

UNDERSTANDING ETHICAL DECISION-MAKING IN MARRIAGE AND FAMILY THERAPY: AN  
ONTOLOGICAL HERMENEUTIC ANALYSIS

by

ROBYN L. MOWERY

(Under the Direction of Jerry Gale)

ABSTRACT

Using Gadamer's ontological hermeneutics as a theoretical and methodological framework, this project explored new ways of understanding ethical decision-making as discussed in five top marriage and family therapy (MFT) journals from 1984 to 2004. Despite the field's commitment to maintaining the highest ethical standards, only 13 articles were identified as explicitly focused on ethical decision-making *processes*. Although there is a plethora of articles identifying what is and is not considered ethical behavior in the MFT literature, few authors articulate the reasoning processes they used or would recommend in reaching these considered judgments. Thus, MFT practitioners have scarce guidance available for evaluating and weighing conflicting moral features when faced with ethical dilemmas.

An extensive overview of ethical theory based on the moral philosophical literature is provided. This review includes discussion of meta-ethics, normative ethics (i.e., classical western, feminist, and post-modern approaches), and applied ethics (i.e., medical ethics, specifically the work of Beauchamp and Childress, 1979, 2001, and Graber and Thomasma, 1989, in press). Strengths and weaknesses of ethical decision-making models found in the extant psychotherapy literature are discussed, with particular attention given to the seminal work of Karen Kitchener (1984).

Based on the understanding of ethical decision-making generated by in-depth exposure to these larger bodies of ethics literature (i.e., moral philosophy and medical ethics), the text from 13 MFT journal articles were deductively and inductively analyzed using an ontological hermeneutic approach. Results suggested that professional discourse to date about ethical decision-making processes in MFT is extremely scarce and fragmented, but that incorporating a broader understanding of ethical theory, and particularly the methods of ethical analysis presented by Graber and Thomasma (in press) offer substantial possibilities for more coherent, rigorous, and systemic approaches to ethical decision-making in MFT. Extensive discussion of the implications of and recommendations for implementing a new paradigm for MFT ethics is presented.

Throughout this project, considerable attention is given to philosophy of science considerations raised by the use of Gadamer's attempt (via ontological hermeneutics) to forge a middle path between modernist and post-modernist views of social science. Philosophical and scientific limitations of this project are acknowledged.

INDEX WORDS: Applied Ethics, Ethical Decision-Making, Ethical Theory, Ethics, Hermeneutics, Marriage and Family Therapy, Medical Ethics, Moral Philosophy, Ontological Hermeneutics, Text Analysis

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by

ROBYN L. MOWERY

B.A., New College of the University of South Florida, 1990

M.S., Colorado State University, 1997

A Dissertation Submitted to the Graduate Faculty of The University of Georgia in Partial Fulfillment of  
the Requirements for the Degree

DOCTOR OF PHILOSOPHY

ATHENS, GEORGIA

2004

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by

ROBYN L. MOWERY

Major Professor: Jerry Gale

Committee: William C. Nichols  
Lynda H. Walters  
David Wright

Electronic Version Approved:

Maureen Grasso  
Dean of the Graduate School  
The University of Georgia  
December 2004

## DEDICATION

This dissertation is dedicated to the glory and honor of my lord and savior, Jesus Christ, for knowing me better than I know myself, whose idea it was in the first place for me to return to graduate school for my doctorate, and whose Holy Spirit guided and sustained me throughout this adventure.

## ACKNOWLEDGEMENTS

Two people, above all, made this dissertation and the completion of my doctorate possible: Jerry Gale and Lynda Walters, who functioned as unofficial co-major professors throughout my program, even as they each took an official turn. My thanks go out to them for investing so completely in me with their time, wisdom, patience, encouragement, humor, and vision of how I could contribute to others. I could not have received better mentoring. The other two members of my doctoral committee, David Wright and Bill Nichols, have also strengthened me with their time and enthusiasm for this project, and I am grateful. Thanks too belong to Diane Adams, Jackie Chastain, Chas Moody, and Kanen Clement for their administrative and computer heroics.

Dean Sharon Nickols and the American Association of Family and Consumer Sciences have my deepest respect and earnest appreciation for their investment of time and funding, without which I would not have been able to pursue the many interdisciplinary opportunities that became foundational to my scholarship. I am grateful, also to John Hardwig and Glenn Graber for reaching out across disciplinary boundaries so I could learn about ethics from experts.

Finally, I would not have made it through the graduate school gauntlet were it not for the community of believers at St. James United Methodist Church in Athens, GA. Words cannot express the privilege I feel for having gotten to participate in God's kingdom on earth with you all, but most especially with members of the praise team and the prayer ministry. Likewise, I am grateful for the love, patience and support of my immediate family, most especially for Dad and Aunt Brenda; and for the sustaining grace of the many friends, who know who they are.

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## CHAPTER ONE: INTRODUCTION

*Often when I tell others that I am pursuing an area of specialization related to ethics as part of my degree in marriage and family therapy, I get one of two responses: “Oh! That’s really needed!” or else, “Oh...?” The latter reaction is usually accompanied by a look suggesting, “What could possibly be interesting about just following rules” (Mowery, 2002)?!*

*To consider ethics as a critically reflective morality highlights the fact that ethics is a process of thinking, not a set of established answers which need only be passively accepted. This conception views ethics as a method of discovery and not as a body of knowledge. Ethics does not consist in knowing the answers but instead in knowing how to inquire; in particular, in knowing what counts as a possible answer, what questions are appropriate and constructive ones to ask, what tendencies in one’s own thinking need to be kept in check, et cetera (Card, 2002, p. 20).*

### Orienting Remarks

The purpose of this investigation is to use a hermeneutic perspective to explore the way(s) in which we talk about and understand ethical decision-making in the field of marriage and family therapy (MFT). As will be made progressively clearer, the assumptions inherent in the hermeneutic (i.e., interpretivist) framework being used here form an alternative conceptualization of traditional social sciences research purposes and practices. Understanding—both everyday and scientific—from this viewpoint, is seen to develop cyclically such that new information is perpetually explored in light of previous interpretations, which then produces new information to again be investigated and re-interpreted (a process referred to as the *hermeneutic circle*). As a result, the image of a spiral is better suited for conceptualizing and reporting hermeneutic inquiry than the linear progression of classical investigations.

In keeping with the hermeneutic notion that all inquiry begins in the middle of an on-going dialogue between what is already familiar to us and what lies before us yet to be understood, this project is part of an on-going engagement of ideas I have been having between moral philosophy and MFT ethics. These sorts of hermeneutic investigations ideally “end” with as many or more questions propelling the conversation than with which they “began.” The goal of the current endeavor, therefore, is

to offer *an interpretation* leading to deeper understanding of MFT ethical decision-making; there is no claim to a *definitive* description or explanation. Following a brief presentation of the evolution of my interests in and understanding of MFT ethics as I start this study, this paper can be roughly divided into two sections. Part one contains important contextual and background information for my overt engagement with the hermeneutic process as recorded in part two.

*“We’re not in Kansas anymore, Toto!” —Current thoughts about MFT Ethics*

My formal foray into the study of ethics began in earnest five years ago during the first semester of my doctoral program in marriage and family therapy. During the process of writing a paper on ethics for a sex therapy class, I ventured into the medical ethics literature. It was there that I discovered the existence of ethical theory and moral philosophy. “Why had I not heard of this in my MFT ethics class during my masters program?” My ethics training had largely consisted of becoming familiar with the AAMFT Code of Ethics, and learning legal risk management strategies. Reading about ethical theory and moral philosophy, I felt like Dorothy in the movie “The Wizard of Oz,” stepping out of the black and white world of Kansas (with lists of ethical do’s and don’ts) into the Technicolor world of Oz (with centuries of philosophical reflection representing the multitude of shades inherent in moral life).

Though often overwhelmed by the vastness and complexity of moral philosophy, the more I read the more intrigued I became by the possibilities opened by ethical theory for thinking and talking about MFT ethics in ways not possible with a strict focus on a code of ethics and legal liabilities. Reading about ethics like this facilitated, too, a new understanding of my clinical work during the previous nine years. I had not ever thought about it as such, but I had been engaging in ethical decision-making with my clients throughout my career. While working in foster care, I was often responsible for writing letters of recommendation to the magistrate answering the question, “What is in the best interest of the child? In my work with hospice, terminally ill patients, their families, and I pondered together, “How does one finish living well?” In providing pregnancy counseling and open adoption services, clients and I wrestled with the question, “How does one plan for the life of another?” MFT ethics, I realized, did not just

involve decisions made by professionals about the process of therapy, but was intimately woven into the fabric of therapy content as well.

I had been trained to see clinical services in emotional, psychological, familial, social, and even legal terms, not moral. Ethical theory gave me the language needed to recognize the extent to which moral and ethical issues like these pervade therapy. My independent reading of moral philosophy motivated me to seek an internship related to medical ethics, for clinical medical ethics tends to provide the groundwork for ethics in other helping professions. For nine months, I had the opportunity to participate in a graduate training program for medical ethicists, housed in a department of philosophy. There I discovered many similarities and differences between how professional ethicists are educated to reason ethically and how I was trained as a family therapist to think about ethics.

So how have my studies of moral philosophy shaped my understanding of MFT ethics thus far? Quite simply, I believe that as human beings we have an obligation to reflect on the quality of our interactions with others so that we may adjust our actions to maximize “the good.” There is a sacred trust by clients that therapists will help guide them in (or co-create) “good” directions. As professional helpers, I believe, therefore, it is especially incumbent upon therapists to reflect on the moral nature of our interactions with clients. While the myth of therapist neutrality has largely been debunked, I contend that it is not enough simply to *acknowledge* that we have values, we must be able to *account* for them and the impact they will necessarily have on the therapy process.

Due to the historical emphasis on therapist neutrality, it appears we have effectively stripped moral language from our professional discourse. Justifying beliefs has traditionally been the realm of philosophy, not therapy; yet just as we are being called upon to justify our treatment models empirically, so must we philosophically substantiate our ethical ideals and standards. I believe that developing a more sophisticated understanding of the interface between therapy and morality is an important developmental task for the maturation of the field of Marriage and Family Therapy. Just as people ideally develop more complex ways of moral reasoning, eventually moving beyond lists of do’s and don’ts out of fear of external sanctioning, so must the MFT profession expand beyond its ostensible primary reliance on a

legal perspective for its understanding of ethics. While it is hoped that ethics and the law have substantial overlap, the two must be distinct; otherwise, we have no recourse for detecting and abolishing immoral laws and we lose important freedom of discretion if every action must be regulated.

What then, do I bring to this discussion? I am a single, heterosexual, white female in my mid-thirties. Growing up an “army brat” and the third of five siblings, I have lived in seven different states in the eastern United States as well as Colorado. My parents were both reared in middle class families in East Tennessee with southern Appalachian values. Higher education is pervasive in my extended family; this seems to have had a moderating effect on the narrow mindedness sometimes found in that region. While not reared with overtly racist or sexist ideology, my understanding of my gender and the privilege that goes with my whiteness has increased in the last few years. Also, while not brought up in the church, as an adult, I am very committed to reflecting carefully on the teachings of Jesus Christ as a foundational guide in my life.

As for an epistemological framework, I have come to the conclusion that I can vacation in a post-modern world, but cannot live there. I am grateful to the increased sensitivity wrought by the critical activities of deconstructivists, feminists, and social constructivists. I take their critiques very seriously; for indeed, much damage has been done by the reification of concepts related to human interaction. Yet I do not believe that everything is purely contextual, though much is. I also do not believe that all positions are relative and equally valid; nor should they be. (For instance, as a therapist, I cannot condone pedophilia.). I contend we have limits imposed upon us biologically and morally. While I agree that much of our social functioning is gendered and socially constructed, I do believe that fundamental truths are accessible, though our understanding of these truths is necessarily limited by our humanity. In short, as I have begun to quip, I am a philosopher trapped in a therapist’s body. I tend to be too philosophical for many therapists and too pragmatic for many philosophers. I seek reflection that informs action that promotes “the good.” Aristotle would approve, I think, as I quest for what he terms *praxis*, or practical wisdom, which is the goal, as he understood it, of all knowledge.

## Ethical Ambivalence

Attention is increasingly being given to the fundamental moral and ethical nature of therapy (Becvar, 2001; Doherty & Boss, 1991; Doherty, 1995; Richardson, Fowers & Guignon, 1999; Tejelveit, 1999). Values about how a society believes people should or should not behave are evident in those phenomena that society defines as good or bad, right or wrong, healthy or pathological. Therapists and clients, like all members of society, come equipped with these sorts of personal beliefs and value systems, the intersection of which creates a nexus around which therapy discussions revolve (Becvar, 2001). Rieff (1966) and Wolfe (1989) noted that twentieth century social scientists and psychotherapists have largely replaced philosophers and priests in the public charge to provide moral wisdom and guidance. Yet we are highly ambivalent about whether it is even appropriate to reason together about the moral ideals that set our priorities and define our way of life, preferring instead, technical solutions, individual preferences or democratic (i.e., majority-rules) decision-making (Richardson, Fowers, & Guignon, 1999).

Habermas (1973), Horkheimer (1974), and others have observed that as we grow in technological capacity, we seem to diminish in wisdom. “The more we dedicate ourselves to gaining control over nature and some social processes, the less we seem able to reflect meaningfully about the ends or goals we should be pursuing, or are really worth pursuing” (Richardson & Fowers, 1998, paragraph 5). Critics from within modern psychotherapy (Cushman, 1995; Fancher, 1995; Frank, 1978; Hillman & Ventura, 1992; Richardson, Fowers & Guignon, 1999) express similar concerns about the helping professions, suggesting that there is a dearth of reflective attention being given to the *ends* of therapy, even as there is increased effort (empirical and theoretical) to establishing the efficacy and effectiveness of the *means* to those under-examined ends (Richardson, & Fowers, 1998).

Habermas (1973) further contends that modern society is largely built upon a misunderstanding of what constitutes practical wisdom (i.e., *praxis*), such that *techne*, or technical capacity, is seen as the goal of knowledge rather than wisdom in living. “This kind of society tends to collapse the cultural and moral dimensions of life into merely technical and instrumental considerations” (Richardson, Fowers, & Guignon, 1999, pp. 183). Similarly, Kane (1998), a philosopher of science, describes the modern age as

characterized by the dissociation of theory and practice, fact and value, explanation and purpose, as well as many other contrasts which in ancient times were all intricately merged together in the pursuit of wisdom. The sciences, including the social sciences, have taken over the quest for the first of these sundered contrasts—theoretical inquiry, fact and explanation—to the neglect of the second set of ingredients required in the ancient view of wisdom—value, purpose, and the practical search for how to live—which are now dismissed as “subjective” or “relative” (Kane, 1998).

In diagnosing our confusion and ambivalence concerning the place of moral values and ethical deliberation in how we conduct our lives, Alasdair MacIntyre (1981), in his widely influential work, *After Virtue*, assessed modern liberal democracies in general as being morally fragmented. He observed that we have inherited splinters of moral traditions rather than cohesive systems of moral guidance, leaving us bereft of adequate tools for moral reasoning and dialogue, especially about valued ends or aspirational goals. As a result, MacIntyre suggests, when we cannot agree on moral content, we default into a reliance on procedural justice and legal discourse.

Yet, as the moral nature of psychotherapy is increasingly recognized, we become aware that therapists and clients are already always making moral and ethical decisions (Tejelweit, 1999). How, then, in a morally fragmented society, do we make sense of these decisions and the process or processes we use to make them? How do we and how can we, as marriage and family therapists (MFTs), understand what it means for us to engage in ethical decision-making? What makes such understanding possible? How do we have conversations about what constitute right or wrong choices, ethical or unethical conduct as therapists, especially in ambiguous situations? In sum, within the field of marriage and family therapy, *how* is ethical-decision-making understood and enacted? These are the types of questions that guide the present inquiry. The goal is neither causal explanation, nor even description in the traditional “objective” sense, but rather, as will be defined later, increased “understanding.”

#### The ‘Who,’ ‘What,’ and ‘How’ of Ethics

Figley and Nelson (1989) conducted an empirical study delineating the most important basic skills for beginning family therapists. Of the top one hundred skills ranked by a pool of experienced MFT

educators/trainers, the first three had to do with ethics. Therapists need to be: (a) familiar with *what* the normative expectations of the profession are as laid out in AAMFT's Code of Ethics (i.e., "knowing the ethics of the profession;" ranked third); (b) able to discern *how* to comply with those standards through ethical reasoning and decision-making (i.e., "observing professional ethics;" ranked first); and (c) persons of character *who* reflect upon their ethical choices and are invested in making and acting on the best possible decisions (i.e., "possessing integrity;" ranked second).

One may reasonably wonder, then, 'How is the profession facilitating the development of these three most important skills?' Mowery and Gale (2002) conducted a preliminary content and theme analysis of titles and abstracts from 354 articles from nine MFT journals published between 1989 and 2002. Articles were identified by searching electronic databases using the key terms: ethics, legal, moral, values, spirituality and religion. Results suggested that as a field we do not appear to have an integrated, coherent way of talking about ethics, that we use the same word to mean different things and different words to mean the same thing. While it is assumed that the field of MFT is replete with persons of upstanding moral character (skill #2), it may be that the lack of a reliable means of talking about ethics hampers coherent reflective discussion in the literature about issues related to professional integrity. While numerous articles discussed what behaviors are deemed ethical (skill #3), little discussion was included regarding how one could or should arrive at such considered judgments in practice (skill #1).

In short, while there are many articles related to ethics, morals, values, legalities, and spirituality being published, few articulate underlying rationales or specific tools for decision-making when faced with tough moral choices, in spite of the fact that this was ranked first on Figley and Nelson's (1989) empirically derived list. It is also disconcerting in light of research by the Josephson Institution of Ethics (1996) which has shown that there tends to be a large gap between what we claim as important ethical values and our actual behaviors.

Doherty (1995) suggests that we have stripped from therapeutic conversation, the language of moral and ethical discourse, replacing it instead with words such as "appropriate/inappropriate" or



“functional/dysfunctional” (versus “right/wrong” or “good/bad”). Because we lack the practice thinking and working in terms of everyday ethical/moral decision-making, it has become invisible to us. Ethics in marriage and family therapy has, to a large degree, been relegated to mere adherence to or violation of our professional code (Doherty, 1995).

When we discuss ‘ethical issues,’ we are usually speaking about following rules of conduct and avoiding ethical or legal trouble. This narrow focus is partly a matter of having too many difficult cases to discuss clinically and too little time. But more important, therapists have lacked the consciousness that moral conversation pervades psychotherapy, and that it behooves us to become better at what we have been doing unwittingly all along (Doherty, 1995, p. 18).

Kitchener (2000), a psychologist who strives to comprehensively address ethical reasoning and practice in psychotherapy, echoes Doherty’s concerns. She notes that behaving ethically involves more than applying ethical rules or making ethical decisions. “Current psychological models of moral behavior (Rest, 1994) suggest that sensitivity to ethical issues, moral motivation, and ego-strength are all critical. Principle- and rule-bound ethical strategies are incomplete” (p. xii). Accordingly, Kitchener (2000) has expanded her previous work on models of ethical decision-making (1984, 1986) to include the importance of the development of ethical virtues and character to support ethical behaviors. Kitchener’s recent work is consistent with Doherty’s (1995) focus on the moral character of the therapist, and with Figley and Nelson’s (1989) ranking of “possessing integrity” as the second most important skill needed by beginning marriage and family therapists.

Another method for assessing the field’s facilitation of the top three skills noted by Figley and Nelson (1989) is to consider the nature of reading material in MFT training programs. Ratliff and Ambrose (1997) surveyed five programs in Texas accredited through the American Association for Marriage and Family Therapy (AAMFT) and looked at the textbooks used across the MFT curriculum. Huber and Baruth’s (1987) book, *Ethical, legal, and professional issues in the practice of marriage and*

*family therapy*, was cited most frequently for use in meeting the COAMFTE accreditation standards for ethics and professional issues. This was consistent with Harris' (1995) survey of ethics course syllabi across the country, who noted that the first edition of the Huber text (Huber and Baruth, 1987) and Vesper and Brock's (1991) book, *Ethics, legalities, and professional practice issues in marriage and family therapy*, were the most preferred texts. Huber's (1999) second edition text is similar to the first edition in that while it briefly mentions the "who" of ethics with its discussion of virtue ethics, and the "how" of ethical decision-making with reference to Kitchner's (1984a, 1984b, and 1986) model for counseling psychologists in the first 12 pages of the text, the remainder of the book focuses on the "what" from both a systems and legal perspective.

More recent publications by AAMFT such as the *User's guide to the AAMFT Code of Ethics* (AAMFT, 2001) and *Ethics in marriage and family therapy* (Woody & Woody, 2001), replicate this pattern of focusing more on what than who or how. Though increased attention to who and how are apparent in these texts compared to earlier publications, their ratios to what remain skewed. The *User's guide* presents the AAMFT Code of ethics broken down by principles and sub-principles, and vignettes are discussed with the apparent goal of illuminating the "true meaning" of each principle. Though this issue will be discussed in depth later, it is relevant to highlight now that there is an implicit decision-making strategy being employed in this text, namely casuistry (i.e., case study reasoning) that imports a number of assumptions neither overtly articulated, nor justified. Woody and Woody (2001) also fail to provide rationales or justifications (including strengths and weaknesses) for the reasoning processes they advocate in their abbreviated review of ethical decision-making models. Furthermore, it is interesting to note that, with one exception (i.e., Woody, 1990) all of the models reviewed have been developed for fields other than marriage and family therapy (e.g., medicine and psychology). While certainly there is much overlap between mental health professions making these models applicable to MFT, one is left wondering about the scarce attention given by MFT theorists to ethical decision-making.

Stephen Cohen (2001) makes an interesting distinction between *compliance* and *ethics*. A compliance-focus tends to be regulatory, utilizes rules and procedures, largely has a legal or quasi-legal

perspective, and is aimed at achieving a minimum level of appropriate behavior. Ethics, on the other hand, “could be characterized as the ‘high end’ of compliance. It is an area that can be concerned with excellence, not only with achieving a minimum level or with meeting the required legal and [professional] standards” (p. 1). This is consistent with Rushworth Kidder’s (1996) discussion of ethics as “obedience to the unenforceable” (p. 66). AAMFT’s latest ethical code (2001) was revised specifically with the aim of creating an “enforceable Code that could be included in state or provincial statutes or rules that locally regulate the profession of marriage and family therapy. ...The Board wanted the new Code to be one that could be advocated for and easily implemented by regulatory bodies” (Hovestadt, 2001, p. iii). Thus, while one can readily assume the good will of AAMFT and its interest in the highest ethical standards, its ostensible efforts appear to be much more compliance oriented.

It is important to emphasize that compliance serves an essential protective function and is not to be viewed negatively, especially in such a litigious society as the United States. Ironically however, given AAMFT’s regulatory conscientiousness and move away from non-enforceable (i.e., aspirational) language in its Code, the American Bar Association has a two-tiered code of ethics that explicitly recognizes the importance of both compliance and aspirational ethics for attorneys and the legal profession as a whole (Kultgen, 1988). The American Psychological Association, the American Counseling Association, and the National Council for Social Work also all explicitly articulate both minimal standards to be enforced and ethical ideals to aspire towards in their professional codes of ethics (Tjeltveit, 1999); thus leaving AAMFT as the only major mental health organization to not do so.

Cohen (2001) noted that ethics does not come cheap; there is a cost. Working toward the establishment of best practice, an ethics focus requires an investment of time and resources beyond that which is needed for compliance. He therefore distinguishes between *ethics training*, which is the rote enactment of specific behaviors related to compliance and *ethics education*, which involves teaching justifications and thinking through areas of discretion (Cohen, 2001). Again, one may assume that the field of MFT aspires to promote ethics education, yet the vast majority of ethics literature in the field—by virtue of its emphasis on what far more than how and the near absence of articulated reasoning

processes—is being geared toward ethics training. Cohen recommends promoting *ethical empowerment* by providing ethics education. Ethical empowerment means giving people responsibility for making ethical decisions and then holding them accountable for those decisions. The key, however, according to Cohen, is at the top organizational level, which is responsible for ensuring that individuals have the resources (e.g., ethics education, not merely ethics training) and wherewithal to make sound judgments. For Cohen (2001) thinking through areas of discretion and justification is at the heart of ethics education, yet MacIntyre (1981) claims that coherent tools for having these sorts of conversations are in short supply. How then are we to proceed?

