4. I feel God's love for me, directly or through others.
   1-Many times a day 2-Every day 3-Most days
   4-Some days 5-Once in awhile
   6-Never or almost never

5. I am spiritually touched by the beauty of creation.
   1-Many times a day 2-Every day 3-Most days
   4-Some days 5-Once in awhile
   6-Never or almost never.

Faith Interview

Write a short, but descriptive answer of the following two questions. Please give reasons to explain your answers.

1. What does it mean to be religious?

2. Do you regard yourself as religious?

The Wellness Index

For each of the following statements subjects were asked to circle the choice that best indicated the extent of their agreement or disagreement based upon their personal experience:

SA = Strongly Agree
MA = Moderately Agree
A = Agree
D = Disagree
MD = Moderately Disagree
SD = Strongly Disagree

Physical Health

1. I exercise or participate in vigorous activities regularly (at least 3 times per week).
2. I need medical care or treatment beyond what I am receiving at the present time.
3. I am in good health.
4. I suffer from shortness of breath.
5. I need supportive or prosthetic aids or devices (cane, brace, walker, etc.).
6. My present state of health permits me to do the things I want to do.
7. I have persistent aches and pains.
8. I am well rested.
9. I have major medical problems.
10. I am physically strong.
11. I feel healthy most of the time.
12. I have good nutritional (dietary) habits.

Morale

1. I am seldom lonely.
2. Every day is the same to me.
3. I am weak and useless.
4. There are certain things that I love to do.
5. I keep myself in good appearance.
6. I often feel unhappy because of the actions of others toward me.
7. I am old and feel it.
8. I like doing new and interesting things.
9. I am happy.
10. It makes sense to plan ahead for next week.

11. I could be much happier than I am.

12. I generally am alert enough to know what is happening around me.

13. I get fun out of life.

14. Most people are by nature selfish.

15. I am a real burden.

16. I look forward to the events of each day.

17. I feel I am an important person.

18. Sometimes I think there is no purpose in going on.

19. I generally have little to do each day.

20. To some people, I am an important person.

Economic Resources

1. My financial resources are sufficient to meet my current needs.

2. My financial resources are sufficient to meet most emergencies.

3. I feel I have enough money to meet my needs in the future.

4. I have enough money to buy those little "extras"-those small luxuries.

5. My social life is affected by my lack of financial resources.

6. I need financial assistance.

7. There are many things I would like to buy but cannot afford.

8. When I need money in an emergency, there is a place where I can get it.

9. I am doing well financially.

10. My financial resources take care of my needs very well.

Religiosity

1. I lead an active prayer life.

2. I read the Bible (Koran, etc.) regularly.

3. I often read devotional and other religious writings.

4. I have a satisfying meditation life.

5. I lead a religious life (Christian, Jewish, Hindu, Buddhist, etc.).

6. I strongly feel my need of God.

7. I often concentrate my attention to God.

8. I often concentrate my attention on the doing of God's will.

9. I often participate in religious or spiritual activities.

10. I am willing to endure ridicule for my beliefs and values.

11. I intentionally strive to have the right relationship with others.

External, Internal, and Quest Scales
of the Religious Life Inventory

For each of the following statements subjects were asked to circle the choice that best indicated the extent of their agreement or disagreement based upon their personal experience:

SA = Strongly Agree
A = Agree
MD = Moderately Disagree
MA = Moderately Agree
D = Disagree
SD = Strongly Disagree

External Scale

1. The church has been very important for my religious development.(1)[a]

2. My minister (or youth director, camp counselor, etc.) has had a profound influence on my personal religious development. (7)

3. A major factor in my religious development has been the importance of religion for my parents. (15)

4. My religion serves to satisfy needs for fellowship and security. (21)

5. Certain people have served as "models" for my religious development. (26)

6. (-) Outside forces (other persons, church, etc.) have been relatively unimportant in my religious development. (34)[b]

Internal Scale

1. My religious development is a natural response to our innate need for devotion to God. (4)

2. God's will should shape my life. (9)

3. It is necessary for me to have a religious belief. (12)

4. When it comes to religious questions, I feel driven to know the truth. (13)

5. (-) Religion is something I have never felt personally compelled to consider. (18)

6. (-) Whether I turn out to be religious or not doesn't make much difference to me. (24)

7. I have found it essential to have faith. (28)

8. I find it impossible to conceive of myself not being religious. (31)

9. (-) For me, religion has not been a "must." (35)

---

[a] The number in parentheses indicates where the item appears among the thirty-five items on the Religious Life Inventory. All items are responded to on a nine-point scale from strongly disagree (1) to strongly agree (9).

[b] A minus sign preceding an item indicates that it is reversed in scoring (i.e., the number circled is subtracted from 10).