### The Quest for Understanding: Hermeneutics

Assessments of right or wrong, and good or bad are evaluative statements of meaning, specifically, of moral meaning. There has been a rising recognition of the need to examine scientifically meaning in human action (e.g., Heidegger, 1962; Patton, 1989; Standen, 1950), but the inadequacies of using traditional scientific method to do so, have also been pointed out (e.g., Barrett, 1979; Garfinkel, 1967; Merleau-Ponty, 1967; Patton, 1989; Polkinghorne, 1984). Jackson and Patton (1992) suggest that a hermeneutic approach is particularly suited to address issues of meaning. Chenail and Bertram (1993) note that as therapy is increasingly conceptualized as an interpretive activity, psychotherapists are beginning to embrace hermeneutic traditions and methodologies with greater regularity (e.g., Chessick, 1990; Conran & Love, 1992; Cushman, 1995; Frank, 1987; Frank & Frank, 1991; Hoshman, 1989; Messer, Sass, & Woolfolk, 1988; Packer, 1985; Packer & Addison, 1989; Richardson & Fowers, 1998; Richardson, Fowers, & Guignon, 1999; Wolszon, 1998). Indeed, the entire issue of *American Behavioral Scientist* in January 1998 was devoted to explicating an interpretive social science perspective grounded in ontological hermeneutics.

Hermeneutics serves as the meta-framework for my query into nature of ethical decision-making within the field of marriage and family therapy. The difficulty, however, is that the field of hermeneutics is not homogeneous (Dostal, 2002b; Schwandt, 2001, Smith, 1993; Wachterhauser, 2002), though in qualitative methods texts it is sometimes misleadingly represented as such (e.g., Guba & Lincoln, 1994).

Specifically, Hans-Georg Gadamer's view of hermeneutics (1975, 1976, 1989) guides this project. As will be discussed later, in using Gadamer's framework—which offers a view of ontology with methodological implications rather than a methodology with an implied ontology or epistemology—some taken-for-granted assumptions of much social science research are challenged. As such, careful attention must be given to what Gadamer is and is not trying to say.

In brief, for a much more thorough explication is provided in the next chapter, philosophical hermeneutics (or ontological hermeneutics as it is also called) follows Heidegger (1962) in recognizing that all understanding, including scientific understanding, is interpretive in nature and that our interpretations are historically and linguistically constituted. In other words, Heidegger asserts that it is *not possible* to methodologically manufacture distance between the knower and the object of understanding, for both the inquirer and the understanding produced (whether in everyday life or in science) cannot be separated from historical and linguistic systems, hence the focus on ontology rather than methodology.

Ontological hermeneutics can be understood as offering a middle alternative to the reified subject-object split of modernism and the relativism of much postmodern and poststructural thought (Bernstein, 2002; Smith, 1993). Gadamer is a realist in that he believes it possible to arrive at genuine knowledge and understanding of ourselves and others, but rejects the notion of certainty based on representational knowledge. Instead, he offers revised (i.e., more fluid) definitions of these terms, largely based on a contemporary rehabilitation of the ancient Greek view of practical wisdom, or *praxis* (Johnson, 2000; Zuckert, 2002).

Gadamer argues that modernists and postmodernists alike have uncritically accepted the ancient skeptics criteria for objective truth as absolute certainty. Modernists claim the goal of absolute certainty is attainable with the development of ever refined methods, whereas postmodernists assert it is impossible, so the search for truth should be abandoned. Gadamer asserts that true understanding is possible, but it is neither as fixed as modernism asserts, nor as subjective and relative as postmodernism suggests (Bernstein, 2002; Smith, 1993).

Central to all forms of hermeneutics is the concept of the hermeneutic circle such that the part can only be understood in relation to the whole context and the context understood only in relation to its parts. Differences between schools of thought within hermeneutics can largely be traced to the relation of the knower to the hermeneutic circle, namely whether or not the knower can distance himself or herself from the contextual circumstances from which interpretations are made (Johnson, 2000). Older versions of hermeneutics imply that it is methodologically possible to step outside the circle, whereas more current thinkers do not. Because ontological hermeneutics emphasizes that all understanding—including scientific understanding—comes to us through history and language, we can never fully avoid the interpretive circle of hermeneutics (Wachterhauser, 2002).

Gadamer's most provocative challenge to traditional social science is his rejection of the requirement that our pre-understanding of a situation (or "prejudice" as Gadamer provokingly calls them) be somehow set aside in order to attain new knowledge (Linge, 1976). "This represents a radical departure from the philosophic programs of Descartes and Kant, who both stressed the necessity that, in his search for truth, man should free himself from prejudice" (Doublet, 2002, p. 60). Gadamer (1975), based on an historical analysis of the term "prejudice," claims that the Enlightenment requirement that prejudices be methodologically controlled has been tantamount to a prejudice against prejudice, "i.e., the refusal to recognize the significance of our own insertion in a tradition that, at some level, we already understand" (Kearney & Rainwater, 1998, p. 109). As even most postpositivists will now agree, there is "no view from no-where" from which to conduct social inquiry, hermeneutics is simply rejecting the view that a "nowhere view" somehow produces more valid knowledge. Rather than ascribe to the ideal of an imaginary starting point (i.e., the view from "nowhere") hermeneutics acknowledges that our inevitable views from "somewhere" (and "somewhere" is always historically and linguistically constituted) are what make social inquiry and understanding possible; thus our prejudices serve a positive role.

Modernist thinkers aim to distance themselves from their prejudices in their quest for certainty of knowledge, while postmodern thinkers suggest that because this cannot be done, certainty of knowledge is a futile goal. Neither stance, however, questions the view that prejudices are problematic (Bernstein,

2002). Gadamer's opposition to the negative view of prejudices in the search for knowledge is what makes him unique; for Gadamer argues that it is precisely our pre-understandings that have the positive function of making new knowledge possible at all (Gadamer, 1976, 1989; Johnson, 2000). In Guignon's (1991) words, "[Hermeneutics] insists on holding fast to the insider's perspective as the source from which all reflection, including [science], ultimately originates....[This] is seen *not as a constraint*, however, but as an *enabling condition* that first gives us a window onto ourselves and our world" (pp. 96-97, emphasis in original).

The ramifications for the social sciences of Gadamer's reversed view of our prejudices are both profound and subtle. While I will bring more clarity to Gadamer's ideas with an extended presentation in the next chapter, to cover his framework and its implications fully are beyond the scope of this project. It is significant to recognize, however, that ontological hermeneutics does not discount the importance or relevance of knowledge gained through traditional or even postmodern scientific methodologies, but it challenges us to revise our understanding of what our methods and our findings mean.

This open admission of the productive power of prejudice in all understanding seems to place Gadamer in explicit opposition to the scientific ideal of prejudiceless objectivity in interpretation, and his most acrimonious critics have been those who regard his work as jeopardizing the very possibility of scientific understanding. ...What Gadamer's conception of understanding threatens is not our efforts at critical interpretation or what is actually achieved by such efforts, but the self-understanding that has accompanied scientific scholarship during the last two hundred years and the inflated claims it has made on behalf of methodological self-control (Linge, 1976, p. xvii).

For instance, subjectivity statements are a common part of many qualitative methodologies (Creswell, 1998; Glesne, 1999; Silverman, 2000) and are intended to make one's biases transparent so that their delimiting influence on the data can be identified. This is understood as a means of accommodating the taken-for-granted requirement that scientists must acknowledge and discount their own reactions to and influences on that which they seek to

understand, thereby increasing the rigor and trustworthiness of the research. In contrast, the subjectivity statement embedded in my orienting remarks at the beginning of this chapter is intended, from a Gadamerian framework, to serve as an entry point for the reader into a conversation about ethics in which I have already been engaged, but that I wish to extend in a new way. For Gadamer, the aim of certainty of knowledge is replaced by the goal of dialogue that perpetuates new understanding—understanding that increases our ability to take action that promotes the good, or in other words, practical wisdom (Gadamer, 1975; Taylor, 1989; Warnke, 1987).

The present study, using a philosophical hermeneutic frame, will be a discourse analysis of a set of articles related to ethical decision-making from five family therapy journals across 20 years (i.e., 1984-2004). Text analysis is considered archetypal for interpretive studies, and since Gadamer focused most of his attention on understanding written documents, his work is a most appropriate guide for this project. The purpose of this endeavor is to engage the MFT ethical decision-making literature in a new way—*based on* my particular set of pre-understandings rather than *in spite of* them—in order to provide new interpretive insight into the texts. The aim is to open up additional new possible interpretations for others, and in so doing, perpetuate the conversation—the goal of inquiry within an ontological hermeneutic framework.

### Overview of Upcoming Structure

In Part one of this paper (i.e., chapters one through four), I lay bare as best I am able my thinking to date about ethics, including thinking that has evolved as a consequence of my exposure to hermeneutics. Part two (i.e., chapters five through seven) constitutes the current study of the MFT ethics literature. Subsequent to this introductory overview, chapter two provides the ontological and epistemological foundation for the present study by presenting Gadamer's philosophical hermeneutics in more detail. With the orienting remarks marking the initial visit to the hermeneutic circle, chapter three represents the next turn and deepens the conversation by discussing historical influences on our understanding of ethics, particularly in terms of moral philosophy and the language of ethical theory.



Chapter four presents my pre-understanding of methods of ethical analysis based on my familiarity with literatures from two larger clinical discourses (i.e., medical ethics, and psychotherapy ethics outside of MFT). The selection of these specific discourses is in acknowledgment of their influence on my thinking about ethics. While other influential discourses are certainly present that could be highlighted (e.g., gender, multicultural issues, and personal and professional events), these are considered beyond the scope of the present study. Indeed, the existence of more constituting factors (of our understanding) than can be discussed at any one time, or in some cases, even be identified, is a fundamental premise of philosophical hermeneutics.

With the ontological and epistemological foundation for hermeneutic analysis established in chapter two, chapter five describes the procedures used to select and code the specific articles within the MFT ethics literature that will serve as text to be analyzed. The ways in which the N6 qualitative data management software is used to track the hermeneutic process will also be explained. Chapter six is a presentation of the results of my engagement with the texts, what Gadamer calls the “fusion of horizons,” in which I discuss a deeper understanding of ethical decision-making made possible by engaging the MFT ethics literature in this new way. Chapter seven, finally, contains a discussion of the implications of this new understanding for practitioners, supervisors and educators, noting opportunities for future conversations. In closing, Gantt (2000) offers an important reminder:

[The] hermeneutic approach seeks to provide a progressive disclosure of our understanding of that which we are studying, all the while recognizing that such a project can never be fully completed. For, given the fact that human existence is by its very nature radically temporal and historical, any attempts to render an account of that existence necessarily inform and alter it and thus create the need for further explication. Such is the essence of the so-called ‘hermeneutic circle’ (Gantt, 2000, paragraph 19).

## CHAPTER TWO: HERMENEUTICS

*As Gadamer points out, the differentia between methodological sterility and genuine understanding is imagination, that is the capacity to see what is questionable in the subject matter and to formulate questions that question the subject matter further. And the precondition of this capacity is that one is open to be questioned by the text, to be provoked by it to risk involvement in a dialogue that carries him beyond his present position (Linge, 1976, p. xxii; emphasis in original).*

### Origins of Hermeneutics

The word hermeneutics has its origins in the Greek word that means, “to interpret” and is associated with the name Hermes, who was considered to be the messenger of the Greek gods to mortals (Johnson, 2000; Packer, 1985; VanManen, 1990). Historically hermeneutics has been associated with the interpretation of ancient philosophical and theological documents, such that careful analysis of words, grammar, sentence structure, and knowledge of the time and culture in which they were produced (i.e., exegesis) yielded progressively deeper understanding of the text (Audi, 1999; Jankowski, 1995; Smith, 1993).

This “understanding,” as sought in ancient times, was not merely intellectual insight which may or may not be applied to concrete situations (as we tend to think of it today), but rather was inseparably tied to practice (Richardson, Fowers, & Guignon, 1999). As Dostal (2002a) explains, “What one understands makes a difference in what one does. The practical application of knowledge is inherent in the very understanding of something. Practical application is not...an external, after the fact, use of understanding that is somehow independent of the understanding. All understanding is practical” (p. 3). In other words, this sort of knowledge was only considered “understanding” if it contained a pragmatic element to it. Aristotle, in the *Nicomachean Ethics* (1999) referred to this as *praxis* (or *phronesis* in Latin), which is often translated as practical wisdom or prudence (though prudence in this sense differs from the modern notion of prudence as self-interest). Thus, a primary function of ancient hermeneutic text

analysis was to increase the practical wisdom needed to function in one's daily existence. In short, what does the text tell us about how we are to live, to be, to act?

### Contemporary Hermeneutics

There are two competing positions in modern hermeneutics: (1) those who see interpretation, or *verstehen*, as a scientific method for social inquiry (e.g., Schleiermacher and Dilthey); and (2) those, such as Heidegger and Gadamer, who see understanding as an “ontological event” between an interpreter and a text (Audi, 1999). The first position can be viewed as a methodology with embedded ontological and epistemological presuppositions, while the second offers ontology with epistemological and methodological implications. While an in-depth discussion of the complex theoretical disputes between these positions is beyond the scope of this paper, a general overview of major differences is in order.

#### *Hermeneutics as methodology with ontological implications.*

Until the early 1800s, hermeneutics existed as diverse exegetical methodologies for interpreting specific sorts of texts, particularly literary, religious and legal texts (Johnson, 2000). While recognizing differences in various disciplines, Friedrich Schleiermacher (1768-1834), a “critical realist” philosopher, believed there to be a universal hermeneutics that cut across the specific sorts of documents being interpreted (Audi, 1999). Schleiermacher proposed two complementary procedures comprising his theory of general hermeneutics. A “divinatory method” included guiding principles for the primary hermeneutic task of “putting oneself in the place of the author in the sense that one would be able thereby to reconstruct the thinking of the author” (Smith, 1993, p. 188). This empathic approach was based on the contention that the nature of humanity is such that one individual contains elements of all others (Johnson, 2000). In his complementary “comparative method” the empathically derived “intended meaning” of several sources are compared so as to develop broader understanding of the text. This larger context then helps shed light on the intended meaning. Each comparison of the part to the larger context

and the whole context to the part has become known as the *hermeneutic circle*, and each step contributes to the fullness of understanding (Schwandt, 2001).

Wilhelm Dilthey (1833-1911) was deeply influenced by Schleiermacher, accepting the nature of general understanding as universal, though he was dissatisfied with Schleiermacher's reliance on "empathy." Dilthey recognized the importance of historical context in the process of understanding human beings. He sought to expand hermeneutics beyond textual analysis to a science of understanding that could serve as a methodological foundation for the cultural and moral sciences (Johnson, 2000; Smith, 1993). In doing so, he "offered a direct challenge to the claim that the method and methodology of the natural sciences must be the basis for the study of 'things human'" (Smith, 1993, p. 188).

Dilthey distinguished between the natural sciences search for explanation and what he saw as the social sciences search for understanding. While rejecting the goal of the natural sciences (i.e., explanation), Dilthey maintained its Enlightenment-derived "faith in method" for ascertaining "objective truth" (Audi, 1999). In this sense, he considered himself to be a "stubborn empiricist" in his quest for the same "certainty of knowledge" about humans that he presumed was available in the natural sciences (Smith, 1993). Thus, while Dilthey viewed all of the human sciences as fundamentally interpretive (i.e., because humans are temporal, historical, self-reflective beings), he asserted that proper attention to methodology aimed at neutralizing historical influences on the interpretive process could produce valid understanding of the human condition (Johnson, 2000). According to Dilthey, following "a set of procedural rules [helps] ensure that the interpreter's historical situation does not distort the bid to uncover the actual meaning embedded in the text, act, or utterance," thereby, also ensuring the objectivity of the interpretation (Schwandt, 2001, p. 114).

Unfortunately, Dilthey was never able to resolve the internal contradiction in his methodological attempts to achieve certainty of knowledge in light of his conviction that all human knowledge is interpretive and historically contextual. In this regard, Dilthey built into hermeneutics a tension that currently remains, namely, disputes about the extent to which the interpreter is part of the hermeneutic circle or context within which the interpretation must take place, or whether it is possible to

methodologically (or otherwise) “step outside” the circle (Audi, 1999; Smith, 1993; Schwandt, 2001).

While Dilthey maintains some followers such as Hirsch and Betti in their *validation hermeneutics* (Smith, 1993), modern hermeneutics is increasingly being associated with those thinkers who assert that we are ontologically bound to the “circle” of interpretation (Flinders, & Mills, 1993).

*Hermeneutics as ontology with methodological implications.*

Martin Heidegger (1889-1976) was familiar with the work of both Schleiermacher and Dilthey. While Schleiermacher, in his attempts to develop a general theory of hermeneutics, could never overcome his reliance on empathy, Dilthey attempted to do so by emphasizing the historicity of understanding. Yet Dilthey, in his distinction between explanation and understanding, limited his theory to a methodology of deciphering (Johnson, 2000). Heidegger, who studied with Edmund Husserl (1859-1938) argued against hermeneutics as methodology in *Being and Time* (1927), asserting instead that it is a phenomenological-ontological condition of being human; it is our understanding that gives rise to our existence as we know it. For Heidegger, “understanding designates less a cognitive (and thus methodological) process than a know-how, an ability, a capacity, a possibility of our existence” (Grondin, 2002, p. 37). Heidegger claims that our understanding of our selves and our world, whether scientific or humanistic, is based on interpretation (Johnson, 2000). As Linge (1976) put it:

Heidegger shows that every interpretation—even scientific interpretation—is governed by the concrete situation of the interpreter. There is no presuppositionless, ‘prejudiceless’ interpretation, for while the interpreter may free himself from this or that situation, he cannot free himself from his own facticity, from the *ontological* condition of always already having a finite temporal situation as the horizon within which the beings he understands have their initial meaning for him. In this way Heidegger ends the long struggle of German philosophy to overcome historicism and relativism by means of ever more refined methodological reflections that would neutralize the knower’s own immediate participation in history” (p. xlvii).

Heidegger's radicalization of hermeneutics from the methodology of Dilthey to the ontological notion of understanding as a constitutive part of our being is considered a major turning point and has led to three major tributaries of hermeneutic thinking, associated most notably with (1) Jurgen Habermas (b. 1929), (2) Jacques Derrida (b. 1930), and (3) Hans-Georg Gadamer (b. 1900) (Schwandt, 2001; Smith, 1997). Each of these versions of hermeneutics shares an opposition to the subject-object split of Enlightenment Fundamentalism and sees language as central to their philosophic investigations (Bernstein, 2002; Smith, 1997). Differences between these schools of thought, however, are apparent in "what they mean by language, what they stress in their analyses, [and] what consequences they draw from their reflections" (Bernstein, 2002, p. 267).

Though all are strongly influenced by Heidegger, each school of thought takes Heidegger's insights in new directions that overlap, but are distinct from one another (Bernstein, 2002). First, Habermas brings in Marx's critical theory to inform *critical hermeneutics*, the primary task of which is to "provoke practical engagement—empowerment and emancipation—in the light of historical truth" (Smith, 1993, p. 192).

Second, Derrida accepted Heidegger's emphasis on historically contextualized knowledge and the importance of language, but withdrew from ontological commitment and embraced skepticism instead (Smith, 1997). Derrida, along with Michel Foucault (1926-1984) formulated radical or *deconstructionist hermeneutics* by combining ideas from Heidegger and Nietzsche. "Its goal is to deconstruct—decipher, decode, or unmask—the reality or truth of the meaning of all notions or ideas that we take for granted and show these meanings to be entirely contingent and relative" (Schwandt, 2001, p. 116).

Third, Gadamer, who was a contemporary of Heidegger, augments the work of Heidegger by rehabilitating Aristotle's theory of practical wisdom. Gadamer's *philosophical* or *ontological hermeneutics* "aims to explicate a way of understanding (or mode of experience in which we understand) through which a truth is disclosed and communicated—a truth that is not a matter of verification through methodical procedures of the empirical sciences" (Schwandt, 2001, p. 193). Gadamer's version of

hermeneutics serves as the framework for the present investigation and so it is to a more detailed description of his assumptions and key concepts to which I now turn.

### Gadamer's Ontological/Philosophical Hermeneutics

According to Linge (1976), a translator of Gadamer's work from German to English, Gadamer saw much of his own efforts as an attempt to work out the implications of Heidegger's discovery of the ontological significance of understanding. In doing so, Gadamer saw his initial task as overcoming the "epistemological truncation by which the traditional 'science of hermeneutics' has been absorbed into the idea of modern science," i.e., the use of method to create distance between the knower and the known (Gadamer, 1976, p. 7). His solution, however, though frequently misidentified with social constructionism (Gergen, 1985; Rorty, 1982) asserts a definitive realist ontology in contrast to the ontological skepticism of postmodernism and poststructuralism (Smith, 1997).

[Ontological] hermeneutic thinkers agree with postmodern critics of foundationalism and the subject-object ontology that we have no direct or immediate access to a 'real' world or transcendent norms independent of our interpretation of things. Claims that we do are really just additional interpretations, and so there is no exit from the circuit of interpretations. ...However, in the hermeneutic view, the typical postmodern attempt to get past modern foundationalism and the disengaged modern self is overly hasty and incomplete. ...It seems that some postmodern or social constructionist viewpoints may be holding on to a significant portion of the foundationalist or representational view of knowledge they seek to discard. They tacitly accept that definition or ideal of genuine knowledge even though they reject the possibility that such knowledge can ever be justified or grounded (Richardson, Rogers, & McCarroll, 1998, paragraphs 22-23).

In other words, positivism posits a reality that can be properly represented through the careful application of rigorous methodology. This representational knowledge is only as valid and reliable as the methodology used to generate it. Postmodernism rejects the idea that an incontestable representation can be made, but it does not offer an alternative type of knowledge (i.e., one that does not implicitly accept

that the justification needed must maintain the subject-object dichotomy). In effect, postmodernism is saying that because the Enlightenment definition of knowledge verification does not work, there is no non-subjectivist definition of knowledge possible; thus, we are left with nothing unified to stand on at worst and ironic detachment at best (Richardson, Fowers, & Guignon, 1999). Ontological hermeneutics rejects this conclusion.

[The] acute moral relativism inherent in this position seems both implausible and destructive to [philosophical hermeneuticists]. ...In our actual lives, it seems we neither can achieve certainty about the uncertainty of our condition nor simply relax and go with the flow of uncertainty. Instead, we find ourselves in a situation where we always do take some beliefs and ideals very seriously *even though* we are often beset by doubt and can never find a final intellectual resting place. To be caught in such a tension seems like a definition of what it means to be human (Richardson, Fowers, & Guignon, 1999, p. 18).

Hermeneutics puts the process of hermeneutic dialogue in place of the modern quest for certainty and the radical anti-foundationalism of postmodern thought (Gadamer, 1975; Taylor, 1989; Warnke, 1987).

Gadamer attempts to step between the modern/postmodern debates by offering an alternative definition of knowledge: understanding as dialogue that is historically, and linguistically mediated. Thus, he suggests we have something to stand on, but it is not what the positivists thought. It is more fluid, but still discernable. It is discernable because we are always already participating in it. Therefore, it is our “participation in,” rather than our “distance from” that makes understanding possible (Bernstein, 2002; Johnson, 2000; Wachterhauser, 2002).