Quest scale

1. As I grow and change, I expect my religion also to grow and change. (3)

2. I am constantly questioning my religious beliefs. (5)

3. It might be said that I value my religious doubts and uncertainties. (6)

4. I was not very interested in religion until I began to ask questions about the meaning and purpose of my life. (8)

5. For me, doubting is an important part of what it means to be religious. (11)

6. (-) I do not expect my religious convictions to change in the next few years. (16)

7. (-) I find religious doubts upsetting. (17)

8. I have been driven to ask religious questions out of a growing awareness of the tensions in my world and in my relations to my world. (20)

9. My life experiences have led me to rethink my religious convictions. (25)

10. There are many religious issues on which my views are still changing. (27)

11. God wasn't very important for me until I began to ask questions about the meaning of my own life. (30)

12. Questions are far more central to my religious experience than are answers. (33)

Unscored buffer items

1. Worldly events cannot affect the eternal truths of my religion. (2)

2. On religious issues, I find the opinions of others irrelevant. (10)

3. I find my everyday experiences severely test my religious convictions. (14)

4. My religious development has emerged out of my growing sense of personal identity. (22)
5. My religion is a personal matter, independent of the influence of organized religion. (23)

6. It is important for me to learn about religion from those who know more about it than I do. (29)

7. The "me" of a few years back would be surprised at my present religious stance. (32)

8. I have found it essential to have faith. (19)

Spiritual Well-Being Scale[a]

Subjects were asked to circle the choice that best indicated the extent of their agreement or disagreement based upon their personal experience:

SA = Strongly Agree	MA = Moderately Agree
A = Agree	D = Disagree
MD = Moderately Disagree	SD = Strongly Disagree

1. I don't find much satisfaction in private prayer with God.
2. I don't know who I am, where I came from, or where I'm going.
3. I believe that God loves me and cares about me.
4. I feel that life is a positive experience.
5. I believe that God is impersonal and not interested in my daily situations.
6. I feel unsettled about my future.
7. I have a personally meaningful relationship with God.
8. I feel very fulfilled and satisfied with life.
9. I don't get much personal strength and support from God.
10. I feel a sense of well-being about the direction my life is headed in.
11. I believe that God is concerned about my problems.
12. I don't enjoy much about life.
13. I don't have a personally satisfying relationship with God.
14. I feel good about my future.
15. My relationship with God helps me not to feel lonely.
16. I feel that life is full of conflict and unhappiness.
17. I feel most fulfilled when I'm in close communion with God.
18. Life doesn't have much meaning.
19. My relation with God contributes to my sense of well-being.
20. I believe there is some real purpose for my life.

[a] Items are scored form 1 to 6, with a higher number representing more well-being. Reverse scoring for negatively worded items. Odd-numbered items assess religious well-being; even-numbered items assess existential well-being.

OPINIONS ABOUT SOCIAL PROBLEMS

In this questionnaire you will be asked to give your opinions about several stories. Here is a story as an example.

Frank Jones has been thinking about buying a car. He is married, has two small children and earns an average income. The car he buys will be his family's only car. It will be used mostly to get to work and drive around town, but sometimes for vacation trips also. In trying to decide what car to buy, Frank Jones realized that there were a lot of questions to consider. Below there is a list of some of these questions.

If you were Frank Jones, how important would each of these questions be in deciding what car to buy?

Instructions for Part A: (Sample Question)
On the left hand side check one of the spaces by each statement of a consideration. (For instance, if you think that statement #1 is not important in making a decision about buying a car, check the space on the right.)

IMPORTANCE:

Great	Much	Some	Little	No	
				√	1. Whether the car dealer was in the same block as where Frank lives. (Note that in this sample, the person taking the questionnaire did not think this was important in making a decision.)
√					2. Would a used car be more economical in the long run than a new car. (Note that a check was put in the far left space to indicate the opinion that this is an important issue in making a decision about buying a car.)
		√			3. Whether the color was green, Frank's favorite color.
				√	4. Whether the cubic inch displacement was at least 200. (Note that if you are unsure about what "cubic inch displacement" means, then mark it "no importance.")
√					5. Would a large, roomy car be better than a compact car?
				√	6. Whether the front connibilies were differential. (Note that if a statement sounds like gibberish or nonsense to you, mark it "no importance.")

Instructions for Part B: (Sample Question)
From the list of questions above, select the most important one of the whole group. Put the number of the most important question on the top line below. Do likewise for your 2nd, 3rd, and 4th most important choices. (Note that the top choices in this case will come from the statements that were checked on the far left-hand side---statements #2 and #5 were thought to be very important. In deciding what is the most important, a person would re-read #2 and #5, and then pick one of them as the most important, then put the other one as "second most important," and so on.)

MOST	SECOND MOST IMPORTANT	THIRD MOST IMPORTANT	FOURTH MOST IMPORTANT
5	2	3	1