Again following Heidegger, Gadamer asserts that “the hermeneutic situation signals the way in which, as human beings, we are ‘thrown’ into a history or set of stories that we did not start and cannot finish, but which we must continue in one way or another” (Warnke, 2002, p. 79). As we gain experience, our understanding is constantly facilitating and constraining possible future interpretations of that experience. Thus, we are already always participating in viewing experience from a specific *horizon*, to use Husserl’s phenomenological concept (Dostal, 2002; Johnson, 2000). Gadamer points out that “a



particular vantage point is a prerequisite for all of our perceptions, judgments, and actions. He sees the horizon as the limit of what can be seen from a particular point of view” (Fowers & Wenger, 1997, p. 166). Our horizons are formed by the intersection of influences that define us ontologically and epistemologically. In other words, just as when we gaze at the earthly horizon, where and when we look determines what we see, and this serves an enabling or orienting function. We can only see the horizon we look at, our view is always hazier in our peripheral vision, and some part of the horizon is always blocked from view; thus our knowledge is limited and finite much like our vision is constrained (Smith, 1993). Gadamer refers to this as our *finitude*, and suggests that history and language are two primary conditions that make our knowledge finite (Gadamer, 1989; Wachterhauser, 2002).

Acknowledging our own finitude creates the awareness that we cannot escape the insider’s perspective, i.e., our rootedness in a cultural, historical, and linguistic context that we can never fully objectify or ground, or, Gadamer would stress, even completely identify (Guignon, 1991). Both history and language (i.e., tradition) stretch back into a past we can never fully retrieve and their manifestation in the future is likewise uncertain, because they operate at least partially dependent on human freedom and choice (Wachterhauser, 2002). Thus, history and language are both fixed and free conditions of knowledge, making genuine understanding both possible and contingent.

This conceptualization, however, does not lead to the relativism of poststructuralism and some postmodernism. Though finite, our horizon is not fixed and isolated; we can move around, thereby acquiring accumulated viewpoints. In other words, we have some, but not unlimited ability to change our horizon (i.e., collections of influences operating at a specific time and place) by opening ourselves up to new influences and those experienced by others. This is what Gadamer (1976, 1989) calls the *fusion of horizons*; patterns are discernable and our understanding can be shared with one another, much like languages can be translated. When our familiar horizon is confronted and challenged by new or ‘foreign’ horizons, dialogue between viewpoints opens up the possibility of new understanding. Fowers and Wenger (1997) offer a helpful description of the fusion of horizons:

Gadamer characterizes the genuine attempt to understand and appreciate others' perspectives as a "fusion of horizons." The fusion of horizons goes well beyond the simple effort to understand the other and requires the development of a shared language or perspective. This means that we must take the other's truth claims seriously, as having potentially valid and important things to say to us. Developing a shared language means that our former understanding of what life consists in and what is of worth may become but one possibility among others. Genuinely and openly engaging in this exploration of what is of value does not mean that we take an "anything goes" attitude. Rather this kind of encounter with the other often leads to a transformed set of standards that we could not possibly have had prior to the dialogue. This profound openness is necessary to develop a shared language with the other, and it requires us to put our own deepest beliefs at risk in the flux of the conversation.... (p. 166).

Because the fusion of horizons is never absolutely complete, there is perpetual potential for additional dialogue to occur resulting in more refined understanding. Though others may never see exactly the same horizon we do, for they can never fully step inside of us, they can shift their horizon to overlap with our own and vice versa; thus, shared understanding at certain levels is possible. Every time we move and gaze at a new horizon (i.e., ask new questions), it affects how we understand the previous horizons we viewed and the ones we will next examine. This is how Gadamer (1976, 1989) conceptualizes the *hermeneutic circle* and it helps explain his insistence that our *pre-understandings* (or as he has intentionally provocatively called them, *prejudices*) make understanding possible in the first place. This schema hangs on Gadamer's conceptualization of three key concepts that are worth unpacking a little more: his notion of historical tradition, the resultant prejudices, and the role of language in mediating these traditions and prejudices (Wachterhauser, 2002).

### *Historicity*

Gadamer uses the term *effective history* to refer to the collective influences at the intersection of traditions that shape our understanding over time (Johnson, 2000; Richardson, Fowers, & Guignon,

1999). We are never without an effective history. We choose neither the historical time nor the place of our birth; nor can we step outside their influence on how we first encounter and understand ourselves, those around us, and the world at large. “For Gadamer (1975), we are always a part of a tradition long before it is a part of us” (Smith, 1993, pp. 195). Our effective history includes traditions of inquiry. According to Wachterhauser (2002), Gadamer’s notion of tradition also has normative force in the sense that it determines which questions are considered most important or worth pursuing by guiding communities of inquiry toward an epistemic ideal that is itself historically conditioned. It also sets boundaries on what conceptual tools may be used in attempting to answer these questions, thereby not only playing a substantive role in determining questions, but also the answers in some sense. This helps us better understand Gadamer’s (1975) charge against the Enlightenment’s “prejudice against prejudice,” which asserted that only knowledge gained through (supposed) detached processes was valid.

Our prejudices do not cut us off from the past, but initially open it up to us. They are the positive enabling condition of historical understanding commensurate with human finitude. ...Shaped by the past in an infinity of unexamined ways, the present situation is the ‘given’ in which understanding is rooted, and which reflection can never entirely hold at a critical distance and objectify. ...The givenness of the hermeneutical situation cannot be dissolved into critical self-knowledge in such fashion that the prejudice-structure of finite understanding might disappear (Linge, 1976, pp. xiv-xv).

### *Prejudice*

Prejudices, then, rather than hampering knowledge or inevitably causing misunderstanding, are seen by Gadamer as the very scaffolding upon which we build understanding. Gadamer (1976) notes that while certainly we are capable of distorting and misunderstanding ourselves and others due to dishonesty, defensiveness, and force, the presumption that misunderstanding is the ontological nature of our ability to perceive the world is an inheritance we received from Descartes’ reflections and interpretation of his own experience (Linge, 1976; Richardson, Rogers, & McCarroll, 1998). “It can be shown that the concept of prejudice did not originally have the meaning we have attached to it. Prejudices are *not necessarily*

unjustified and erroneous, so that they inevitably distort the truth” (Gadamer, 1976, p. 9, italics added). We cannot understand the ‘foreign’ without relying on bridges built by extending the ‘familiar’ in new ways, and while some bridges may be faulty and not hold up as well as others, some bridges succeed in helping us reach new fertile soil for developing understanding. Gadamer continues,

In fact, the historicity of our existence entails that prejudices, in the literal sense of the word, constitute the initial directedness of our whole ability to experience. Prejudices are biases of our openness to the world. ...There is always a world already interpreted, already organized in its basic relations, into which experience steps as something new, upsetting what has led our expectations and undergoing reorganization itself in the upheaval. Misunderstanding and strangeness are not the first factors, so that avoiding misunderstanding can be regarded as the specific task of hermeneutics. Just the reverse is the case. Only the support of familiar and common understanding makes possible the venture into the alien, the lifting up of something out of the alien, and thus the broadening and enrichment of our own experience of the world (1976, pp. 9, 15).

A reliance on methods and techniques as a means of achieving reliable and valid knowledge implies, to a certain extent, that all factors influencing understanding are knowable *in the present*. Gadamer points out that this ignores the influence that the past has on our knowledge of and interpretation of the present and the influence that the present has on our knowledge and interpretation of the past (i.e., the temporal and dialogical nature of understanding, the fusion of past and present horizons). Our knowledge of and interpretation of both the past and the present are largely mediated by language.

### *Language*

“Understanding as a fusion of horizons is an essentially *linguistic* process. ...Since our horizons are given to us prereflectively in our language, we always possess our world linguistically... [and] the limits of our understanding coincide with the limits of our common language” (Linge, 1976, p. xxviii, emphasis in original). It is precisely because so many of our prejudices are embedded and passed on in the language we use, are thereby taken for granted, and are outside our conscious ability to submit them to

methodological control, that Gadamer suggests our preunderstandings are more powerful in facilitating rather than hindering the process of understanding. This is illustrated by examining the way in which we literally learn languages as adults (Linge, 1976). Our ability to master one language is the prerequisite for subsequently learning new ones, for we not only learn the grammar of the mother tongue but also the way to make other languages intelligible. In this way, we do not learn a new language from scratch, but on the basis of our first language and this new language then enriches and potentially alters the first with perpetual fluidity. In other words, learning a new language is an expansion of our initial linguistic horizon. “To know a language is to have horizons from which we enter into a subject matter that broadens those very horizons” (Linge, 1976, p. xxxviii).

All traditions of inquiry have their own conceptual languages; the more embedded the tradition, the more invisible the language (Wachterhauser, 2002). “Gadamer points out that in its actual life, language does not draw attention to itself but is transparent to the realities that are manifested through it. Language is profoundly unconscious of itself” (Linge, 1976, p. xxx). The conceptual language available for us to use when seeking to apprehend something alien to us is initially determined by the traditions in which we participate growing up, and later by those professional discourses into which we are socialized. Thus, we are always already biased in our thinking by our linguistic interpretation of the world (Gadamer, 1976).

All contexts of human understanding are constituted in terms of some linguistic framework. That this linguistic framework always affects us far more than our ability to be aware of its influence is the defining mark of our finitude, and the primary, but not the only constituting mechanism, for history’s effect on us (Wachterhauser, 2002). As we have some, but not unlimited, control over the words we use to understand the world, language both facilitates and constrains us.

[Although] Gadamer says that we always understand the world in a language that is our own, it’s important to emphasize that what we understand is not simply our own world, but *the* world, the one we all have in common. Gadamer is an uncompromising realist. ...Gadamer is not saying that all reality or “being” is literally “just words.” What he is

saying is better comprehended by saying that all intelligible reality is “enhanced” or “increased” by the words we find to comprehend it. ...The “languages” we speak provide a window onto the world that otherwise would remain shut. Such “languages” are therefore not a hindrance to our comprehension of the world, but a condition of its possibility (Wachterhauser, 2002, pp. 66-67).

It is critical to understand, however, that while historical effects are refracted through language, this is not the same as suggesting they are reducible to language (Gadamer, 1976). Nor should language be understood as a tool that we wield as though it is separate from us; rather words make the world comprehensible much as light makes color visible and water makes a swimmer a swimmer (Gadamer, 1975, 1989; Johnson, 2000). A swimmer does not *use* water as a tool; it is the medium which allows a swimmer (versus a skateboarder) to *be* a swimmer. Likewise, language is the medium which makes understanding possible as we know it. To put it another way, insofar as a knower is possessed by tradition and language, Gadamer is suggesting a distinct answer to the question, ‘What is the relation between the knower and the thing to be known?’ Is the knower a source of error (i.e., a traditional social science view), or is the knower the means through which the thing gets known (i.e., Gadamer’s view)? The ontological belief in the knower as a source of error has led to the identification of understanding with scientific (i.e., methodologically controlled) understanding. Gadamer does not assert that there is not important information to be gained through this sort of understanding; rather he argues that it is neither the *only* type of understanding possible, nor the most foundational to our being (Linge, 1976).

### *Hermeneutic Social Inquiry*

While discussion of social inquiry from a philosophical hermeneutic perspective is provided throughout this paper, particularly in chapter 5, a few general remarks are appropriate in rounding out this overview of philosophical hermeneutics in preparation for the current project. Gadamer’s emphasis on our embeddedness in history and language has sometimes led to the view of the hermeneutic circle as vicious, offering little guidance for critically evaluating rival interpretations (Richardson, Fowers, & Guignon, 1999). As in the translation between languages, not just any interpretation will do, for the text

itself constrains the interpreter to remain true to the language of the text, even while absolute certainty that the interpretation is true of the text is not possible (Johnson, 2000; Richardson, Fowers, & Guignon, 1999). In this way, interpretations are subject to revision without being relativistic.

For Gadamer, the critical self-consciousness of the interpreter includes the process of reflecting on preunderstandings/prejudices, bringing to the foreground of awareness those factors that operate in the background of the interpreter's being. Those background factors may never fully manifest themselves. However, in the process of being open to the text, often the existence of these background prejudices may become more apparent. The movement from background to foreground helps produce new opportunities for interfacing with the text in new ways, thereby perpetuating the hermeneutic circle and evidencing the ways in which the existence of prejudices promote rather than interferes in the process of producing deeper knowledge (Linge, 1976). Thus, the relations between the part and the whole in the hermeneutic circle are dynamic, rather than determinate, precisely because the possibility exists that we may achieve a more sophisticated vocabulary through additional fusions of varying horizons.

For Gadamer (1975, 1989), dialogical understanding consists of an interplay between openness and application. Genuine openness to having our beliefs and prejudices challenged by the text actually involves granting it provisional authority (Johnson, 2000; Warnke, 1987, 2002), much as we would esteem the feedback of a respected colleague. "Application involves testing whether an insight or point of view reveals new aspects of our current motives and dilemmas and helps make sense of new circumstances" (Richardson, Rogers, & McCarroll, 1998, paragraph 30). In other words, in a dialogue, the point is to find out what the "old" has to say to the "new" and what the "new" has to say to the "old." Openness is seeking what the "new" has to say to the "old" and application is listening for what the 'old' reveals about the "new." Johnson (2000) describes how legal hermeneutics illustrates the importance of both openness and application.

When a judge interprets the law, the needs of the present are fundamentally important.

But this does not mean that the judge's interpretation is arbitrary, or the making of totally new law. The judge must recognize the legal significance in the particular case. While

the task of the judge is not to make law, it is to make law live. The judge helps the law speak to the citizens. Moreover, the judge is not exempt from the law. The authority of the law is not an arbitrary authority that is not subject to the law. Rather the law has authority because it binds everyone, even the judge. The judge is not removed from the implications of the law. The judge belongs to the legal situation in which his or her judgment has effects. But the judge does not know the law and then simply place it on a particular case. In considering each case, the judge understands, and interprets for the citizens, the meaning of the law. The judge must remain open to the claim the law makes. Not every interpretation is allowed within the meaning of the law. (Johnson, 2000, p. 35).

For Gadamer (1989), we each function like a judge in that we come to understand the general through particular situations and our understanding of those individual instances is guided by our understanding of the universal. We must conscientiously remain open to the experience of tradition as well as the truth claim encountered in the current situation. In sum, Gadamer's framework not only offers a world view that guides the current study of MFT ethics, but because of its focus on meaning-making, it is particularly helpful for understanding the moral life generally.

At this point it is useful to return to the topic of ethics in marriage and family therapy, this time bearing in mind the hermeneutic frame that guides this project. Chapters three and four can be understood as presenting my current horizon, the vantage point from which I currently understand MFT ethics. Chapter three reviews the historical influences of Western conceptualizations of ethical thought and presents an overview of classical, feminist and postmodern ethical theories in which I have been immersed during the last five years. This is followed by a discussion in chapter four of ethical decision-making models found in the non-MFT psychotherapy literature, and a review of methods of ethical analysis and models for relating theory and practice utilized by medical ethicists. Part two, then begins with chapter five, and includes the procedures (chapter five), results (chapter six) and discussion of



implications and recommendations (chapter seven) of my current efforts to fuse my current horizon with the view(s) of ethical decision-making found in the MFT literature.

## **CHAPTER THREE:**

### **TRADITIONS OF ETHICS (CURRENT HORIZON, PART ONE)**

#### Introduction

As mentioned in the orienting remarks, my discovery of moral philosophy and ethical theory had a profound affect on my understanding of my own professional practice. Having the language of ethical theory opened up new horizons for understanding the moral nature of therapy, and having the language of hermeneutics helps me understand how this transformation took place (i.e., the fusion of horizons).

Our possession of language, or better, our possession *by* language, is the ontological condition for our understanding of the texts that address us. The appearance of particular objects of our concern depends upon a world already having been disclosed to us in the language we use. Our experience of particular objects and our manipulation of them is therefore not self-founding, but presupposes that we are always already oriented to a particular world by means of language (Linge, 1976, p. xxix).

Even though the limits of professional codes of ethics in psychotherapy are readily documented (e.g., Kitchener, 2000; Kultgen, 1988; Tejelweit, 1999, 2000)—though typically very briefly in MFT sources (e.g., AAMFT, 2001; Huber, 1999; Vesper & Brock, 1991; Woody & Woody, 2001)—my original MFT training only discussed ethics in terms of the AAMFT Code (1991) and the laws governing psychotherapists. Thus, I could only think about and talk about ethical issues in the language provided to me by my professional tradition. This gives credence to Gadamer's point about the invisibility of language within a tradition. As a beginning therapist, I accepted the code as a straightforward reified standard and went about my business trying to serve my clients.

Only as I gained experience as a full time clinician and increased my sensitivity to moral nuances (Rest, 1994) in therapy practice, did I begin to notice for myself the limitations of relying solely on a professional code for guidance. Working in the trenches of community mental health agencies taught me

the realities of an imperfect mental health system, an imperfect social services system, and an imperfect legal system. In my training, I was told to take ethical dilemmas to my supervisors who would presumably have all the answers. But in my professional experience, I learned that not all supervisors are equal in the trustworthiness of their guidance and some, in fact, engage in unethical behaviors themselves. I could not imagine that I was alone in these sorts of experiences. Yet I often felt at a loss for words to help me think about and resolve the dilemmas I faced. Likely, such on the job training unwittingly primed me to be on the look out for a broader conceptualization of ethics.

Just as I was trained to see individual therapeutic difficulties in their systemic contexts, so have I discovered that MFT ethics is tied to larger intellectual contexts (i.e., traditions). It is to these larger contextual perspectives—the development of ethical thought in the West—that I now turn my attention. My limiting this discussion to western conceptualizations of ethics is not to imply that these are the only traditions relevant for thinking about ethical issues in family therapy, as much as to say that these are the ones that have most influenced my thinking and that serve to shape my current ethics horizon. While there is some reference in the MFT literature to ethical theory as a resource for decision-making (Doherty & Boss, 1991), presentations tend to rely on the further application of secondary sources (e.g., Zygmund & Boorhem, 1989), fail to account for the breadth of moral theory (e.g., Woody, 1990) or simply give cursory attention to the topic (e.g., Woody and Woody, 2001). Thus, there exists within the MFT literature *no detailed explication* of the wide variety of ethical theories available, what those theories tell us, and how they might apply specifically to marriage and family therapy.

The remainder of this chapter, therefore, is devoted to using broad strokes to review ethical theory and the ways in which I have begun to apply it in the creation of a model for ethical decision-making. Specifically, I will discuss:

- (1) Meta-ethics, which includes distinctions between theoretical views of the nature of moral principles as created or discovered, and the relevance for family therapy;

- (2) Normative ethics, which includes numerous theoretical approaches to establishing criteria for right or good action (e.g., virtue, deontological, teleological, feminist, and narrative theories); and
- (3) Mowery's Seven Ps of Ethical Reflection, which is my preliminary model of ethical decision-making based on meta- and normative ethical theories.

The following chapter continues to present my current ethics horizon by reviewing specific models of applied ethical analysis and decision-making in medicine and psychotherapy generally.

### Overview of Ethical Traditions

The development of ethical thought in the west cannot be separated from historical socio-political and intellectual revolutions throughout the ages. As our views of ontology and epistemology changed, so have our views on ethics. Our ethical horizons have in turn been shaped by Plato and Aristotle in antiquity, by the Judeo-Christian church in the middle ages, by Descartes and science during the Enlightenment's Age of Reason, and by more recent challenges from a wide variety of postmodern thinkers (Cary, 2000b; Clark & Poortenga, 2003).

More specifically, Aristotle is generally credited with first defining the field of ethics and writing a treatise on it (i.e., *The Nichomachean Ethics*), though the issues he addressed had previously also been dealt with by Plato, albeit less systematically (Cary, 2000a). Philosophically sophisticated theologians such as Thomas Aquinas and Augustine, who sought to articulate a coherent view of Christian ethics, fused their theological horizons with those of Plato and Aristotle in their attempts to interpret difficult passages of scripture (Cary, 2000b). Enlightenment philosophers such as Immanuel Kant and John Stuart Mill sought to establish a 'science of ethics,' in which detached human reason, without resorting to external authority (but not denying its existence), could identify one universal moral criterion with which to establish moral conduct. The hope was that logical reason could provide as firm a foundation (i.e., unanimity, precision, and certainty) for moral knowledge as it had for fields such as mathematics (Clark & Poortenga, 2003). Most recently, postmodern philosophers have challenged that non-contradiction and coherence—prerequisite qualities of the sought-after ultimate criterion—are not always or inevitably

achievable; thus modernity's quest for certainty in ethics is abandoned to various degrees, and replaced by the willingness to live with ethical tensions (Bauman, 1993). Each of these traditions talks about ethics in different ways, and though none are without critiques, each maintains influence on current ethical dialogue and debate.

These historical views on ethics still have some bearing on the field of psychotherapy today. Writers such as Cohen and Cohen (1999), Doherty (1995), Jordan and Meara (1990), Kitchener (2000), Lageman (1993), and Meara, Schmidt, and Day (1996) discuss the importance of therapist's moral virtues, based on Aristotle's virtue ethics. Though the discussion has expanded beyond Judeo-Christian theology, the role of spiritual values in the lives of clients and therapists is receiving increasing attention (e.g., Aponte, 1994; Becvar, 2001; Haug, 1998a, 1998b). The language of AAMFT's Code of Ethics (2001), with its emphasis on client rights and therapist responsibilities and cost-benefit analysis, flows directly from the Enlightenment era conceptualization of ethics.

Additionally, I would venture to suggest that postmodernism has recently influenced the generally implicit—and sometimes explicit (e.g., Woody, 2001)—expectation that therapists assume a stance of moral relativism such that all client values are considered equally valid. Rarely are these sorts of historical traditions acknowledged and when they are (e.g., references to virtue ethics), they do not tend to consider competing conceptualizations of ethics. Indeed, it was only upon my discovery of and immersion in the vast terrain of moral philosophy and the language of ethical theory that I could begin to recognize and discuss this issue.

### Moral Philosophy

Ethics, as equated with moral philosophy, involves systematizing, defending and recommending concepts of right and wrong (Pojman, 1998). This field concerns itself with the discovery of, and the relations between, valid principles as they apply to actions, consequences, character and motives. Philosophical ethics focuses less on what "is" than on what "ought" to be. This "is/ought" distinction is important because it separates *descriptive ethics*, which is a sociological or anthropological study of how ethics *is* enacted in different cultures within or between societies, and the philosophical study of how

ethics *ought* to be practiced. Generally speaking, the study of philosophical ethics (i.e., moral philosophy) is usually divided into three intricately related domains: (1) meta-ethics, (2) normative ethics, and (3) applied ethics (Pojman, 1998). This chapter will focus on meta-ethics and normative ethics, while discussion of applied ethics is saved for the next chapter.

### *Meta-Ethics*

Meta-ethics examines the origin, nature, and meaning of ethical concepts (Fieser, 2000), and the objectivity and source of objectivity, or lack thereof, of moral claims (LaFollette, 2000). Ricoeur (1973) asks the central question of meta-ethics: Are values created or discovered? In Ricoeur's words, "If values are not our work but precede us, why do they not suppress our freedom? And if they are our work, why are they not arbitrary choices?" (p. 156). Similarly, in reviewing the history of ethics, Rae (1995) notes that views on the nature of morals and moral authority can be roughly grouped into two basic categories:

The first includes those who see morality as essentially a human creation, that is, morality that is *created* by human beings. A second group includes those who see morality as something that *transcends* human nature, that is, morality that is not a human creation but that is *discovered* by a variety of means (e.g., reason, intuition, and divine revelation)....For the first group, moral authority is immanent: that is, human beings have the authority to create their own moral rules and systems. For the second group, moral authority is transcendent, that is, the authority exists outside of ordinary human experience. In the latter case, moral rules are discerned by human beings who recognize that the source of these rules is someone or something that is 'above' them. ...Basic conflict between these two groups over current moral issues still exists today. In fact, the issue that separates the different sides in [many] current conflict[s] is still the ultimate source of moral authority (p. 45, emphasis in original).

Within the meta-ethics literature, these two views have been called moral realism and moral relativism. While there is some effort by recent philosophers (e.g., LaFollette, 1991) to transcend the

binary of moral realism and moral relativism, discussion of these perspectives is beyond the scope of this project, and at the risk of oversimplification, the distinction between morals as created or discovered described by Rae (1995) will guide this discussion. Epistemologically, moral realism contends that moral knowledge is possible, some moral beliefs are true, and there are external methods for justifying moral beliefs, while moral relativism asserts that independent moral knowledge is not possible, the truth-value of moral claims is dependent on people's beliefs, and they are internally justified (Pojman, 1998).

Pojman (1998) organizes the varied metaphysical/ontological assumptions associated with realism and relativism as representing a continuum. Moral realist positions include absolutists and objectivists. *Absolutists* say that there exist moral principles that can never be overridden under any circumstances. This view has been criticized as untenable because moral principles can exist that arise in conflict with one another. *Objectivists* hold that while universally valid or true moral principles exist (prima facie duties), they can override one another as the circumstances warrant (actual duties).

Types of moral relativism can be distinguished based upon the agent and applicability of moral principles to others (Pojman, 1998). *Subjective Universalism* suggests that morality is created through individual choice. To be moral, however, those individual choices must have universal application (i.e., my choice is valid in so far as it would be reasonable for all others to make the exact same choice). *Conventionalism* is the classic form of relativism and views the creation of morality as a group endeavor. Moral principles are chosen at the social level or through interpersonal agreement; they need not apply to other groups or individuals. *Subjectivism* suggests that moral principles are chosen solely by individuals and their application extends no further than to the choosing agent. Absolutism and Subjectivism tend to dominate characterizations of the realists and relativists positions, thus creating more controversy and conflict than may be in order if other more moderate views are recognized (Pojman, 1998).

Finally, *amoralists* contend that moral truth does not exist and that all moral claims are false, whereas moral *skeptics* are dubious about concluding either that moral values exist or that they do not, believing instead that the status of moral principles is unknowable. Each of these positions has a long tradition in which its strengths and weaknesses have been identified. The relevant point here is to

recognize that different justifiable views exist, and that implicit or explicit assumptions about the nature of morality have pragmatic clinical consequences.

*Relevance of meta-ethics to MFT.* Not recognizing these differences, for instance, can lead unwittingly to the imposition of values by individual therapists or even by the profession. In the ethics text published by AAMFT, *Ethics in Marriage and Family Therapy* (Woody & Woody, 2001), the Woodys state:

[There] can be no professional dispute about the gay/lesbian couple's right to receive services from a marriage and family therapist: "When seeking therapy, lesbian and gay couples have the *right to expect* that their coupleness will be affirmed by the therapist as being *equally valid and significant* as heterosexual marriage" (Bepko & Johnson, 2000, p. 409) (Woody & Woody, 2001, p. 210, emphasis added).

The first clause in this statement is a straightforward claim of professional consensus about the right to receive treatment and is supported by the moral principles of beneficence and justice, and the provision within the AAMFT code of ethics (2001) to provide services without discrimination based on sexual orientation. But by linking this clause to the quote by Bepko and Johnson (2000), the Woodys may be interpreted as attempting to justify the mandate to avoid discrimination by presupposing a meta-ethic of moral relativism whereby moral positions must be considered equally valid.

Alternatively, they could be basing their recommendation on a meta-ethic of moral absolutism by suggesting that the only true moral position that will meet the requirement to not discriminate on the basis of sexual orientation is to actively affirm homosexual coupling. Either way, the authors fail to be transparent about the moral presuppositions they are using to substantiate their stance (and hence their recommendations to the profession), and they specifically do not acknowledge that the positive or negative moral nature of same sex coupling can be argued from a variety of meta-ethical positions and is not automatically linked to affirmation or rejection of the moral nature of discrimination.

More generally, in this example there does not appear to be recognition that descriptive relativism does not necessarily presuppose moral relativism. We live in a pluralistic society, whereby descriptive



relativism is inevitable; meaning it is a sociologically verifiable fact that many different moral views exist. A therapist who holds a moral realist perspective (i.e., moral truths exist and are externally justifiable) may believe that homosexual behaviors are objectively morally right or morally wrong, or a therapist may hold a moral relativist perspective suggesting that the moral rightness or wrongness of homosexuality is dependent on people's internal beliefs. Each therapist may believe that his or her position is justifiable and correct and that contrasting positions are unpersuasive or even wrong, but because of descriptive relativism, both must be willing to humbly and respectfully acknowledge that someone else (e.g., a client, a colleague, a supervisor, et cetera) may believe that the therapist is wrong or has an unpersuasive rationale for his or her belief.

The MFT profession consists of those holding a wide diversity of moral positions. As a profession and as individual therapists, we must be prepared to respectfully interact with other therapy stakeholders who hold views differing from our own, and not base the availability of services on whether or not others agree with our values. However, contrary to what the Woodys seem to be suggesting (at least regarding issues associated with same sex couples), this does not necessarily mean we must agree with or affirm the alternative perspectives of others or consider them equally valid to our own (though we certainly may).

To automatically equate nondiscrimination (or respect or tolerance) with active affirmation of a particular moral stance runs the risk of confounding descriptive ethical relativism with the meta-ethic of moral relativism (Pojman, 1998). One may affirm that homosexuality is an *insufficient* justification for injustices based on discrimination (e.g., denied access to services, jobs, housing, health care, inheritance, hospitalization visitation, and so forth), and advocate for changes in specific policies directly tied to concrete injustices *with or without* assuming a stance that all moral values involved must be seen as equally valid and significant. Avoiding discrimination may be accomplished by a variety of respectful means without implicitly or explicitly imposing any one meta-ethical stance.

It is possible to arrive at defensible deeply held moral beliefs with which not everyone will agree (Beauchamp & Childress, 2001). Indeed, part of the goal of ethical analysis (including awareness of meta-ethical distinctions) is to “stimulate our moral imaginations in order to develop a sense of commitment and responsibility, [and to learn] how to respect diverse ethical viewpoints without compromising our own deeply held, carefully considered moral beliefs” (Nash, 1996, p. 12). Most likely, outside of philosophical circles, few of us have taken the time to carefully examine our own meta-ethical presuppositions or those of others; yet doing so may give us language with which to converse with one another about our most deeply cherished convictions, neither unwittingly imposing our values nor resorting to polarizing politically charged discourse to justify our positions.

Some ethicists (e.g., Beauchamp & Childress, 2001) suggest that discussions of meta-ethics are limited in their practical utility, and indeed, we may still need to evolve different language to resolve concrete disagreements. I would submit, however, that the language of meta-ethics allows us to acknowledge our differences in the presuppositions that invisibly shape our values and convictions. Recognizing that *any* meta-ethical stance requires a leap of faith, and that its veracity is unverifiable by empirical means, may engender increased respect for our differences. Once such mutual respect is established, the stage may then be set for the discovery of unexpected common ground.

Furthermore, the language of meta-ethics opens up a new horizon whereby the strengths and limitations of empirical science can perhaps be better understood as they relate to therapy. For example, though often focused on empirical evidence related to treatment efficacy or measurable outcomes, I would argue that much of the debate in our field about moral issues such as treatment related to homoerotic attraction (e.g., Green, 2003; Rosik, 2003a, 2003b) and same sex marriage could be clarified by recognition that the different meta-ethical assumptions described above inevitably shape cultural and professional discourse as much as or more so than scientific evidence. The question of whether a treatment goal should focus on embracing or rejecting one’s own homoerotic attraction, for instance, is not a question science alone can answer.

While empirical science can inform such debates by providing rigorously obtained facts about an issue that correct misunderstandings or stereotypes, by themselves these facts cannot answer the question of what we should do; to suggest otherwise is to commit what is known in moral philosophy as the *naturalistic fallacy* (Pojman, 1998; Tjeltveit, 1999). As discussed in the context of family science research by Mowery and Walters (in press), all prescriptive actions combine descriptive facts (which science can rigorously provide) and normative values (which involve morals and ethics); thus, transparency about both the scientific and ethical analysis used to formulate recommendations is critical. This is important because not all questions relevant to the practice of marriage and family therapy can be addressed through empirical science (Richardson, Fowers, & Guignon, 1999).

It is important to note that there is a complex historical relationship between science and various views on the nature of morality that is beyond the scope of this paper to discuss in depth. Pragmatically, however, Tjeltveit (1999) advocates a reasonable stance regarding the roles of science and ethics in clinical practice:

I am convinced that practice should be based on *relevant* scientific findings, *when available*. Where science has a clear word to offer the psychotherapist, the therapist ought to listen.... [When] faced with a question for which relevant scientific knowledge is not available [or is inconclusive], therapists need not rely [only] upon scientific findings. Indeed, since we cannot in principle obtain answers to some ethical questions from science, and since ethical issues are always a part of psychotherapy, it would be absurd to expect therapists to base their practice solely upon science.... [Psychotherapy] should be based on *relevant* scientific findings. But psychotherapy should also be based on ethics. And until psychotherapists do so more explicitly and with greater sophistication, psychotherapy will never reach its fullest potential (p. 129, italics in original, underline added).

Relations between ethics and spirituality must also be considered, as there is increasing recognition of the role of spirituality in therapy (e.g., Becvar, 2001; Haug, 1998a; 1998b; Stander, Piercy,

Mackinnon & Helmeke, 1994), and because it is not uncommon for therapy stakeholders to base their values on religious or spiritual convictions (Tjeltveit, 1999). Stander, et al. (1994) present some historical reasons why spirituality and religion have been marginalized in conversations about ethics in therapy in spite of the large percentage of religiously committed clients and therapists. Increased attention needs to be given to the interface between meta-ethical presuppositions based on spiritual revelation as well as individually or socially constructed judgments. Perhaps as a field it is time to deconstruct the taken-for-granted assumption that ethics discourse within the therapy room as well as ethics discourse in the professional literature must be limited to secular presuppositions and language.

In sum, the presuppositions a person holds regarding a particular meta-ethical view of morality wittingly or unwittingly commit a person to a certain view of the nature of reality (i.e., metaphysics), a specific theory of knowledge (i.e., epistemology) and a certain view of human nature (i.e., anthropology) (Rae, 1995). Within MFT, the rich diversity of epistemological influences is apparent in the literature, but the link between these epistemologies and their moral ramifications has only limited discussion (e.g., Donovan, 2003; Flemons, Green, & Rambo, 1996). Questions for therapists to consider include the extent to which they believe all “created” or “discovered” moral knowledge is equal or if they would consider some views less valid (e.g., oppression based on racism or sexism). Therapists need to consider the limits (if any) of what they view as morally appropriate epistemologies. The next step is to carefully reflect on how they justify those limitations and how such limitations might affect their therapy practice.

[It] is vitally important that psychotherapists critically examine values and ethical theory, their own and those of others, and especially those held by clients. This means thinking about alternative analyses of values and ethics (including the best ethical answers from across the centuries and from other cultures), exposing one’s own beliefs to rational scrutiny, and entering into dialogue with those holding other views (Tjeltveit, 1999, p. 13).

## *Normative Ethics*

The second major domain of moral philosophy, known as *normative ethics*, attempts to discover the moral standards that regulate right and wrong action (Fieser, 2000), and is what most people think of when they think of ethics. Strategies for ethical decision-making can largely be categorized into five traditions. The first, *virtue ethics*, based on Aristotelian thought sees ethical behavior as stemming from virtuous character. *Deontological* and *teleological* (or consequentialist) ethics are products of the Enlightenment quest to formulate a science of ethics by articulating a universal criterion for moral behavior (Pojman, 1998). Deontological theories (“deon” meaning duty in Greek) assert there are categorical and/or *a priori* obligations based on universalizable moral principles that determine right action, whereas teleological theories (“teleo” meaning end in Greek) emphasize consequences as the sole criterion for determining the moral worth of an action (LaFollette, 2000). The fourth, *feminist ethics*, challenges traditional moral systems as being oppressive to women, neglectful of the role of feelings in moral evaluation, and is offered to replace and/or supplement male-dominated theories (Rave & Larson, 1995). *Narrative ethics*, a fifth strategy, has its roots in the postmodern emphasis on the uniqueness of context (Charon & Montello, 2002). Though an exhaustive explication of each of these traditions is well beyond the scope of this paper, it is worth briefly considering how each may relate to ethics in marriage and family therapy.

(1) *Virtue Ethics*. The heart of virtue ethics is the belief that one’s character serves as the basis for intuitive decision-making, particularly when time does not allow for extensive ethical analysis or reflection (Pence, 1993). Aristotle considered human beings in teleological terms such that the end or goal of being human was to be good at being human (Cary, 2000a). The Greek word for being good at being human is typically translated as ‘virtue.’

Virtues are like skills that are learned through habituation and practice until they become second nature. In order to develop virtues, one must be skilled at making good decisions in concrete situations. This requires finding emotional pleasure in doing ‘right’ and emotional pain when doing ‘wrong,’ which in turn requires intellectual judgment to recognize ‘right’ action (Cary, 2000a). Aristotle saw virtuous

action as the mean response between the vices of deficiency and excess (Clark & Poortenga, 2003). For instance, the virtue of courage is the mean between rashness and cowardice. Determining such means is the work of practical wisdom, or *praxis*, which is a habit of good judgment in the midst of specific circumstances—and all situations are specific and unique at least in part (Cary, 2000a).

Just following rules is considered inadequate because in the specificity of any particular situation, either no rule may apply or there may be too many rules that apply. Furthermore, rules by themselves do not account for the motivation to do ‘right,’ (i.e., feeling emotional pleasure with right action) nor the reasoning involved in determining the applicability of any given rule (i.e., reflective judgment) (Cary, 2000a; Clark & Poortenga, 2003). Right actions for the wrong reasons or wrong actions with the right motives are judged less virtuous than right actions for the right reasons.

Kultgen (1988) characterizes most professions as primarily being comprised of “persons of ordinary conscientiousness” (p. 34) who do what they think is right if the cost is not too great, and “persons of limited good will” (p. 35), who view moral rules as legitimate and are prepared to obey them without the threat of external sanctioning so long as others do the same. Other authors discuss specific virtues associated with psychotherapy. Doherty (1995), for instance, discusses the virtues of caring, courage, and discernment, and suggests that it is in our daily practice that we build up the character required to face those ethical dilemmas that challenge our ordinary conscientiousness and limited good will (Kultgen, 1988).

But the small acts of courage of everyday practice—confronting someone when we’d just as soon leave the issue alone for now, being honest with ourselves about our internal reactions and personal issues as they come up, refusing to blame clients for our mistakes, advocating for clients with their insurance companies—these everyday acts of courage prepare us for the big challenges of suicide, serious conflict with other professionals, the erosion of therapeutic practice in the face of market forces, and threats to our own emotional and physical safety. Firmness of spirit is an acquired virtue that, as therapists, we are called to embrace and cultivate throughout our careers, for the good of our clients

and the community, and for the enrichment of our own humanity” (Doherty, 1995, p.161).

Using a slightly different approach, Cohen and Cohen (1999) distinguish between therapist virtues that facilitate client autonomy such as congruence, unconditional positive regard, and empathy, and those virtues that help establish client trust, such as honesty, candor, discretion, professional competence, diligence, loyalty, and fairness. Karen Kitchener’s most recent work (2000) expanded her seminal approach to ethical decision-making (1984, 1986), by emphasizing the character of the therapist and five specific virtues, practical wisdom, integrity, respectfulness, trustworthiness, and compassion. Jordan and Meara (1990) and Meara, Schmidt, and Day (1996) also advocate for an inclusion of virtue ethics by psychotherapists.

(2) *Deontological Ethics*. Rather than basing moral action on character, proponents of versions of deontological ethics (i.e., duty-based ethics) see ethical behavior as based on clear, specific, foundational obligations or moral principles (Pojman, 1998; Singer, 1993; Tjeltveit, 1999). The motivation for moral action is seen as the strict adherence to one’s duty as defined by core moral principles. Moral validity is based upon guiding principles rather than on the outcome of the action (Fieser, 2003). In short, deontologists would reject the view that the end alone justifies the means. There is some distinction between those who evaluate the moral worth of each separate act, and those who suggest instead that it is the general rule more than the individual act that must be based on core moral principles (Pojman, 1998). Three duty-based theories are described below: (A) Kantian Ethics, (B) Prima Facie Duties, and (C) Rights Theories.

(A) Kantian Ethics. Kant’s obligation-based theory is historically the most influential form of deontological moral reasoning and is based on a single universalizable principle of duty, a categorical imperative that simply mandates action regardless of one’s personal desires (O’Neill, 1993). According to Kant’s categorical imperative, we are only to act in such a way that we would be willing to mandate that every other person in like circumstances act in the same way (Pojman, 1998). In some respects, this

is a modified version of the Golden Rule, such that one is to “do” only that which he or she would have all others “do.” A specification of this principle is that people are to be treated as ends in themselves, never as means to another person’s ends. In other words, the human dignity of a single individual must not be violated, even if by doing so, great benefit to others would result; thus, deontological ethics rejects the claim made by teleological theorists, who assert that outcomes are the only consideration when weighing moral value (Fieser, 2003). Kantian ethics has been criticized as too rigid in its absoluteness, because circumstances may arise in which a person may be faced with multiple morally mandated duties (Pojman, 1998).

(B) Prima Facie Duties. A second deontological theory has been expressed by W. D. Ross and is known as the theory of prima facie duties. Ross asserts that there are multiple principles of duty that maintain general moral force; he calls these prima facie duties because their moral relevance is readily apparent to our intuitive moral sense (Fieser, 2003; Pojman, 1998). Ross’ seven prima facie duties reflecting our actual moral convictions include: (1) fidelity: keeping promises; (2) reparation: compensating others for harm; (3) gratitude: thanking those who help us; (4) justice: recognizing worth/merit; (5) beneficence: improving conditions of others; (6) self-improvement: living up to one’s potential; and (7) nonmaleficence: avoiding injury to others (Fieser, 2003). According to Ross, each person, when encountering conflict between duties will be able to intuitively determine which is her actual duty (what she must actually do) and which is a prima facie duty (what she morally must consider doing). The reasoning behind Ross’ theory of prima facie duties is widely accepted today, even if lists of prima facie duties may differ (e.g., Beauchamp & Childress, 2001, discussed below). Some, however, question Ross’ reliance on moral intuition as a basis for establishing moral obligation.

(C) Rights Theories. Ethical issues are frequently framed in terms of moral rights and moral duties (Fieser, 2003). A duty is the moral requirement to do or refrain from doing something. A duty is derived from either general ethical principles or specific actions. A moral right is a morally justified claim. It doesn’t have to be claimed to be a right. According to Joel Feinberg (1989), rights claims must have four elements: (1) a content—a specific intended good; (2) a holder—someone who possesses the



right; (3) an addressee—someone whose duty it is to facilitate the enactment of the right; and (4) a source of validation or justification for the right. There are rights of action (i.e., entitlement to do something) and rights of reception (i.e., entitlement to receive something) (Almond, 1993; Pojman, 1998; Sim, 1997). If one has a right to do something, the right to *not* do it is equally present. A person cannot have both a right and a duty to do something. If one has a right, generally someone else has a duty to fulfill that right. “Like duties, rights must be justified; they must be grounded in something more fundamental which gives them their moral authority. Too often, rights are claimed without any clear statement as to what justifies their status” (Sim, 1997, p. 24). There are a variety of rights theories which base the existence of human rights on diverse sources as God, national and international law, moral consensus across human groups, or rationally justified argument (Nickel, 2003).

Formal and informal rights language is pervasive in the United States, largely due to the rights theory of John Locke, which had a profound influence on Thomas Jefferson during the formation of the United States government. For Locke and Jefferson, all people have certain natural rights given by God and all others are obligated (i.e., have duties) to acknowledge and support those rights (e.g., life, liberty and the pursuit of happiness). There are four features that traditionally describe these rights (Fieser, 2003). First, they are natural, meaning they are not established by governmental decree, though they may be incorporated into law. Second, these rights are universal and do not change across countries and cultures. Third, they are equal in that the same rights apply to all people regardless of gender, race or ability. Finally, these rights are inalienable; they are non-transferable to other people. Though there are philosophical critiques of some of these features (e.g., Nickel, 2003), they largely capture what most of us have come to regard as qualities associated with human rights.

An important challenge facing most of us practicing therapy in the United States is the loose nature of “rights” discourse, both by professionals and clients. Rights language is often evoked to substantiate a claim (e.g., the claim discussed in the meta-ethics section above about what attitudes clients have a right to expect from therapists), but failure to explicate a theory of rights (e.g., based on law, divine decree, international agreement, and so forth) leaves the claim in danger of being merely vacuous.

Principle one in AAMFT code of ethics (2001) importantly asserts that marriage and family therapists have a duty to respect clients' rights, but the subprinciples listed do little to clearly specify what rights are being referred to and there is no reference to a theory of rights to substantiate any list the profession might be implying. Thus, rights language can sometimes create more confusion than it solves in the midst of moral dilemmas. Kultgen (1988) notes that client rights are connected with the principle of respect for autonomy. "The practical import of the connection is obscure, however, because none of the codes articulates a theory of rights. Individual, human, legal, and civil rights are mentioned in various places, but no effort is made to state what those rights are or how they are grounded" (Kultgen, 1988, p. 232).

(3) *Teleological (Consequentialist) Theories*. Given vast cultural differences, deontological theories have often been criticized for being based upon the questionable existence of universal moral principles. Further, they are often characterized as too rigid and too reliant on internal intentions (Fieser, 2003; Pojman, 1998). Moral worth, say teleologists (the Greek word "telos" means end), should be evaluated strictly on the outcome of a given behavior. These theories were developed as a quick way to assess moral behavior based on experience rather than intuition or lists of duties.

An action is considered morally appropriate if good consequences outweigh bad consequences. A key concern of critics of teleological approaches is whose consequences are considered. In ethical egoism, the balance of consequences favors only the agent making the decision, while in ethical altruism, scales favor everyone except the agent. Utilitarianism is the most familiar form of consequentialism, or teleological moral reasoning. The principle of utility is the primary determinant of moral action. A cost-benefit analysis of prospective positive and negative outcomes seeks to always produce the maximal balance of positive versus negative consequences for the greatest number of people irrespective of specific relationships (Goodin, 1993; Pettit, 1993). Utilitarianism thus attempts to be more egalitarian in that the balance of consequences ideally favors everyone.

Numerous versions of utilitarianism have been articulated. In act-utilitarianism, Jeremy Bentham espoused a separate evaluation of consequences for each act. He also focused the cost-benefit analysis on the pleasure lost or gained by all parties in hedonistic utilitarianism (Fieser, 2003). Based on

the limitations of an act approach, John Stuart Mill's articulation of rule-utilitarianism centered its examination at the level of behavioral rules or codes rather than individual actions.

Differences among teleological theorists also have to do with what outcomes are being assessed, with some attempting to calculate pain versus pleasure or happiness versus unhappiness. This is problematic because what may produce happiness for one person may create unhappiness for another. Recent critiques of psychotherapy have centered on the types of outcomes psychotherapy *should* be promoting (e.g., Cushman, 1995; Hillman & Ventura, 1992; Richardson, Fowers, & Guignon, 1999). These critics maintain that psychotherapy's predominant focus on individual happiness has created a dearth of consideration for other sorts of relational, community or social goods.

Family therapists have sometimes asserted that these criticisms do not apply due to the inherent relational focus of systemic therapy theories. Whereas superficially this appears to be true, Richardson, et al. provide a persuasive case that family therapy has uncritically accepted society's functional definition of family life as a harbinger and facilitator of individual happiness, thereby continuing to promote an emphasis on individualism, though perhaps more indirectly than other forms of psychotherapy. Thus, if consequentialist reasoning is to be used to justify therapy, we must heed the call by our critics (Cushman, 1995; Hillman & Ventura, 1992; Richardson, Fowers, & Guignon, 1999) to give more reflective attention to the ends we desire to promote in marriage and family therapy even as we seek to establish the efficacy and effectiveness of our therapeutic methods.

An assessment of outcomes is essential to consequentialist moral theories and science plays a critical role in determining causal and correlational interactions associated with specified outcomes. Denton and Walsh (2001) make the case that the use of scientific evidence when determining approaches to treatment is an ethical imperative and a matter of competence, the avoidance of which is a violation of the AAMFT (2001) ethics code's mandate to practice competently. To the extent that therapists are involved in the most intimate and core aspects of people's lives, the stakes are too high for the family

therapy profession to not rigorously evaluate the efficacy and effectiveness of our services. The same can be said in support of the need to rigorously assess the moral ramifications of our actions as well.

(4) *Feminist Ethics*. Western ethical traditions have been criticized for dismissing as morally uninteresting the relational views and experiences of women (LaFollette, 2000; Sterba, 2000) by overvaluing culturally identified masculine traits such as independence and autonomy, and masculine styles of moral reasoning which emphasize rules, universality, and impartiality, while devaluing culturally feminine traits (e.g., interdependence and connectedness), and feminine ways of moral reasoning that focus on relationships, particularity and partiality (Jaggar, 1992). Thus, in feminist ethics, rather than focusing moral decisions on abstract reasoning regarding principles such as utility or universalizability, the traits valued in intimate relationships such as sympathy, compassion, fidelity, discernment, and love can have primary guiding force in moral reasoning (Grimshaw, 1993; Porter, 1999). As most traditional systems of ethics were based on men in positions of privilege, ethics has long been a gendered activity (Tong, 2003).

Feminist ethicists can trace their roots to Mary Wollstonecraft (1759-1797), who expressed that part of the reason that women were historically seen as morally inferior to men is that they were not given the education sufficient to fully develop their reason. Wollstonecraft argued that if reason leads to the development of moral virtue, then the education of women is critical (Tong, 2003). Current feminist approaches to ethics vary and carry diverse labels such as: (A) Feminine Ethics, (B) Maternal Ethics, (C) Feminist Ethics, and (D) Lesbian Ethics. Their common aim is to create moral theory that emphasize gender equal moral principles, policies, and practices (Tong, 2003).

(A) *Feminine Ethics*. Feminine approaches to ethics are largely associated with the work of Carol Gilligan (1982) and Nel Noddings (1984, 1990). Gilligan is a former student of Lawrence Kohlberg, whose theory of moral development, claimed Gilligan, was biased toward a male emphasis on universalizable notions of justice, and failed to account for and actively value women's traditional emphasis on caring personalized relationships. Whereas Gilligan's ethic of care evolved out of social

science descriptions of differences in moral reasoning used by men and women, Nel Noddings has worked to develop a normative moral theory based on feminine, relational ethics.

For Noddings, ethics is about particular relationships between two parties, the ‘one-caring’ and the ‘cared-for.’ Caring is not simply a matter of feeling favorably disposed towards humankind in general, of being concerned about people with whom one has no concrete connection.... Real care requires actual encounters with specific individuals; it cannot be accomplished through good intentions alone (Tong, 2003, paragraph 30).

(B) Maternal Ethics. Maternal approaches to ethics suggest that most of our day to day relationships are not between equally-informed and equally-powerful persons who create just contracts with one another, but rather between unequal persons with diverse personal strengths and weaknesses such as parents and children, physicians and patients, confident and anxious friends (Ruddick, 1989). Mothering emphasizes attention to preservation of life, and fostering the growth and training of others and these are important ethical considerations for both men and women. Virginia Held (1993), also an advocate of maternal ethics, seeks to develop moral theory that emphasizes the relationships and activities found in the private rather than the public domain (Tong, 2003).

(C & D) Feminist and Lesbian Ethics. Whereas feminine and maternal approaches to ethics focus on the value of women’s experiences and the insights thereby gained for both genders, fully “feminist” ethics adds a political dimension by emphasizing power relationships, and striving to eliminate women’s—and other oppressed persons’—subordination in all its manifestations (Tong, 2003). Issues of power are addressed even before questions are asked about good and evil or care and justice. Views regarding the sources of female subordination vary among “liberal,” “Marxist,” “radical,” “socialist,” “multicultural,” “global,” “ecofeminist,” “existential,” “psychoanalytic,” or “postmodern” feminists (Tong, 2003). With their focus on women-oppressive systems and structures, distinctly feminist (versus simply feminine or maternal) ethics have a fourfold function: (1) articulate critiques of activities perpetuating women’s subordination; (2) prescribe morally justifiable means of resistance; (3) envision morally desirable alternative to unjust practices; and (4) take women’s experiences seriously, though not

uncritically (Jaggar, 1992). Lesbian approaches articulate similar goals as feminist ethics, but take the focus on particularity one step further by specifically addressing lesbian experiences (Tong, 2003).

In some respects feminism presents an interesting juxtaposition within moral theory with its aversion to universalizable moral reasoning, and its reliance on a universal concept of justice to fortify its normative emphasis on gender equality. Nevertheless, feminism in general has had a tremendous impact on the field of family therapy, particularly in drawing attention to the role of social context as it relates to power in family and therapeutic relationships. Other ethical issues highlighted by feminist therapists include: the affects on women of being given diagnostic labels for behaviors often associated with gender socialization; the role of monetary reimbursement in the therapy process as a potentially limiting factor on client choices; the role of power in overlapping relationships; violence against women; reproductive health concerns; the affects on women of a patriarchal medical system whose research has historically focused largely on men; care-giver concerns related to children and seniors; and finally, more detailed attention to issues of self-care for the therapist (Larsen & Rave, 1995).

(5) *Postmodern / Narrative Ethics*. Postmodern approaches to ethics are still concerned with the same issues addressed in classical moral theory, but attempt to address these moral questions in new ways, by rejecting the assumption that guided Enlightenment ethicists (e.g., Kant, Bentham, or Mill) that the messiness of the human moral condition can be transcended through reason. The postmodern turn in normative ethics is to see that non-contradiction and coherency –prerequisite qualities of the sought-after ultimate criterion --are not always or inevitably achievable; thus modernity's quest for certainty in ethics is variously abandoned and replaced by the willingness to live with ethical tensions (Bauman, 1993).

Postmodern ethicists recognize that the route modernist thinkers took to establish universal moral standards was to appeal to increasing levels of abstraction. Yet moral problems in real life have very concrete features that not only shape the definition of the moral dilemma, but must also be considered in reaching a solution in actual practice. Thus, postmodern ethics is distinguished from modernist moral theories by the degree to which it attempts to abandon abstract reasoning processes in favor of engaging

the concrete particularities of the moral situation at hand (Bauman, 1993). Though there are numerous postmodern writers addressing ethics, this discussion will focus primarily on narrative ethics.

Narrative ethics is one post-modern approach that has gained increased recognition over the last two decades. In her introduction to a symposium on the “narrative movement,” Hilde Nelson describes the heart of this approach:

Narrative approaches to ethics have in general been based on two interrelated propositions. The first is that moral principles are not law-like, universal, and unyielding, but modifiable in light of the particulars of a given experience or situation. The second is that these particulars either naturally take a narrative form or must be given a narrative structure if they are to have moral meaning (Nelson, 1997, p. ix).

Yet like feminism, there are varying approaches to ethics utilizing a narrative framework. John Arras (1997) describes three distinct formulations of narrative ethics, each increasingly challenging the notion that universal moral principles exist, or that by themselves offer sufficient guidance for moral decision-making. In the first, personal narrative is seen as supplementing and thereby balancing deductive systems of principle-based reasoning (e.g., the guiding principles of utility or respect for persons, or more mid-level principles such as autonomy, beneficence, nonmaleficence, and justice). Attending to narratives increases moral sensitivity to the implications of a client or professional’s dilemma and the meanings associated with various possible solutions. “Principles retain their moral force; narrative sensitivity just makes them work better” (Arras, 1997, p. 70) by creating a dialectical or reciprocal relationship between abstract principles and our considered judgments about concrete cases.

Second, proponents of historical narrative as the basis of morality such as Alasdair MacIntyre and Stanly Hauerwas suggest that “our capacity to view things as reasonable, valuable, noble, appropriate, interesting, and so on is developed within the context of a certain narrative tradition that subtly shapes all our knowing and valuing” (Arras, 1997, p. 73). Such foundational stories (e.g., the traditions associated with Greek epic poetry, the Bible and various commentaries such as the Talmud, or Confucianism, or some combination of traditions) provide accounts of who we are as people and how we got this way;

these stories serve as starting and ending points of our ethical reasoning. In other words, at some point in our moral reasoning, we all must take a leap of faith as to which ontological, epistemological, or axiological story we believe offers the best account of the human condition.

The final formulation of narrative ethics discussed by Arras (1997) is more distinctly “postmodern” in its outright rejection of universal principles and totalizing foundational stories. In this view, justification of an ethical claim is based on the authenticity of the narratives in the moral dilemma. Here emphasis is placed on attention to a single case in social context (i.e., consideration of socioeconomic, cultural, religious, and gendered contexts). These social contexts contribute to how the individual will see herself and how others will see her. “How others see her crucially influences how they will respond to her, so it matters whether they get these contextual features right” (Nelson, 2002, p.39).

For instance, Rosemarie Tong (2002), a bioethicist, relates the story of a physician who prescribed a feeding tube for a man with Alzheimer’s type dementia as the “right” medical treatment. A crisis occurred for the wife, however, who could not participate in the care the medical tube required because it meant restraining her husband in the bed they had shared as lovers and life partners. Thus, the “right” medical response from the doctor’s point of view was deeply “wrong” for the wife who saw the doctor’s mechanical solution to keeping the feeding tube in place (i.e., restraints) as a deeply offensive act. This is not unlike the situations faced by therapists regarding protecting children from suspected child abuse. To mechanically report a family to child protective services because the law mandates the therapist to do so, does not automatically mean the therapist has acted ethically; for how one reports, the process one uses, requires nuanced narrative understanding of the rationales and consequences for each particular option (e.g., tell the family you are reporting or do not tell the family, call with the family there, get the family to call while the therapist is present, and so forth).

To summarize, normative ethics encompasses a broad spectrum of moral considerations theorists suggest ought to be considered as morally relevant when deciding what is right or good to do. It is critical to note that with one exception, the main categories of ethical theory presented in this chapter represent a comprehensive, but by no means exhaustive, overview of moral philosophical traditions. One major



tradition, natural law theory, is absent from this discussion, but not because it is unimportant or has not been influential; just the opposite is true. This tradition has deep ties to religion (but not only religion), and frequently serves as justification for our notions of fundamental human rights. This chapter, however, serves as a presentation of my current horizon regarding moral philosophy, and as I have had little exposure to the literature on natural law theory, it is not included in this review.

I would argue that we commonly utilize a combination of the ideas contained in meta-ethics and normative ethics to reason about or justify our everyday personal and professional choices, though rarely do we use the formal labels and distinctions articulated by moral philosophers. John Dewey (1977 in Tong, 2001) suggests that ethics, like science, is essentially an inquiry. Ethics is inquiry about what we ought to do in a situation that is morally ambiguous or otherwise confusing, and the role of both scientific and ethical theory is to help us cut through our confusion (Tong, 2001).

To consider ethics as a critically reflective morality highlights the fact that ethics is a process of thinking, not a set of established answers which need only be passively accepted. This conception views ethics as a method of discovery and not as a body of knowledge. Ethics does not consist in knowing the answers but instead in knowing how to inquire; in particular, in knowing what counts as a possible answer, what questions are appropriate and constructive ones to ask, what tendencies in one's own thinking need to be kept in check, et cetera (Card, 2002, p. 20).

My own experience of studying ethical theory is that there is a steep learning curve such that the jargon of moral philosophy and the many fine distinctions made among theorists within a major theory can at first seem more overwhelming than pragmatically helpful to the practicing clinician. Yet once major concepts are grasped, the expanded understanding that the language of ethical theory opens up sheds light on Kurt Lewin's reported observation that there is nothing so practical as a good theory. This chapter concludes with an introduction to a model I have been developing based on the theories described above, and entitled, "The seven Ps of ethical reflection: Scaffolding for ethical decision-making." It is important to

note that this model is a work in progress, based on my clinical experiences and studies in moral philosophy and medical ethics, and does not yet represent a fully developed model for ethical decision-making.

### Mowery's Seven Ps of Ethical Reflection

The 7 Ps model utilizes classical, post-modern and feminist philosophical thought to provide flexible scaffolding upon which the clinician, client, researcher or educator can construct sensitive moral reflection, discussion and action, and is designed to address the morally relevant features and reasoning processes emphasized in a broad spectrum of ethical theory. The aim of this system of questions is to create a thick rich description of the moral terrain—with all its inherent tensions and contradictions—from the perspective of all stakeholders in order to diagnose biases and ethical blind spots in the process of creating a well-thought out plan that addresses as many moral features of the case as is practical. The more one internalizes awareness of the wide variety of answers possible to each question in advance of a crisis, the more helpful and efficient this scaffolding will be in practice.

One must weigh the relative strengths and weaknesses associated with each type of consideration in formulating a conclusion. No single formula exists in ethics for determining the weight or priority given to each factor; the weight given to each of these questions will likely vary according to the considered judgments of the actors involved and the circumstances in question. Each question may be thought of as producing an air stream. The direction and force of each air stream are likely to vary. Sometimes they work together to create a prevailing wind, propelling you in a clear direction for right action. Other times the winds will work against one another and you will have to rely more on discretion and moral intuition than is comfortable. Such is the gut-wrenching ambiguous nature of true ethical dilemmas.

#### (1) *What do I (and others) PRESUPPOSE about the nature and source of morals and ethics?*

This question has its roots in the meta-ethics domain of moral philosophy, and recognizes that people will see the source, applicability and validity of their conclusions about the way things *should* be in different ways. As previously discussed, moral principles typically have been seen as either discovered (i.e., moral

realism) or created (moral relativism). The point is to recognize what our personal views are, and be aware that other thoughtful, caring and reasonable clinicians, supervisors, educators, researchers, clients, students, and research participants may hold different presuppositions. By understanding our own position (or combination of positions) and those of others, we can simultaneously increase confidence in our own views, while maintaining humility in the face of difference.

(2) *What kind of PERSON do I (and others) want to be?* This question acknowledges that knowing what to do is not necessarily the same as being motivated to do it. (Conversely, we may be motivated to do the *right* thing, but may make errors in judgment about what that right thing is.) Thus, at issue are the relatively stable qualities and/or patterns of action in our general character contributing to our motivation to attend to the moral aspects of our practice, research and teaching. A related question asks, “Will I be able to live with myself (and others live with me) if I act in a certain way?” Such questions are typically discussed within virtue/character ethics. Common virtues emphasized in the helping professions include: prudence/practical wisdom (i.e., the ability to reason well about moral matters and flexibly apply such reasoning to real world problems), integrity, respectfulness, trustworthiness, compassion and courage.

(3) *What duties or obligations PUSH me (and others) in certain directions?* This question admits that we may have certain constraints on our options or recommended courses of action that exist prior to our encountering a specific situation. In other words, there may be certain principles that we should generally strive to maintain in all (or at least most) situations. We often consider it our *prima facie* duty to uphold the moral principles of beneficence (i.e., benefit the welfare of others), nonmaleficence (i.e., avoid harming others), veracity (i.e., truth-telling), respect for autonomy, and justice. These considerations pull from deontological moral theories. Our duties are often codified into professional codes of ethics and laws regulating the practice of psychotherapy. Other duties or obligations may be created by implicit (e.g., to put the welfare of your client above yourself) or explicit (e.g., managed care) social contracts. They may also have their roots in family or cultural traditions, political ideologies, or religious convictions. Again the point is to identify what obligations we, our clients, and other

stakeholders perceive to be relevant; these obligations may differ in type or strength, and may conflict with others obligations within or between individuals.

(4) *What are the possible future consequences that might PULL me (and others) in certain directions?* This question concedes that we have at least some responsibility for the results of our decisions and actions; thus careful speculation about the future is warranted. In moral philosophy, these considerations characterize teleological/ends-based ethics, the most common version being utilitarianism (i.e., maximize the greatest good for the greatest number). In western society, we have been socialized to predominantly think in terms of cost-benefit analyses in decision-making, especially regarding policy formation and research protocols. The concern here is with the impact our decisions may have on us, our circumstances, our environment and those of others.

These consequences can be short-term or long-term, affecting a few or many, private or public, avoidable or inevitable. They may be psychological, emotional, social, spiritual, physical or economic. Some outcomes may be tied to prior duties or obligations such as when we are sanctioned for breaking a promise, breaching a contract or a professional code of ethics, or penalized for breaking the law; thus, there tends to be a dialectical relationship between what pushes us and what pulls. Scientific methods are particularly useful in clarifying probabilities associated with specific outcomes. This highlights the essential relevance of empirical research on treatment models to ethical decision-making; though again, science cannot answer all questions relevant to ethical practice by therapists or the moral issues faced by clients.

(5) *What are the contextual PERSPECTIVES of all those who will be affected by my decision?*

This question recognizes that there are forces and circumstances that shape and influence our identity, our point of view, our sense of power and efficacy, and those of others with whom we interact or who may be affected by our actions. These include, but are not limited to, issues associated with race, gender, ethnicity, religion and social class; for we do not live in a world free of racism, sexism, and classism based on socio-economic status. Thus, there is a need to be sensitive to the larger social forces contributing to the perspectives of all involved. While these issues appear in numerous approaches to

ethics, they are particularly emphasized in postmodern moral philosophies. Sensitivity to contextual perspectives does not preclude the recognition that some moral positions may be prioritized as more (or less) justifiable than others (e.g., racism, sexism, etc.). In addition to being aware of larger societal influences, this question also invites consideration of moral meaning within the stories and lived experience of each individual stakeholder. As discussed in narrative ethics, it is important to consider whether an action makes sense in light of personal histories and life trajectories.

(6) *What are the qualities of relationships in which I want to PARTICIPATE?* This question emphasizes the relational nature of most, if not all, ethical conundrums. In doing so, it considers that we are motivated to relate to others not only through reason, but also through feelings of care and compassion. We tend to relate to specific others, not just to humanity in general. It is important to consider how specific relationships will be affected by a course of action. For instance, we are mandated reporters of suspected child abuse, but we must take care to consider how our general duty will affect particular relationships; there are more and less compassionate ways to fulfill one's duties. It is not enough to consider what is fair, obligated, or produces the least amount of harm in determining right action, but also, what also exhibits compassion. Furthermore, males and females can approach relationships differently; so actions that support relationships for men may not nurture relationships with women. These ideas are generally highlighted in feminist ethics, which also emphasizes sensitivity to power relationships. Indeed, the question could equally be: what sorts of POWER relationships are involved here?

(7) *What does PARTICULAR experience say about this specific situation?* This question takes into consideration that we are facing a decision within the flow of time, place and history. Chances are good that we are not the first to encounter the sort of dilemma or choice that we are facing and it is possible that we ourselves have prior experiences with similar situations. What related precedents or collective experience (mine or others) apply? What conclusions have previously been reached and why? Ethics case books typically rely on this approach, known as casuistry. Vignettes are presented

highlighting morally relevant features within classes of cases (i.e., paradigms) which can be compared to the situation at hand. Consulting with supervisors, attorneys, peers, or others also provides important outside perspective.

### Conclusion

To conclude this chapter, most of us have taken-for-granted moral positions that have never been considered, let alone critically examined. Our self-understanding can usually be improved upon through moral discourse with those who hold opposing views. However, it is also possible to arrive at defensible deeply held moral beliefs with which not everyone will agree. Scaffolding provided by the seven Ps, which is grounded in ethical theories, allows us to unpack much of what we tend to intuit or take for granted. Doing so opens up our intuition for examination and education by diagnosing our blind spots, creating overt space for those who may intuit or reason differently, and establishing common language for moral discourse. To be clear, it is not the complex jargon of moral philosophy that is of primary interest. Instead, it is hoped that the concepts and variables identified through philosophical ethics can help us have fruitful moral conversations, and further, help us to see how urgently we need to do so. At least identifying the terminology of professional ethicists, however, allows us to also tap into part of a larger, on-going discourse, thereby learning from the strengths, weaknesses, successes and failures of other professions similar to our own.

It is important to be aware of diverse approaches to determining what is right or best in a given situation because therapists and clients may differ, just as individuals within a couple or family may have different approaches to ethical decision-making. It is plausible to consider that outcomes that are labeled by therapists as dysfunctional or even pathological may be attributable to conclusions based on alternative forms of ethical decision-making. If therapists are not trained to be aware of their ethical decision-making style or pattern of reasoning, it is even more likely that families are unaware of these patterns of resolving moral conflicts. Also, depending on the severity of the decision to be made, awareness on the part of the therapist of the strengths and weaknesses of the varying ethical approaches provides direction to the therapist for exploring the client's moral positions. One of the best ways to respect the moral

agency of the client is to be aware of the strengths and weaknesses of one's own moral preferences and decision-making strategies, and the array of alternative approaches that abound.

While the seven Ps represents my initial efforts to formulate a model for ethical decision-making based on a diversity of ethical theories, others have sought to develop clinical ethics in other ways. Representing a continued presentation of my current understanding of ethics, Chapter four includes a discussion of the third domain in the philosophical study of ethics, applied ethics, as well as reviews specific approaches to decision-making found in the larger psychotherapy literature.

## **CHAPTER FOUR:**

### **METHODS OF ETHICAL ANALYSIS (CURRENT HORIZON, PART TWO)**

#### Introduction

As mentioned in the previous chapter, the study of ethics has been grouped into three domains: meta-ethics, normative ethics, and the focus of this chapter, applied or practical ethics. This third domain is a more recent emphasis in moral philosophy, with the tools from meta- and normative ethics being used to try to resolve controversial moral issues in practice, particularly in the professions. The current chapter includes discussions about methods of ethical analysis described in the medical ethics literature, the functions of professional codes of ethics, as well as seminal models of ethical decision-making found in the general psychotherapy literature. Specifically, I review:

- (1) Beauchamp and Childress' Principlism. This is because current codes of ethics for most major mental health organizations, including AAMFT (see Haverkamp & Daniluk, 1993), implicitly or explicitly draw on the principles of beneficence (seek the welfare of the patient), nonmaleficence (do no harm), respect for autonomy, and justice, as articulated in the classic, *Principles of biomedical ethics*, by Beauchamp and Childress (1979, 2001), now in its fifth edition.
- (2) General Psychotherapy Models of Ethical Decision-Making. The seminal work of Karen Kitchener (1984) describes a model of ethical decision-making for psychotherapists that draws from the work of Beauchamp and Childress (1979), Hare (1981), and Rest (1983, 1984). Thus Hare's (1981) intuitive and critical-evaluative levels of ethical decision-making, and Rest's (1983, 1984) model based on moral development research are also discussed. Included also is the feminist model of ethical decision-making by Hill, Glaser, and Harden



- (1995), which is an extension of Kitchener's model, and a brief review of family therapy models.
- (3) Codes of Ethics. John Kultgen's (1988) book examines the role codes of ethics play across a variety of professions. Particularly relevant is his distinction between the social and human functions of professional codes of ethics. The strengths and limitations of case-study reasoning (i.e., casuistry) for interpreting codes are also discussed.
  - (4) Graber and Thomasma (1989, in press): Models of Ethical Analysis. Considerable attention is given to reviewing the models of ethical reasoning identified by these authors based on an extensive review of the biomedical ethics literature. Graber and Thomasma (in press) offer conceptual distinctions in the reasoning processes professional ethicists use for prioritizing conflicting moral considerations. As there is scant attention to reasoning processes in the MFT ethics literature, it may be that the schemas described by Graber and Thomasma (in press) may further understanding of reasoning processes used in MFT.

It is important to clarify that the inclusion of medical ethics literature in this study is not to suggest that MFT ethics can or should be subsumed medical ethics. Instead, it is emphasized for four reasons. First, although family therapy was founded in reaction against the individualistic paradigm of clinical practice, medicine retains moral force as the prototypical healing profession in ancient as well as modern society. Second, almost all mental health ethics implicitly or explicitly rely on the moral values of medicine (e.g., the sanctity of the relationship between the person seeking care and the caregiver and the mandate to do no harm). Third, as medical ethics is a branch of applied ethics, it serves as an existing bridge abstract theory and the realities of clinical practice; thus its established scholarly literature may be a resource for understanding MFT ethics in new ways. Finally, in their review of values and ethics in family therapy, Doherty and Boss (1991) specifically exhorted the MFT profession to dialogue with medical ethicists.

[One] new focus to be explored is the growing literature on applied professional ethics, particularly work in the field of biomedical ethics....These ethicists offer a rich

grounding on which family therapists can develop more sophisticated approaches to ethics and values in the next decade (p. 634).

### Beauchamp and Childress' Principlism

The four principles promulgated by Beauchamp and Childress (1979, 1983, 1989, 1994, 2001) have their origins in the work of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1974-1979). In their position paper, "The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research," the commission noted that broader ethical principles were needed to guide investigators in navigating and interpreting the wide variety of codes of ethics in existence at that time. Members of the commission found common ground in three mid-level principles—respect for persons (later called respect for autonomy by Beauchamp and Childress), beneficence (which included the notion of nonmaleficence, which Beauchamp and Childress would separate), and justice—in spite of disagreements over the primacy of more abstract normative theories (e.g., Kantianism vs. Utilitarianism) or sets of conflicting rules (Graber, personal communication, February 5, 2004). While the "Belmont Report" provided guidance to investigators using human subjects in biomedical research, Beauchamp and Childress (1979) sought to articulate a framework whereby these principles served as guidance for physicians providing clinical services to patients.

Beauchamp and Childress (2001) assert that morality is a social institution and we all grow up learning about basic moral standards and responsibilities; thus, the norms of basic morality (e.g., do not lie, steal, break promises, and so forth) are readily understood. Furthermore, "all persons serious about morality are comfortable with these rules and do not doubt their relevance and importance" (Beauchamp & Childress, 2001, p. 3). Though critics have challenged this notion of "common morality," Beauchamp and Childress are quick to dismiss the relevance of debates over the justification of moral principles beyond their seeming assumption of intuitionism (Beauchamp & Childress, 2001). Whereas early conceptualizations of principlism (as the work of these authors has come to be known) failed to account for the moral character of the agent, current formulations incorporate virtue ethics as complementary to

the principles approach (Beauchamp & Childress, 2001). Principlism has dominated the bioethics profession since its introduction in 1979, and although alternative perspectives (e.g., feminist and narrative) are increasingly being recognized (Tong, 2002), it is worth discussing Beauchamp and Childress' (2001) model in more detail.

#### *Four Moral Principles*

(1) Beneficence is the positive requirement to take certain steps to promote the interests and well-being of others such that they are better off than they previously were as a result of the action taken. Beneficence includes those actions that actively protect others from harm in addition to those that directly confer benefit. Nonmaleficence is the negative requirement to not harm others or to refrain from doing that which would make them worse off than previously (Beauchamp & Childress, 2001). Many writers, following the framework set forth in the "Belmont Report," collapse these two terms together such that beneficence is seen as "doing no harm." The problem with this is that as a standard of practice to attain, it remains a minimal standard (Sim, 1997). In other words, is doing no harm the best therapists can do? In many respects legal statutes and ethical codes are written as nonmaleficence (i.e., don't go below) whereas aspirational ethics are expressed more in terms of beneficence (i.e., going above and beyond).

(2) Nonmaleficence is typically viewed as primary over beneficence because failing to improve a situation seems less reprehensible than making a situation worse (Sim, 1997). It is as though acts of commission are seen as worse than acts of omission. From a practical standpoint, it is easier to consistently observe the principle of nonmaleficence than beneficence. It is seen as more realistic to expect constant avoidance of those few occasions where one is likely to do harm than to expect clinicians to constantly engage the myriad opportunities to do good for others. Further, nonmaleficence is seen as having far greater negative consequences for society than the corresponding neglect of beneficence (Beauchamp & Childress, 2001). In theory, a lack of beneficence leaves society with the status quo, while the lack of nonmaleficence yields unending deterioration of society. The problem with this view is that not everyone in society is even committed to nonmaleficence. It also presupposes that the status quo is at some level acceptable, a stance that feminism argues against.

(3) The third basic ethical principle, respect for autonomy, is the requirement that one should preserve and even enhance the self-determination of others. This usually applies only to those who are or who have previously been autonomous (e.g., children are usually seen as less autonomous than adults in Western society). Though not a univocal concept, most definitions of autonomy include notions such as the capacity to think, decide and act on the basis of such thought and do so freely and independently (Beauchamp & Childress, 2001). Autonomy is seen as a subset of “liberty” which is defined as the ability of a person to do what she wants, and to have significant options that are not closed or made less eligible by the actions of other agents. Withholding information or giving false information impinges on autonomy by interfering with the factual and rational basis for decision-making regarding one’s actions. One must respect both autonomy related to action and autonomy related to thought. Making one’s values transparent, therefore, may actually do more to promote the client’s autonomy of thought than keeping them hidden. Psychotherapy’s emphasis on patient confidentiality draws normative force from this principle of autonomy.

(4) Justice, the fourth ethical principle, is the requirement to treat others fairly and in accordance with their individual merit. One’s actions, within a framework of justice, should be based upon a fair adjudication between any competing claims (Beauchamp & Childress, 2001). The benefits and burdens within a society should be apportioned in a way that is morally justifiable. Likewise, the differential treatment of others must also be morally justifiable. Justice can be analyzed in terms of distributive justice (i.e., the allocation of societal costs and benefits) and retributive justice (i.e. rewards or punishment, and retribution or restitution or compensation). Assumptions about egalitarian sex roles can be linked to assumptions about the ethical principle of justice.

#### *Specification and Balancing*

Moral Conflict occurs when two or more ethical principles are at odds in a situation. A moral dilemma occurs when one has no choice but to perform one of two or more actions, each of which has morally undesirable consequences and there seems to be no way to assign priority of one choice over the other(s) (Sim, 1997). Beauchamp and Childress (2001), rely on W. D. Ross’ distinction of prima facie

and actual obligations as a basis for their analysis. The four principles described above are considered *prima facie* duties, meaning they each carry a binding obligation unless two or more conflict, in which one may override or outweigh others as circumstances warrant. The actual duty in these cases is determined by what Beauchamp and Childress (2001) call the complementary processes of specifying and balancing principles and rules.

Specification entails a substantive refinement of the range and scope of norms, whereas balancing consists of deliberation and judgment about the relative weights or strengths of norms. Balancing is especially important for reaching judgments in individual cases, and specification is especially useful for policy development (Beauchamp & Childress, 2001, p. 18).

This process can be briefly illustrated in terms of the AAMFT Code of ethics (2001). The principle of justice is specified in terms of norms regarding non-discrimination (sub-principle 1.1). Continuing therapy only so long as the client is benefiting (sub-principle 1.9) is the principle of beneficence specified. Sub-principle 1.4, the prohibition of sexual intimacy with clients, is a specification of the principle of nonmaleficence, while obtaining informed consent (1.2) and respecting clients' decisions (1.8) specify the principle of autonomy. The various weights given to each of these sub-principles, or specified norms, would be balanced against one another given the facts of a particular case.

It is important to not assume that one ethical principle is intrinsically more important than another when seeking to resolve a moral conflict (Beauchamp & Childress, 2001). Within certain moral perspectives, some principles may have a tendency to be more insistent than others, but the facts of the specific situation may not always coincide with this tendency. In western societies, for instance, where there is so much emphasis on individualism, there has been a tendency to privilege the principle of respect for autonomy over other consideration. This is a distortion of Beauchamp and Childress' model.

#### General Psychotherapy Models of Ethical Decision-Making

Karen Kitchener (1984, 1986, 2000), a counseling psychologist, can be considered the progenitor of principlism for psychotherapists by formulating a model of ethical decision-making based on the

principles of Beauchamp and Childress (1979), and Hare's (1981) adaptation of classical normative ethical theories for psychiatrists. Kitchener's (1984, 2000) adaptation of Beauchamp and Childress and Hare is still frequently cited in both the MFT literature and the larger psychotherapy literature, and has spawned numerous additional adaptations, including a direct application to family therapy by Zygmund and Boorhem (1989). Similar to Beauchamp and Childress (2001), Kitchener's more recent efforts incorporate virtue ethics into her comprehensive approach to psychotherapy ethics, as well as drawing from the moral development research of James Rest (1994).

Kitchener's brilliance seems especially to be her ability to synthesize the work of others in new pragmatic ways and fully illustrate the dialectical relationship between theory and practice, thereby modeling praxis. Cottone and Claus (2000) conducted a comprehensive review of the ethical decision-making models in the counseling psychology literature and concluded that Kitchener's (1984) work has become established as seminal. Readers are referred to Cottone and Claus' (2000) excellent review for discussion of other models of ethical decision-making in psychology; but because Kitchener's work is also seminal within the MFT ethics literature, it will serve as the primary focal point of the current discussion.

To fully understand Kitchener's (1984, 1986, 2000) contributions, however, it is important to review the foundational sources from which she draws her ideas. In addition to the review of Beauchamp and Childress (2001) above, careful attention will next be given to Hare (1981, 1991) and Rest (1984, 1994). Following that, Kitchener's version of these ideas is presented. A feminist critique of Kitchener's work is also offered, followed by a brief presentation of models of ethical decision-making in the MFT literature, and a discussion of the functions, and strengths and weakness of professional codes of ethics generally. The chapter concludes with a return to the medical ethics literature with a careful review of the strengths and weaknesses of various methods of ethical reasoning.

#### *Hare: Philosophical Basis of Psychiatric Ethics*

Frequently cited by others formulating models of ethical decision-making in psychotherapy (e.g., Kitchener, 1984; Woody, 1990), Hare (1981, 1991) distinguishes between intuitive and critical levels of

moral thinking. The intuitive level, with its *prima facie* duties and principles, is the level of everyday moral decisions. These decisions, made quickly and without much thought based on values absorbed through one's upbringing (i.e., intuitively), are decisions of conscience. However, in so much as one's conscience is socially constructed, this basis for moral judgment is subject to the strengths and weaknesses inherent in the society in which and at the time one lives (Hare, 1991). While codes of ethics often attempt to articulate these general principles of practice, they too shape and are shaped by culture and history. Thus, one's own intuitions and even professional codes of conduct are insufficient in and of themselves to resolve all moral issues.

Hare (1991) encourages therapists to develop critical thinking skills, by considering a wide variety of particular cases to "think about the ethics of their profession and try to decide what principles and practice would, on the whole, be for the best for those affected by their actions" (p. 30). This is where a critical awareness of one's underlying assumptions, especially those informed by one's culture and time in history, becomes so important. As one attempts to sort through general ethical principles, it is vital to include, to the extent it is humanly possible, an awareness of the social construction of the priorities one may determine.

The intuitive level of moral thinking, according to Hare, deals more with character development of the therapist. When the therapist has no time to think through a moral conflict, one relies on gut instinct. The critical level of moral thinking deals more with the training of the therapist. When the therapist has time to think through general ethical principles, one should be actively aware of the method being used to reason it out. In terms of the intuitive and critical levels of moral thinking, moral character traits lead to intuitive moral thinking while the sensitivity to the moral demands of professional practice leads to critical moral thinking (Hare, 1991).

Hare notes that there is dialectical relationship between intuitive and critical thinking such that our intuitive consciences can, and sometimes should be, educated through critical level thinking. This is akin to what Kidder (1996) describes as the development of moral fitness. The more we carefully reason about moral matters, the more morally fit we become, improving our ability to make good and right

choices spontaneously, just as athletes quicken their reflexes through weight training. Kidder (1996) suggests, then, that ethical decision-making is “intelligence functioning at intuitional velocity” (p. 180). Likewise, Hare (1991) suggests that developing both intuitive and critical thinking allows for the most comprehensive approach to ethical therapeutic practice.

Hare’s distinction between intuitive and critical levels of problem solving offers a useful superficial description of how most of us make many of our personal and professional decisions. His model, however, is not without significant problems. Hare (1981, 1991) is purportedly articulating the philosophical basis for psychiatric ethics (i.e., providing philosophical justification); yet it is difficult to ascertain clear (and accurate) links in his model to moral theories. For instance, having already identified intuitive level reasoning with virtue ethics (i.e., the therapist’s character development), Hare (1991) goes on to suggest that the first level of thinking is best related to what he calls the “absolutist” approach, while the second level benefits most from the “utilitarian view.” It is difficult to establish exactly how Hare is defining the “absolutist” and “utilitarian views,” though apparently he is attempting to contrast deontological and teleological reasoning. Sometimes he presents the absolutist view in terms of Rawls’ contract theory (which is a theory of justice only, was never intended to be a general moral theory, and thereby does not attend to non-justice moral issues); while at other times he talks about it in terms of Ross’ theory of prima facie duties.

Although he briefly attempts to distinguish his definition from utilitarianism as presented in moral philosophy (in spite of the fact that he is supposedly presenting the philosophical basis of psychiatric ethics), his presentation of the “utilitarian view” is also a confusing suggestion that seems to equate it with paternalistic calculations of patients’ best interests. By collapsing all of moral theory into these two vague conceptualizations, Hare (1991) fails to acknowledge the complexity of reasoning involved in deontological views, and does not give an adequate account of why he privileges teleological reasoning over other moral theories. Finally, Hare’s discussion of intuitive level thinking seems to be simultaneously descriptive (i.e., our intuitive moral sense is developmental) and normative (i.e.,



references to deontological normative theories); thus perpetuating rather than reducing confusion about the philosophical basis of therapy ethics.

This is especially problematic because Hare is frequently cited by psychotherapists who may or may not be familiar with original sources in moral philosophy. For instance, in Jane Woody's (1990) model of ethical decision-making in MFT, Hare (1991) is her primary source for ethical theory, importing Hare's obfuscating definitions of absolutist and utilitarian views, and his incorrect portrayal of Rawls's contract theory of justice as a general moral theory. Given these problems, and the tendency in the ethical decision-making therapy literature (particularly in MFT) to use secondary sources for ethical theory, it may be no wonder that the actual promise of ethical theory for ethical guidance remains untapped, particularly for MFTs.

While Kitchener (1984, 1986, 2000) appears more grounded in moral theory generally speaking, she relies on a combination of moral principlism and Hare's intuitive and critical levels of moral thinking. A superficial view of Hare's levels seems to have some pragmatic utility, especially if one relies primarily on a distinction based on speed of processing time. In some respects this is what Kitchener (1984), and thereby others who refer to Hare's work via Kitchener, appear to do with pragmatic success. Kitchener, apparently, has kept the shell of Hare's critical evaluative level of moral reasoning, but replaced his cumbersome approach to classical ethical theory, with Beauchamp and Childress's mid-level theory of critical ethical analysis. This could be understandable if one accepts, as Kitchener seems to have, Beauchamp and Childress' quick dismissal of more abstract theories. Yet, as will be discussed more below, Beauchamp and Childress' efforts to remain at mid-level theoretical considerations have drawn critiques from those who would argue for stronger theory as well as those who rely more on concrete case specifics (see Graber and Thomasma, in press).

### *Rest: Moral Development*

James Rest (1983, 1984, 1994), a neo-Kohlbergian researcher of moral development, has suggested that there are four psychological processes involved in moral behavior. According to Rest (1994) ethical behavior is impacted by

- (1) sensitivity to moral issues,
- (2) the ability to reason about and evaluate ethical options,
- (3) the motivation to act ethically, and
- (4) the ego strength, or character, to carry out ethical decisions.

First, we must have moral sensitivity, which involves having the ability to perceive the ways in which our actions may help or harm others. With its attention to identifying what the ethical issues and considerations are, it would appear that the majority of ethics literature in MFT is especially helpful in developing this first component of moral behavior.

Second, we must be able to utilize moral judgment in evaluating the various ethical considerations identified through educating our moral sensitivity in order to formulate morally justifiable courses of action (Rest, 1994). The need for increased attention to *how* we do and should make moral decisions in MFT is the primary focus of the current project. Research in cognitive moral development (e.g., Kohlberg, 1984; Rest, Narvaez, Bebeau, & Thoma, 1999) makes clear that our capacity for the complex reasoning necessary to fully evaluate ethical dilemmas is influenced by our level of moral development. Neukrug and Lovell (1996) speculate about the relations between level of moral development and counseling ethics:

In most cognitive developmental models...lower level thought characteristically tends toward dualism, rigidity, oversimplification, stereotyping, self-protectiveness, and authoritarianism, whereas higher level thought is more flexible, complex, contextually sensitive, and allocentric. Therefore, counselors who are at lower developmental levels

may need the supportive structure that a clearly written ethical code can provide, whereas ethical reasoning for individuals at higher levels of development becomes a more abstract and complex process, thus requiring less rigid adherence to codified ethical guidelines. For those at the highest levels of moral development, ethical guidelines might serve as but a tool in a deeply reflective decision-making process. For “lower level” counselors, guidelines might be regarded as the singular authority, with any further “soul searching” deemed a needless exercise in complicating matters (p. 103).

Furthermore, Rest’s (1979, in Kitchener, 1986) data suggest that the development of increased sophistication in moral reasoning requires a sustained effort (i.e., longer than three months) in which attention is explicitly focused on moral reasoning processes (i.e., how to evaluate moral considerations, not simply identify what they are). Thus, while students can become familiar with moral principles, brief exposure to decision making models during a workshop or as a passing focus in a single ethics class is not likely to augment the level of moral development that therapists may need to actually utilize more sophisticated models in practice (Kitchener, 1986).

Rest’s (1994) third psychological component to moral behavior is having the motivation to privilege moral values over other compelling non-moral considerations, such as money, ambition, self-interest, or even time and effort. This is not to say that personal values are not to be factored into the equation, for that would be unrealistic, but Rest is recognizing that truly moral behavior will at times require submission of non-moral considerations to moral values. Kultgen (1988) has observed that most professions are occupied by persons of “ordinary conscientiousness” and “moderate good will,” meaning they will do what they think is right if the cost is not too great and if others are prepared to do the same (even without the threat of sanctions). While we might find comfort in the thought that therapists are by nature extraordinarily conscientious and extra full of good will, reality suggests otherwise. If true, professional ethics committees and regulatory boards would be less busy adjudicating ethics complaints. Additionally, in an empirical study by Smith, McGuire, Abbott, and Blau (1991), professional clinicians

were more likely to refer to formal professional and legal standards when determining what they *should* do, but capitulated to personal values and practical considerations when determining what they would *actually* do. Kultgen (1988) argues that professional codes must strike a middle ground, clearly articulating and enforcing through sanctions baseline standards that discourage malfeasance, but also not demanding “heroic virtue” (p. 34). In other words, “if the provisions of a code are to be exacting, there must be institutions that make it possible to observe them without martyrdom” (Kultgen, 1988, p. 34).

The fourth component to moral behavior according to Rest (1994) is moral character, which involves having the “ego strength, perseverance, backbone, toughness, strength of conviction, and courage” (p. 24) necessary to follow through on a moral decision. Though closely related to moral motivation, the third component, moral character, according to Rest (1994), refers to having the wherewithal to actually behave morally, as compared to the motivation to privilege moral considerations. This is not to be confused with character ethics or virtue theory as discussed in the previous chapter, which is more complex and comprehensive than Rest’s more modest use of the term. A key element of moral character involves learning to tolerate the ambiguity that is inherent in moral decision-making. Generally being persons of ordinary conscientiousness and moderate good will (Kultgen, 1988), the prospect of balancing a lesser harm against a greater harm is inevitably anxiety provoking. No matter what option a therapist chooses when faced with a genuine moral dilemma she will likely be left with feelings of regret and dissatisfaction that some ethical requirements were violated in order to meet others. This is inescapable.

How one manages his anxiety, however, is a critical piece of ethical decision-making often not recognized. Research on decision-making under stress indicates that the more cognitive stress we experience, the fewer variables we are able to evaluate and manage in the formation of our decision (Janis, 1993). One could argue that this highlights the need to create parsimonious decision-making models. However, parsimony at the expense of ignoring the complex realities and ambiguities of moral life may be self-defeating, result in poor decisions, and is certainly not morally admirable. Instead, comprehensive ethics education that emphasizes moral reasoning skills, rather than ethics training

focused on rote enactment of appropriate behaviors (Cohen, 2001) may mitigate (though not eliminate) stress by giving therapists an opportunity to rehearse and think through complex situations that are not reducible to the code of ethics. Once given tools for identifying and analyzing moral situations, the perceived ambiguity may diminish.

*Kitchener: Intuition, Critical Evaluation, and Ethical Principles*

Through her integration of Hare's (1981, 1991) distinction between intuitive and critical-evaluative moral reasoning, the mid-level principlism of Beauchamp and Childress (1979, 1983, 1989, 1994, 2001), and the psychological components of moral behavior articulated by Rest (1983, 1984, 1994), the significance of Karen Kitchener's (1984, 1986, 2000) contribution to psychotherapy ethics can hardly be overemphasized. In a nutshell, Kitchener's (1984) model begins at the intuitive level of moral reasoning, and while she credits Hare (1981) for distinguishing between intuitive and critical thinking, she largely substitutes Beauchamp and Childress' view of ordinary morality for Hare's definition of intuition. This is combined with what Kitchener simply refers to as "facts of the situation," though there is no discussion of how one determines which facts are most relevant (e.g., factors related to clients, therapists, supervisors, institutions, relationships, culture, gender, history). Kitchener suggests that often, but not always, our own pre-reflective moral sense (i.e., intuition) combined with the facts of the case (however they are determined and defined) will be sufficient to guide decisions. However, because our intuitions may be faulty, it is necessary to engage in second order reasoning or critical evaluation.

Whereas Hare uses utilitarian theory to describe his version of critical level reasoning, Kitchener draws upon three sources which are referred to sequentially as needed with each level progressively more abstract:

- (1) Moral Rules (i.e., codes of professional ethics and laws),
- (2) Moral Principles (i.e., beneficence, non-maleficence, justice, autonomy, and fidelity), and
- (3) Moral Theory (i.e., higher order ethical principles of universalizability and balancing).

The first check of one's intuition recommended by Kitchener is identifying relevant moral rules as articulated in professional codes of ethics and laws. Included here are references to casebooks which rely

on casuistry (i.e., similar cases ought to be treated similarly) for interpretation of codes and laws. Often these rules will provide sufficient direction; if they do not one advances to considerations of moral principles.

At this second tier, Kitchener has incorporated Beauchamp and Childress' four principles—beneficence, nonmaleficence, respect for autonomy, and justice—while adding a fifth, fidelity, which emphasizes being faithful, keeping promises, respecting privacy, etc., and is seen as essential to therapeutic relationships. Though she does not say so explicitly, it appears that Kitchener is also importing Beauchamp and Childress' method of specification and balancing, whereby the ways in which each of the principles are manifest in the situation at hand are specified, and then one attempts to balance the interests identified by these specified principles in an attempt to formulate an ethical response. If the interests associated with two or more moral principles conflict and a balancing compromise not reached, one resorts to the third and most abstract level of reasoning in Kitchener's model, which is ethical theory.

While mentioning classical formulations of deontological and teleological theories as single principle approaches, Kitchener notes correctly that their unitary approach is inadequate and rejected by most current philosophers. Though their ability to serve as a sole criterion has been rejected, the considerations deontological and teleological theories identify have maintained credibility. Kitchener (2000) relies instead on Engelhart (1986) and Baier (1958), when articulating the criteria she finds useful for adjudicating between moral principles. She discusses three criteria, or tests, which together formulate a "good reasons approach" (Baier, 1958 in Kitchener, 2000, p. 35). One could reasonably hold that one's decision is a good one if: (1) "others in similar circumstances ought to act or be treated in a similar manner (Kitchener, 2000, p. 35) (a version of Kant's universalizability rule, modified to make room for exceptions as needed); (2) it is made from the impartial moral point of view (though feminists would challenge the notion of the moral point of view being strictly impartial); and (3) roles can be reversed such that one would be willing to be on the receiving end of the action one is about to take (i.e., The Golden Rule). Thus, while Kitchener acknowledges more abstract theories, like those discussed in the previous chapter, she spends very little time describing them (compared to her emphasis on principles),

and offers fairly diluted and oversimplified forms of these theories. This seems to be closely parallel to Beauchamp and Childress' approach to higher order theory, and is not without critiques.

It is important to recognize that adapting Kitchener's model to other forms of therapy is adapting what is already an adapted amalgamation of other theories. Beauchamp and Childress (2001) and Kitchener (1984, 2000) make assumptions and decisions in their models that as family therapists we may or may not wish to import, or that may be useful, but incomplete. For instance, Kitchener's original model (1984a) relies on only two of the three classical approaches to normative ethics: a Kantian version of deontology (what she calls "universalizability") and a teleological or consequentialist analysis of potential harms. While her later work (2000) picks up the third classical approach, virtue or character ethics, it still does not readily account for the sorts of postmodern and feminist concerns so influential in the field of marriage and family therapy.

#### *Hill, Glaser, and Harden: A Feminist Model*

Hill, Glaser, and Harden (1995) propose a feminist model of ethical decision-making in response to feminist critiques of the work by Hare (1981, 1991) and Kitchener (1984, 1986). These authors are concerned that intuition is permeated by cultural values that have traditionally been detrimental to women and other historically undervalued groups, and even at critical-evaluative levels of moral reasoning, interpretation of ethical codes and their underlying moral principles varies based on the context of power associated with the interpreter's race, gender, class, and so forth. Hill, et al. (1995) take issue with the assumption made by Beauchamp and Childress (1979, 1983, 1989, 1994, 2001) that the moral principles they discuss as fundamental to clinical ethics is based on a common morality. They assert instead, "one's position in the culture, particularly in relation to power, deeply affects how one defines each of these principles and thus is at the very heart of one's ethical decision-making" (Hill, et al., 1995, p. 21).

Furthermore, Hill et al. (1995) are concerned that most ethical decision-making models tend to be almost exclusively cognitive, giving little consideration to the intense feelings usually associated with complex moral dilemmas, and the person of the therapist as a legitimate factor in decision-making. While

some authors (e.g., Beauchamp & Childress, 2001; Jordan & Meara, 1990; Kitchener, 2000; Meara, Schmidt, & Day, 1996) look to virtue ethics to address similar sorts of limitations to focusing exclusively on principles, virtues are still seen to be universal characteristics; thus, feminists would not see this as sufficient attention to the value of personal experience in decision-making. Most decision-making models include a role for consultants, but few address the values of the consultant as influencing guidance, and finally, Hill et al. (1995) are concerned about how rarely clients are an active part of the therapist's decision analysis. Based on these concerns, Hill and her colleagues (1995) have devised a model that combines the cognitive features of Kitchener's decision-making model with a focus on the feeling-intuitive process of the therapist, attention to power differentials, and efforts to avoid cultural bias.

#### *Brief Review of Family Therapy Models of Decision-Making*

While many models of decision-making exist (see Cottone & Claus, 2000), few are developed with family therapy in mind or are being published in explicitly MFT sources. There are only three comprehensive models of ethical decision-making specifically addressing family therapy (Thomas, 1994; Woody, 1990; and Zygmund & Boorhem, 1989). These models were introduced a decade or more ago, but have not received the on-going attention they deserve (both theoretical and empirical), given the field's ostensible commitment to the importance of ethical decision-making. Kaplan (1999) reviews these models.

First is Volker Thomas' (1994) model, which utilizes Bronfenbrenner's ecological model of development (e.g., 1989) and Hegelian dialectics. Thomas' model examines six presumably core professional values (i.e., responsibility, integrity, commitment, freedom of choice, empowerment, and the right to grieve) across three levels of self-evaluation (i.e., the individual level of the therapist, the micro system level of the therapist in relationship to the profession, and the meso system level of the therapist in relationship to her clients). Second is Zygmund and Boorhem's (1989) straightforward presentation of Kitchener's (1984) model of ethical decision-making using family therapy examples. Third is Jane Woody's (1990) pragmatic model which describes five types of considerations evoked by ethical dilemmas in marriage and family



therapy: formal and informal theories of ethics, professional codes of ethics, the clinical techniques and views of human flourishing or well-being presupposed by specific clinical theories, sociolegal contexts (i.e., personal values and biases, legal statutes, and organizational contexts), and personal and professional character. As Woody (1990) and Zygmund and Boorhem (1989) are part of the current study, more will be said later about these models.

Kaplan (1999) summarizes six overarching lessons to be derived from these models. First, introspection and self-knowledge by the therapist are critical. Second and third, knowledge of professional standards (i.e., codes of ethics) is essential, but cannot make up for the importance of having strong character. Fourth, therapists are expected to go beyond the avoidance of harm to the active promotion of client well-being. Fifth, one's clinical theoretical orientation is an insufficient justification for violating ethical standards. And finally, the more complex the ethical dilemma, the more helpful using a systematic framework for decision-making will be.

#### Codes of Ethics

Codes of ethics play important roles in ethical decision-making schemas of most professions, and marriage and family therapy is no exception. During a panel discussion at the 2004 AAMFT annual conference (Mowery, Becvar, Carlson, Gale, & Nichols, 2004) William C. Nichols chronicled the evolution of the current AAMFT code of ethics based on his written history of the profession (Nichols, 1992), and personal experience as a former leader in the organization. Nichols notes that through the 1960s and 1970s the professional code consisted largely of ad hoc considerations rather than being grounded in fundamental ethical principles. "I saw no evidence that during that period there was any significant effort made to question the sources of our ethics and seriously critique them. We tended to assume we 'knew' what was ethical and what our members should do" (Nichols in Mowery, et al. 2004, p. 1). Kultgen (1988) has observed that across professions, collections of ad hoc considerations and piecemeal rules in response to complaints or troublesome areas of practice often serve as early forms of codes of ethics, but these rules need to be systematized and organized under general principles and a tight logical structure.

In 1980 Nichols, as president of AAMFT, adapted to family therapy, and the board approved, eight standards based on the moral values of the profession articulated by the American Medical Association. Nichols observed that although these principles continue to ostensibly structure the code, there appears to be a shift in orientation away from deriving provisions from moral values. Instead, Nichols suggested that the distinction between legal and ethical issues began to be blurred in the code, and an “allness” stance developed that somewhat denies the inherent ambiguity of moral dilemmas. “By ‘allness’ I refer to an approach in which actions are prohibited if there is even the slightest possibility that those taking the forbidden action would do anything wrong, or if the ethics committee might have difficulty in enforcing the rule” (Nichols in Mowery, et al. 2004, p. 2). This is in keeping with the previous discussion about the apparent compliance focus of AAMFT and the move in the 2001 code to increase enforceability.

Preister, Vesper, and Humphrey (1994) also recounted content changes made to the profession’s codes, as well as the ethics committee, from 1962 through 1991. They noted a change in the philosophy of the ethics committee in the late 1980s and early 1990s to a more assertive stance toward initiating more complaints against members for ethics violations, and closer collaboration with state regulatory boards. The ethics committee at this time also increased its attention to training about the code in an effort to prevent ethics code violations (Preister, et al. 1994). Still, “[it] remains the conviction of the Ethics Committee and of many of the Association’s leaders that AAMFT must continually look for ways to better educate members about ethical issues in the practice of marriage and family therapy” (Preister, et al. 1994, p. 25). Understanding the functions, strengths and weaknesses of professional codes, and their role as teaching tools is important for assessing educational needs.

Based on a review of the literature, Neukrug and Lovell (1996) summarize some presumed benefits of professional codes of ethics:

- (1) protect consumers and enhance the professional standing of an organization in the eyes of the public;

- (2) serve as a vehicle for professional identity both for the individual practitioner as well as the profession;
- (3) guide behaviors toward the underlying values of the profession;
- (4) provide some direction for decision-making; and
- (5) provide some measure of protection to the therapist when faced with litigation.

Likewise, they summarize some limitations associated with codes of ethics:

- (1) cannot adequately address all ethical issues that arise in practice;
- (2) enforceability of codes can be difficult;
- (3) all stakeholders are rarely included in the formation of codes (e.g., clients, research participants, etc.);
- (4) different institutions (e.g., the law, medicine, psychotherapy, etc.) may address issues in codes differently;
- (5) conflicts are possible within a single code, between codes, between a practitioner's values and codes, between institutional policies and codes, etc.; and
- (6) as codes are usually formulated in reaction to past problems, they may not address "cutting edge" concerns (Neukrug & Lovell, 1996).

John Kultgen (1988) offers a useful analysis of the *role* of ethics, and codes in particular, across professions. Ostensibly, the function of professional codes of ethics is moral; their professed aim is to enhance the ethical practice of professionals. Kultgen, however, evaluates codes of ethics from the standpoint of their social functions (i.e., ways in which codes keep systems of action in balance or propel those actions in particular directions) and their human functions (i.e., ways in which codes support human welfare from the moral point of view). The social functions of professional codes must be distinguished from their human functions because they are often confused, and, despite the rhetoric of morality and appeal to conscience, "social functions sometimes obstruct and sometimes facilitate human functions" (Kultgen, 1988, p. 211).

### *Social and Human Functions of Codes.*

Codes function socially to maintain the status of occupations and strengthen the network of societal institutions (Kultgen, 1988). Codes contribute to professions in two ideological ways. First, part of what makes a profession a genuine profession is that there is an operational ethic guiding professional behavior, identifiable to the public, which is intended to instill trust and confidence in actual practices. Such ideologies may indeed be codified descriptions of actual behaviors or at least those standards of conduct leaders want to foster. Kultgen (1988) stresses that codes are instruments of persuasion, and as such, need to be simple and plausible to a wide audience of profession members and the public. Furthermore, codes serve a unifying function for professionals by creating a common sense of values primarily communicated through the socialization of professional schools, and reinforced by licensure regulations, and enhancing the sense that ethical behavior is part of professional competence (Kultgen, 1988).

A second ideological contribution of codes is the function they serve in professional discipline. As noted above, in the late 1980s, the AAMFT ethics committee became more assertive in its efforts to police ethics code violations. Certainly there was, and continues to be, a moral concern by AAMFT leaders to deter unethical acts in an effort to protect the public. Kultgen, however, asserts that professions generally are motivated to self-discipline members not only for moral reasons, but for public relations reasons as well. “No doubt many are concerned for morality for its own sake, but all are highly concerned with appearances, the reputation of the profession, the honor and dignity of the professional” (Kultgen, 1988, p. 214). From this perspective, AAMFT’s training emphasis on compliance with the code of ethics and legal risk management is an important means of protecting not only the individual therapist from legal liability, but the profession from a tarnished reputation. This is a legitimate and worthy practice. Difficulty arises, however, as Kultgen (1988) warns, if these social and ideological functions overshadow human functions of the code and efforts to equip members of the profession with the interpretive and reasoning skills necessary to attend to the human moral issues they and their clients face.

In terms of moral guidance, codes are generally considered most useful to practitioners for articulating consensus about issues an individual member may or may not have thought through, especially since most professionals do not reflect carefully on ethics concerns until face to face with a moral dilemma. Yet to be most effective, codes must contain provisions that represent the conclusions most informed practitioners (not just most attorneys) would have reached had they taken the time to reason it through. Thus, while codes can simplify the moral terrain for practitioners, they cannot make decision-making mechanical; personal judgment is still required and all of ethical decision-making cannot be reduced to a professional code of ethics (Kultgen, 1988).

[T]here are the invisible consequences of reducing the ethical sense to abstract arguments over the meaning and application of codified rules. The ethical sense must not be replaced with a strictly codified approach, as this can lead to ethical atrophy. Ethical codes are tools, and not replacements for a vital and well-exercised ethical sense.

Depending on either the law or ethical codes exclusively means that the ethical substance remains fragile, subject to technical manipulation and authoritative amendment. The profession of psychotherapy must see the law as only one colour on a richly varied ethical palette (Bell-Boule, 1999, paragraph 37).

### *The Hermeneutic Hurdle*

Part of the inherent limitation of codes resides in the tensions between the public relations motives inherent in the social functions of codes and the moral requirements of the human functions. At this interface is the fact that codes are texts that must be interpreted in order for individuals to access the guidance they offer.

Identification of the functions of a code must be predicated on an understanding of what it says to those affected by it, since their understanding, not the analyst's, produces behavior and the consequences categorized as functions. The hermeneutic task appears easy, since codes are written in plain language. However, words mean different things to different audiences. What will be termed the interpretive community of professional

codes is heterogeneous. It is quite possible that the formulas of a code mean something different to their authors, to the leaders of professional associations, to practitioners in the field, to the public, and to ethical theorists (Kultgen, 1988, p. 218).

The AAMFT Code of ethics does not contain a section defining terms or otherwise providing explicit guidance on how to decipher its provisions. Although discussion of the code of ethics is an important component of ethics courses in accredited family therapy programs, the tools offered by AAMFT for interpreting the code appear fairly limited. Apart from workshops presented by ethics committee meetings at divisional and national conferences, AAMFT seems to have relied heavily on consultation with the AAMFT attorney and ethics casebooks (e.g., AAMFT, 2001; Brock, 1994; Woody and Woody, 2001) for its interpretive needs.

While certainly AAMFT's legal consultant will guide practitioners according to the moral and legal issues involved in their individual needs and circumstances, one can also question whether any legal consultant working for a profession would not also sometimes get caught in the tensions between social and human functions of a code. In other words, who is the client for whom the attorney is interpreting the code—the institution or the individual professional? If an attorney is being paid by a professional organization, it only stands to reason that the interpretations offered by that attorney to members of the profession may be heavily (and legitimately) influenced by the needs of the professional organization as a social institution (i.e., avoid law suits at all cost because of the public relations damage they can cause to the profession). Thus, a strictly moral (i.e., human functions of codes) accounting of the ethical and legal issues in an individual case need not inevitably be weighted so heavily toward a conservative legal interpretation of the code of ethics. As Kultgen (1988) puts it:

[No] set of rules, even the best that people can devise, is absolute. To treat rules as absolute is code-fanaticism, regulatory, or nomomania. Any rule should be broken when obvious and grave disutilities would flow from its observance in extraordinary circumstances and those disutilities would outweigh the disutility of weakening the rule for ordinary circumstances. Disutilities of this character justify violation of the rule

regardless of the probability or magnitude of the benefits following from actions according to the rule in other situations (p. 31).

In other words, there may be stronger moral considerations than the law at the level of any given case (i.e., a law suit may not be the greatest possible harm to avoid) even though privileging legal considerations is generally a good rule of thumb. This is the distinction ethicists make between the moral assessment of acts and rules; what is considered moral in a given situation at one level may or may not be considered the best ethical response at another level.

This is also why it is so critical to not interpret ethics as equated with law, and why it may be faulty logic to have a provision in a code of ethics that automatically equates a legal violation with an ethics violation. Furthermore, so long as the wording of the code of ethics is interpreted to mean that the provisions have an absolute rather than prima facie nature, current efforts to incorporate the AAMFT code of ethics into licensure laws may be problematic, in spite of potential benefits to the professional institution of family therapy. Efforts to augment enforceability of an ethical code should not confuse ethical accountability with legal accountability, though certainly the two can be closely related.

#### *Case Study Reasoning (i.e., Casuistry)*

Just as reliance on the law or consultation with a professional organization's legal counsel offers both benefits and possible limitations, relying on casebooks, too, is full of strengths and weaknesses. Kultgen (1988) argues that the explanatory value of case commentaries provided by professional associations is restricted in that they tend to (1) only indicate their rationales implicitly, (2) are commands issued from the top, and (3) "do not represent an argued consensus among the membership of the association or the profession, not to mention the public" (Kultgen, 1988, p. 222). Furthermore, casebooks typically are constrained to only offer thumbnail sketches of moral dilemmas. What moral or situational features are highlighted by the authors during the construction of case narratives (or presentation, in the case of real scenarios) are interpretive acts in and of themselves that delimit the types of moral considerations to be discussed and predetermine which provisions of the profession's code will receive greatest weight.

In the *User's Guide to the AAMFT Code of Ethics* (AAMFT, 2001), vignettes tend to be short paragraphs devoid of complexity and the details most likely to elicit the genuine affective responses characteristic of real life dilemmas. Discussions of these vignettes tend to be “straight forward” applications of rules from the ethics code, with little or no rationales given to support the interpretations offered. Rarely are alternative interpretations or solutions presented, and those that are tend to be of the “straw man” variety, presumably supplied to reinforce the “authoritative” interpretation of the code provided by the author.

To be fair, the guidance offered in the *User's Guide* (AAMFT, 2001) appears to be largely very sound, with interpretations of the code resonating quite closely to circumscribed descriptions of ethical dilemmas. The main points here are not that good guidance is not available in this casebook, but rather that: (1) authors fail to be transparent about the moral (meta-ethical and normative) assumptions shaping both their descriptions of cases and their interpretations of the code; (2) circular logic appears frequently (though not exclusively) whereby the code itself is used to justify applications of the code rather than appealing to larger moral principles for rationales; and (3) while short vignettes can never capture the complexity of real-life moral dilemmas, the types of considerations that might justifiably alter the conclusions presented by the authors are rarely acknowledged or discussed.

AAMFT is full of very smart, caring professionals who, like the contributors to these ethics casebooks, are committed to maintaining and promoting the highest ethical integrity among members of the profession. It may be that the more general pedagogical emphasis in AAMFT on ethics training with its focus on compliance, rather than the broader reasoning-skills approach of ethics education is largely shaping the style and content of ethics casebooks. It is important to note too that the concerns listed above do not just apply to AAMFT ethics casebooks, but to the limitations of case-studies as a form of moral reasoning more generally.

Case-study reasoning, formally known as casuistry, is a well known and largely time honored means of discussing clinical ethics; its pedagogical utility readily affirmed by practitioners across professions. This is likely because this sort of reasoning by analogy (i.e., what is the situation at hand



most like?) plays a large role in ordinary day-to-day moral thinking. Perhaps this is the common sense Karen Gautney, AAMFT Deputy Executive Director, refers to when she says, “So, combining the aspirations and guidance offered by the AAMFT Code of Ethics, the desire to do the right thing, laws and legal precedents, what we know of best practices, clinical supervision, and common sense will generally make the ethical path clear in even the most complicated situations” (AAMFT, 2001, p. ii). Indeed, casuistry seems to be the implicit reasoning process being assumed by writers of ethics casebooks. Apparently the idea is that each case presented has a moral to the story and will provide guidance when future situations are encountered that are similar to those presented in the casebook.

Yet in the field of marriage and family therapy, we seem to be relying on a modified version of the casuistic reasoning utilized by professional ethicists. Ethicists seek to identify a variety of possible moral analogies with which to analyze a case, in contrast to the tendency noted above in the MFT literature to provide one authoritative analogy. Furthermore, Richardson (2003) notes, “[R]easoning from cases must at least implicitly rely upon a set of organizing judgments or beliefs, of a kind that would, on some understandings, count as a moral ‘theory.’ If this is correct, it provides another kind of reason to think that moral considerations could be crystallized into principles that make manifest the organizing structure involved” (section 2.3). This supports the concerns listed above about the need to articulate underlying moral assumptions guiding the analysis of the case. While a diluted form of case-study reasoning (i.e., casuistry) appears to be the predominant reasoning tool ostensibly promoted by the profession, Graber and Thomasma articulate six additional schemas used by medical ethicists which may shed clarity on reasoning processes used in MFT.

#### Graber and Thomasma: Models of Ethical Analysis

Based on a comprehensive review and analysis of the bioethics literature, Graber and Thomasma (1989, in press) delineate and assess the strengths and weaknesses of six schema or models used by professional bioethicists to structure their reasoning processes when reflecting on relations between ethical theory and clinical practice. They refer to these schemas as (1) the application model; (2) the mediation model; (3) the validation model; (4) the determination model; (5) the origination model; and

(6) the virtue model. In consideration of the strengths and weaknesses of these six models, they then move toward the development of a unitary theory of normative clinical ethics by introducing what they call practical biomedical hermeneutics (Graber & Thomasma, in press).

While both Graber and Thomasma are moral philosophers, and much of their analysis involves technical philosophical distinctions or clinical practices unique to medical practice (a review of which is beyond the scope of this paper), the typology of reasoning processes they describe may advance our understanding of the overt or covert reasoning being deployed in the psychotherapy ethics literature. Thus, some time will be devoted to laying out these frameworks, included their strengths, weaknesses, and some initial thoughts on how they may related to reasoning about issues in psychotherapy.

#### *Application Model Reasoning*

In the Application Model (Graber & Thomasma, in press), moral principles such as autonomy, beneficence, nonmaleficence, justice, utility (i.e., greatest good for greatest number), or universalizability (i.e., act as you would wish all others to act) can methodologically be applied to concrete situations by rigorously following rules of logical deduction, classification, measurement, and even statistical probability. A clear distinction between theory and practice is assumed by this model, such that the task of justifying or critically examining the normative principle is neatly separated from the technical task of applying it to the situation at hand; thus technical skills used in philosophical analysis, rather than general reflective judgment, are emphasized. Differences in conclusions about what to do are seen as procedural errors in the deductive process of applying principles to concrete situations. One may be accused of failing to account for contextual features because they were not taken into account in the “right” way (i.e., morally relevant features were assigned weights differently as compared to the critic’s assignment of moral weight).

The strengths of the application model include its logical rigor and the support it gives for acting on principle alone, which mitigate against extreme relativism. Weaknesses include its susceptibility to degenerate into legalism, insensitivity to context, its lack of a mechanism for prioritizing fundamental principles, and the lingering question as to whether such pure deductive reasoning is even possible. When

practitioners think about ethical theory and roll their eyes, it likely is because they are thinking about the application model and questioning its practical utility. While this model is one of the most established ways of thinking about ethical theory, it is by no means the only way to think about it (Graber & Thomasma, in press).

### *Mediation Model Reasoning*

In the Mediation Model (Graber & Thomasma, in press), conclusions are derived from principles, as in the application model, but the deductive process is mediated by external moral considerations. This can be seen as a way of maintaining the rigor associated with a deductive system, while accommodating the need for minimal compromise to deal with conflicting principles. There are three forms of mediating considerations. First, a prioritizing mechanism, a “normative priority rule,” arbitrates which principle should receive the greatest weight when principles are in conflict. The Canadian Psychological Association (2000) has inserted such a rule into its Code of Ethics by explicitly prioritizing respect for the dignity of persons over its other three overarching principles (i.e., responsible caring, integrity in relationships, and responsibility to society). Alternatively, as in W. D. Ross’ system of prima facie duties, moral intuition or perception may be a mediating source for weighting principles.

Second, moral considerations may be mediated based on how terms are defined (e.g., lying is wrong, but withholding the truth may or may not be defined as lying). Within the family therapy field, there is now a recognition that exploitive relationships are wrong, but dual relationships may or may not be defined as exploitive. Third, conclusions based on or derived from principles may be mediated by specifications contained in rules or policies (e.g., exception clauses). Relying on rules or policies is more efficient and leads to greater consistency than case-by-case reasoning; however, whether a rule applies to a specific case in the first place must always be individually assessed. Beauchamp and Childress’ model (2001) can largely be understood as a mediation model, with their four principles being mediated by the process of specifying and balancing.

The strengths of the mediation model include:

- (1) it maintains some deductive rigor, though not as much as in the application model;
- (2) it allows for agreement in practice when faced with disagreement in principle (i.e., agreement at a concrete level or at a policy level is possible by adjusting the mediating principles without compromising fundamental principles); and
- (3) it respects some relativity, thereby permitting dialogue in the face of cultural pluralism.

These same strengths, however, can be seen as weaknesses when viewed differently. For instance, the appearance of deductive rigor can be illusory. When the source of mediating principles are not clear, their origins are likely to be inductive inferences from contexts, facts, or circumstances; without the inductive elements being made explicit, the deductive reasoning process seems to be too formal or rigid for the inclusion of less rigorously identified elements. Furthermore, this model sidesteps the need for resources for reconciling conflicting fundamental principles. By offering resources only at the mediating level, thereby requiring the renegotiation of mediating variables with each case, agreement at the level of mediating principles is possible, but not necessarily inevitable, and this can result in disagreement over the interpretation of middle principles in addition to disagreement about moral principles.

### *Validation Model Reasoning*

The Validation Model is often presented as an alternative to the approach to ethics often found in casebooks, which typically present a case vignette involving a moral dilemma, followed by analyses typified by application model or mediation model reasoning (Graber & Thomasma, in press). In other words, one ethical principle is invoked and then applied to the case in deductive fashion, or else a catalogue of multiple ethical principles important to the case is presented followed by an argument for giving one of these principles priority in reaching the final conclusion about what should be done in the situation. Such procedures are often met with disdain by clinicians because of their “cookbook” flavor and failure to account for the complexities in daily clinical practice (Graber & Thomasma, in press).

In the validation model (Graber & Thomasma, in press) the goal of moral reasoning is the creation of policies that deal with sets of situations that create similar types of problems. Central to this

perspective is the attempt to preserve and respect the “spirit” of the principle, or an appreciation for all values, and reconciling conflicts in a way that makes the best of admittedly less than ideal situations. The more moral elements in a type of case the policy respects, the more valid the policy. Principles are no longer viewed rigidly, but rather as summary statements of “historical policies” whose justification is validated by concrete practice. Consensus and clearly stated procedures (e.g., seek consultation from a supervisor) are offered as substitutes for substantive normative guidelines.

The claim of this model is not so much that theories arise from practice, as much as conflicting theories may find reconciliation in policy. Policy can tailor ethics toward practical concerns in ways more abstract theories cannot. Whereas the mediation model deduces policies from one or just a few moral principles, the validation model proceeds less straight-forwardly in an attempt to fit together in an acceptable framework the spirit of as many principles as possible. Also, in the validation model, clinical, legal, and practical data may mediate moral considerations, not just normative reasoning. One might speculate that current AAMFT practices suggest a reliance on validation model reasoning in that the Code of Ethics seems to *function* as a set of policy statements used to resolve ethical dilemmas, or justify actions with little explicit attention to or reliance on higher order moral principles, though AAMFT casebooks often assume the authoritative and more rigid flavor of application model or mediation model reasoning in discussions of the code.

The strengths of the validation model include:

- (1) its respect for descriptive data provided by scientific disciplines and law to help determine weighting of principles, though normative force (albeit somewhat diluted) still comes from moral principles;
- (2) its recognition of the pluralism of principles;
- (3) its allowance for the combination of pragmatic (e.g., cost effectiveness and public utility) and moral considerations; and
- (4) its provision of policy as the mechanism for resolving conflicts between principles.

A crucial weakness of validation model reasoning, according to Graber and Thomasma (in press), is that it is subject to misrepresenting the role of facts such that they are used to validate moral principles rather than as guides for the interpretation and use of moral principles. Facts help determine what rules are relevant for weighting principles; they cannot validate or invalidate moral principles directly. Thus, the validation model is at risk for perpetuating the naturalistic fallacy as described in the previous chapter (i.e., confusing factual statements of what “is” with normative statements of what “ought” to be).

Another weakness of the validation model is that there may be too much dependence on consensus about non-morally validated ends (i.e., the outcomes policies are intended to accomplish) in the absence of a higher standard of reference (beyond the policy level) against which conflicting ethical intuitions may be judged. In other words, consensus about policy in and of itself may not be sufficient moral justification for action. This last concern seems to happen in the *Users Guide to the AAMFT Code of Ethics* (AAMFT, 2001) in which it is not uncommon to find authors using circular logic by using the code of ethics to justify the provisions found in the code of ethics.

#### *Determination Model Reasoning*

In the Determination Model (Graber & Thomasma, in press), the context itself, as compared to specific policies, functions as the moral rule in determining how moral principles should be weighted. Thus, a role for moral principles and theories is retained, but which principles or theories “apply” is inductively determined (i.e., “elicited”) by the context of practice. For example, in medical care, the priority given to the principle of autonomy is highest in primary care settings (i.e., out-patient care for non-serious conditions), lessened in secondary care settings (i.e., in-patient care for serious medical problems that still may be reversed), and is lowest in tertiary care settings (i.e., emergency room care for a life threatening condition). Much of the discussion within MFT about the ethics of dual relationships in urban versus rural settings seems to be based on determination model reasoning. Other important contextual features may be the physical structure of the facility where one is working, staffing patterns, and the nature of the conditions being treated.

Though it is beyond the scope of this paper to do so now, it is worth future reflection on the extent to which our understanding of ethics in mental health also changes according to the context in which therapy is taking place. How might ethical priorities differ if one is working in private practice with the “worried well,” versus an in-patient drug and alcohol unit, or a residential treatment facility for emotionally disturbed youth, or a correctional facility for sex offenders, or a crisis hot-line, or the school system, or hospice, or community mental health? Are there relevant features of these contexts and the presenting problems being addressed that elicit differences in how ethical considerations are or should be weighted and balanced? It may well be that the debate within the MFT field about the ethics of multiple role relationships is at least in part a debate whether determination model reasoning has a place in how the field of family therapy is willing to think about ethics.

The obvious strength of the determination model is its sensitivity to context, which makes it especially compatible with clinical practice. The determination model offers a stronger weighting scheme than mere reliance on single policy decisions because professional norms emerge from (i.e., are inductively determined by) the treatment context itself. With the context serving as the explicit criteria for prioritizing moral considerations, they can more readily be critiqued and refined, compared to the implicit criteria often used by more deductive models.

A primary weakness of the determination model is that it is even more susceptible to the naturalistic fallacy than the validation model. On the face of it, it appears that descriptions of the context (i.e., “is” statements about the structure and function of a treatment setting) are in danger of being viewed as being the source of moral authority for prescriptive (i.e., “ought”) actions, rather than retaining their actual function as the source of guidance for how one weighs and balances moral considerations. In other words, it is easy to confuse the context as the moral principle, rather than as the mediator between moral principles. Such confusion can lead to the reification of traditional health care practices and the view that “because we’ve always done it this way, it must be good.” Finally, the force of moral principles can be weakened by an uncritical reliance on the relativity of context, and the determination model fails to address multi-problem situations in which the care required does not readily fit into any single context.

### *Origination Model Reasoning*

Whereas in the previous two models, one appealed to policies or contextual categories of practice for guidance on weighting pre-existing principles or theories, in the Origination model (Graber & Thomasma, in press), one relies on a purely inductive process to determine appropriate action. This model is the “grounded theory” (Glaser & Strauss, 1967) of ethical reasoning. This model is case driven (i.e., troublesome cases prompt reflection), relies on eclectic sources from many disciplines to inform the reasoning process, and is analytically diverse. This last means that generalizations and parts of arguments produced by the origination model appear to be identifiable aspects of larger accepted theories, though any sort of commitment to these larger theoretical systems remains unacknowledged.

Finally, axiomatic conclusions are reached through the internal compromise between clinical, pragmatic, and moral considerations. There is no theoretical debate, nor is a priority rule utilized in reaching a conclusion. Instead, one begins with a few notions based on observations of cases. One gains experience with lots of similar cases leading to thoughts about classes of cases. These thoughts evolve into policies, which then determine practices. Narrative ethics, as previously described, and casuistry, or case-study ethics, are examples of origination model reasoning.

Proponents of narrative ethics emphasize the power of narrative to grip the moral imagination and stimulate normative intuitions (Graber & Thomasma, in press). Narratives bring order and meaning to the collections of facts, contexts and characters involved in a moral dilemma. While other models attend to facts, context and character, they fail to consider the ways these factors operate together to bring idiosyncratic meaning to the situation. These threads of meaning must be included in reasoning processes, and are, in fact, at the heart of moral reasoning from a narrative perspective.

While narrative approaches focus on the particularities of the case in and of itself, casuistry utilizes case narratives differently. In casuistry, certain cases function as paradigms or archetypes to guide actions in immediate cases. The task is to identify which paradigm case the immediate case is *most* like, and proceed in ways suggested by the process and outcome of the paradigm case. While this appears to be a straightforward process, in actuality, how one arrives at the point of analogy between the test case



and the paradigm case is not always clear; sometimes similarities between cases are based on descriptive features and sometimes on normative features.

Strengths of origination model reason are largely related to its emphasis on the lived realities of clinical practice, especially as they relate to the doctor-patient (and likewise, the therapist-client) relationship. Other strengths include its responsiveness to cultural change without resorting to relativism, and the availability of inductive methods to derive cross-cultural moral theories. The origination model claims that the health professions are in and of themselves moral enterprises, resting, as it were, on hidden or at least “ambient” assumptions (e.g., the importance of acting to assist human need, reverse impairment, and not harm others), which make it possible to inductively arrive at moral guidance.

Not all bioethicists, however, are convinced by this argument, and major objections of this model center around concerns about the naturalistic fallacy, either that it is attempting to claim it is possible to directly derive normative force from descriptions of practice, or its importing hidden normative assumptions in the form of ethical principles generally “floating about” in one’s culture invalidate its claim to be a purely inductive model. Additionally, the origination model falls victim to the danger of neglecting content in favor of formalism. In other words, in an age of pluralism, an effort to avoid impositions of moral viewpoints may result in a formalist, procedural, bureaucratic public-policy ethic that “inordinately focuses on human freedom, patient autonomy, and informed consent as preconditions for ethics rather than as values, among others, to be negotiated in the context.

### *Virtue Model Reasoning*

Whereas the previous models described various reasoning processes used to relate theory to practice in determining right action (i.e., what to do), the Virtue Model (Graber & Thomasma, in press) considers the relationship between theory and practice as it relates to right, or virtuous, character (i.e., who to be). As in the previous discussion of classical virtue theory, the virtue model in applied ethics attends to issues of motivation and affect often neglected by models emphasizing cognitive and external considerations. Whereas more cognition-based ethical theories can make good sense when assessing an

act from the outside, the internal experience of the virtues focuses on the emotion embodied in the virtue being expressed (e.g., one expresses the virtue of gratitude because one feels grateful). Attention to psychotherapists' virtues has gained increased emphasis in recent years (e.g., Jordan & Meara, 1990; Meara, Schmidt, & Day, 1996). Graber and Thomasma (in press) articulate three possibilities for the proper role of motive and virtuous character in clinical ethics: (1) an adjunctive or supplemental role, (2) a mediating role, and (3) a substitute role.

(1) In the supplemental role, motivations to “act rightly” are encouraged through (a) threat of social sanctions (e.g., focus on criminal or civil legal prosecution, or revocation of licensure), (b) economic incentives (e.g., emphasizing ethical conduct as a public relations effort to make the field appear more credible so as to increase reimbursement and other financial opportunities), or (c) moral education (i.e., promoting “role models” in childhood development or professional education). Graber and Thomasma (in press) find this approach unsatisfying.

In the last analysis they do not foster true *virtue* at all. Surely the settled disposition (a) to avoid social and legal sanctions is not a virtue. The settled disposition to obey the law from a motive of respect for the law in itself and the social system of laws is, indeed, a trait we would admire. But this (law-abidingness or respect for the law) is quite different from acting from fear of sanctions—a species of prudentialism which we might call C.Y.A. (“Cover Your Anatomy”). And the threat of legal sanctions does nothing to foster this admirable trait. Similarly, a settled disposition (b) to respond to economic incentives is, at best, prudentialism (and perhaps cupidity). This is not a particularly admirable trait. Nor is it clear that a settled disposition (c) among adults to imitate the patterns of action one has observed in role models is a trait that should be admired—especially if it is a matter of blind imitation, unaccompanied by insight into the moral *point* of acting in this way. And yet it is this unreflective imitation that is all too often promoted in medical education (Graber & Thomasma, in press, p. 166).

It could be argued that thus far, the MFT profession seems to emphasize ethical motivation in these ways. As discussed in previous chapters, the field appears to rely heavily on the development of professionals who are motivated to be ethical for fear of legal or professional sanctioning. Furthermore, our approach to ethical training of supervisors could be seen as a role model approach. According to Graber and Thomasma (in press), this view of role models focuses on the seriousness of putting rules and principles into practice rather than careful attention to ethical reasoning processes. The MFT supervision literature tends to focus on the gate-keeping duties of supervisors to enforce the code of ethics and minimize liability concerns. Therapists are frequently exhorted to consult supervisors for ethical guidance, but as there is scant attention to ethical reasoning processes in the MFT literature generally, one wonders what reasoning processes supervisors are relying on in reaching conclusions upon which they base their guidance; thus the process tends to be imitative rather than reflective.

(2) The second role for moral motivation and virtuous character discussed by Graber and Thomasma (in press) is that of a mediating role. Here, a virtuous person uses feelings that stem from a settled disposition (e.g., care and compassion) to sort through moral options rather than relying only on intellectual intuition, policies, or some other priority rule. In this view, virtues have both cognitive and affective features that are internalized and contribute to a settled disposition characterized by the sort of moral sensitivity, moral motivation, and ego-strength mentioned by Rest (1994) as necessary for moral behavior. Although Graber and Thomasma (in press) do not explicitly address feminist ethics, one could reasonably argue that this view of the role of at least some virtues in decision-making resonates easily with feminist concerns.

(3) In the third possible role for moral motivation and virtuous character in relation to moral reasoning processes in practice, virtues act as substitutes for the moral principles and rules discussed in earlier models (Graber & Thomasma, in press). This view captures the sense that most of us prefer to think of health professionals acting out of a caring disposition rather than calculated duty. Right actions that somehow spring from the core of our being, the type of person we are, are seen as more praiseworthy

than right actions mechanically enacted. This can be seen in couples therapy, especially treatment models like Emotionally Focus Therapy (Johnson, 1996), which seeks to help couples access the emotions that engender attachment behaviors, not merely imitate them. In fact, the concern that therapists are so focused helping clients to act from a base of feeling rather than duty has become a source of critique in our field (e.g., Doherty, 1995).

Strengths of the virtue model include:

- (1) its compatibility with professional codes of conduct and its intuitive appeal to practicing clinicians;
- (2) its inclusion of the affective dimension; its provision of potentially more comprehensive and spontaneous motivations than a strict calculation of consequences or an allegiance to principles; and
- (3) its ability to withstand relativism, while allowing for variations in decision-making.

Weaknesses, on the other hand, include:

- (1) its lack of mechanism for resolving moral disagreements (one's virtue is another's vice);
- (2) its inability to address problems that cannot be traced to character deficiencies;
- (3) its dependence on independent principles or standards for action; and
- (4) its vulnerability to confusing moral character traits and "guild" or etiquette rules for conduct between professionals (Graber & Thomasma, in press).

#### *A Practical Model of Bioethical Hermeneutics*

"Ethics, like medicine [and by extension, psychotherapy] is theory about practice. It arises from, and returns to, practice" (Graber & Thomasma, in press, 183), but it ideally incorporates careful reflection and reasoning along the way. In real life, rarely do we follow step-by-step linear models of deductive or inductive rational decision-making. The models presented above are likely more valid as retrospective reconstructions of central argument reasoning, which help us identify important conceptual distinctions, but fall short of fully accounting for the complexities involved in any decision-making process. In an effort to be more comprehensive, Graber and Thomasma (in press) advocate both inductive and deductive

reasoning, and seek to retain “both a place for standards (on the basis of which a critique of values takes place), and the practical realities that cause the crisis and feed into the standards themselves” (p. 187).

Based on the strengths and weaknesses of the above models, Graber and Thomasma (in press) offer their own unitary theory of clinical ethics, what they are calling a “practical model of bioethical hermeneutics.” They summarize their unitary theory as follows: “Certain conditions (C) are present in this case such that the probability (x) exists that value (V) A will be judged more important than B by (I) interpreters because the Principle (P) p’ will more likely apply to the case than p” (Graber & Thomasma, in press, p. 210). By focusing on *both* the concrete situation (i.e., “certain conditions present in *this* case”) and relevant moral principles, Graber and Thomasma (in press) are advocating the fusion of both inductive and deductive reasoning. Furthermore, they explicitly recognize the interpretive nature of moral reasoning by acknowledging the central role played by the person or persons involved in the decision-making process.

Though only speaking of hermeneutics in broad terms (i.e., an emphasis on interpretation), and never specifically mentioning ontological hermeneutics, many of the presuppositions and constructs articulated by Gadamer appear to be embedded in Graber and Thomasma’s model. For instance, in sorting through which features of prior ethical theories to keep or avoid, Graber and Thomasma, like Gadamer (in press), reject the Enlightenment skeptics’ criteria that absolute certainty is necessary for knowledge in human affairs to be valid, suggesting instead that ethical theory should embrace a more probabilistic certitude. This means that under certain conditions, there is “x” probability that one value will be judged more important than another value because one principle is more applicable than another one (Graber & Thomasma, in press).

Additionally, Gadamer’s concept of finitude (i.e., our understanding is always circumscribed by time and language so we can never fully know either antecedent conditions or future consequences), finds resonance with Graber and Thomasma’s assertion that rather than understanding moral principles as atemporal, a sophisticated understanding of complex decision-making requires ethical theory to distinguish between long- and short-term perspectives, but include both. A short-term perspective

focusing on the expedient conditions found in the realities of concrete practice must be checked by the struggle about theoretical issues characteristic of long-term reflection (Graber & Thomasma, in press). As the future can never be fully predicted, long-term perspectives must necessarily be more abstract, conceptual, and critical than short-term thinking.

It is inadequate to rely only on either deductive reasoning from abstract principles (though doing so might be helpful in establishing a long-term perspective), or inductive processes based on the realities of concrete cases in day to day practice (which encourages salient short-term thinking). The first is less helpful in short-term considerations of concrete cases, and the second can become too mired in immediate specificity to adequately accommodate that inherent uncertainty of the future; both types of reasoning and the perspectives they produce dialectically strengthen the other.

In assessing the strengths offered by the six schemas described above (i.e., application, mediation, validation, determination, origination, and virtue models), Graber and Thomasma (in press) conclude that a unitary theory of clinical ethics must require careful attention to the virtues possessed and enacted by all the principle players involved in a moral decision. The character of the individuals or institutions involved in a moral dilemma “imbues the care taken about the values involved, the thoroughness by which they are examined, as well as the compassion and commitments one must take for granted in the discussion” (Graber & Thomasma, in press, p. 207).

Furthermore, a unitary theory of ethics must make provision for ranking values. However, the method or methods one uses to resolve conflicting values may vary according to the task at hand, not unlike the way a carpenter will utilize different tools at various points in the design and construction of a house. For instance, in some circumstances a professional code of ethics may contain a rule, or an institution a policy that resolves a moral conflict; alternatively a paradigm case may be described in a clinical ethics casebook, or the unique characteristics in a case narrative may be the tool that accomplishes the task of ranking values. Tools used in building a house are not typically arranged in hierarchies, such that one must first try to use a hammer before a screwdriver in all situations. So too,

methods used for resolving conflicting values are not prioritized in this view, unlike more linear models such as Hare (1981, 1991), or Kitchener (2000).

Graber and Thomasma (in press) assert that moral principles and theories should be seen as flexibly and fallibly (given the “uncertainty of moral certainty”) establishing and articulating parameters for ethical conduct, and key elements of conscience with which societies, institutions and individuals carry out decision-making. Yet the moral features of principles, theories, contexts, and concrete cases must all be interpreted.

In other words, the application, mediation, determination, validation, and origination of moral theories in relation to clinical practice must be interpreted both inductively and deductively. The authors argue that each ethical theory can be seen as articulating an interpretation (i.e., a hermeneutic) of the good. As consensus does not exist, meaning about the proper interpretation of the good life must be negotiated in a multilateral hermeneutic process.

If Graber and Thomasma (in press) had been using Gadamer’s terminology, they might suggest that ethical theories offer varied horizons (i.e., particular limited vantage points) from which to understand a moral dilemma. Recall that horizons are not closed or fixed; instead they change as we encounter new circumstances or new understandings come to light as we seriously consider alternative truth claims as having potentially valid and important things to say to us (i.e., the fusion of horizons). Only by seriously considering both inductive and deductive guidance offered by the interpretation of abstract principles, priority rules and policies, institutional and individual case narratives, and so forth, can possibilities for shared meaning about what it good and right to do be fully explored. The more horizons fused together in the search for ethical guidance, the more comprehensive the understanding, and the more justifiable the action taken may be. In this way, “practice both utilizes and limits theory, and theory constantly checks and balances practice” (Graber & Thomasma, in press, p. 217).

### Conclusion

In conclusion, in spite of the length of this review of models of ethical reasoning, it has barely scratched the surface as to the sophisticated thinking that exists in the broader ethics literature to guide

mental health care practitioners. Physicians are not so different from psychotherapists in their impatience with abstract theories that fail to address or consider the practical realities of clinical practice. The field of marriage and family therapy has a long history of emphasizing practical/technique oriented solutions; certainly this has been a strength of the profession. Clinical wisdom, however, cannot be reduced to mere practical techniques, no matter how empirically validated those techniques or clinical procedures may be or become.

Following Aristotle, Gadamer asserts that the wisdom that comes from genuine understanding involves praxis—technique combined with reflective judgment. How much stronger could the MFT profession be, however, by combining pragmatic and reflective considerations? Perhaps the lack of exposure in the psychotherapy literature to breadth of approaches to clinical ethics may explain the MFT field's seeming reticence to deal with theoretical as well as practical ethical considerations. However, as Graber and Thomasma (in press) argue above for medical ethics, and as I have been arguing throughout this paper, there are strong reasons to advocate for a comprehensive approach to ethics in MFT.

At this point, it is time to fuse these pre-understandings of MFT ethics with a careful review of articles that specifically addressed ethical decision-making processes as published in five MFT journals during the last twenty years. In the next chapter, procedures are presented describing the process used to deepen my understanding of MFT ethics from a Gadamerian framework. Chapter six describes the results of my fusion of horizons, and chapter seven discusses implications and future directions.



## CHAPTER FIVE: PROCEDURES

### Applying Philosophical Hermeneutics to the Current Study

The purpose of this chapter is to describe the procedures I used to conduct a philosophical hermeneutic analysis of the MFT ethical decision-making literature. Central to philosophical hermeneutics is the belief that meaning “will be found through interpretation modeled on dialogue and conversation” (Schwartz, 2001, p. 194). Chapters 1-4 of this project invited the reader into the on-going conversation I have been having with a wide variety of ethics literatures, including how adopting Gadamer’s philosophical hermeneutics has affected my understanding of this topic so far. The remaining chapters explicitly address my research question: *How can ethical decision-making as discussed in the MFT literature be understood in light of previous exposure to ethical theory and medical ethics?*

This section represents a more focused dialogue between my pre-understanding of ethical decision-making models in the larger professional ethics literature and articles from the MFT literature specifically focused on ethical decision-making processes. It is important to remember that while philosophical hermeneutics does not preclude the use of specific research methodologies, the *meaning* of procedures and outcomes is interpreted differently than with classical social inquiry (Richardson & Fowers, 1998). Disclosing my pre-understanding of ethics in the previous chapters has *not* been done as a means of neutralizing their influence, but rather to illuminate their function as a foundation for future interpretation and understanding. By using publicly accessible data (i.e., journal articles) and having been so overt and forthcoming with my prior thinking, I brought the background into the foreground. This motivated me to be more intentionally open to the text and facilitates more accountability to my readers and the texts themselves.

Hermeneutic dialogue also helps reconcile criticism and commitment. In this view, serious moral and political commitments actually encourage us to be as open as possible

to challenges from the outside. Because of the importance of the subject matter, we have a motivation to get things right. ...In turn, openness and the critical testing of our beliefs and values against new circumstances and unforeseen challenges deepen our understanding and refine our commitments (Richardson, Rogers, & McCarroll, 1998, paragraph 31).

Repeated attempts at critical understanding will always be necessary. The repeated fusing of horizons allows us to gain critical awareness of our prejudices and to correct them as new understanding warrants, but this correction cannot be regarded as moving in the direction of a prejudice-free understanding. If hermeneutic dialogue is the path to understanding, does this mean that methodology is no longer relevant? According to Smith (1993), social inquiry, from a philosophical hermeneutics perspective, is primarily a practical and moral activity rather than an epistemological or technical activity. Whereas there are no particular or special procedures that *must* be followed, the inquirer is free to utilize various methodological techniques during the attempt to understand another (e.g., triangulation and member checks). The remainder of this chapter articulates the procedures used to identify articles in the MFT ethics literature specifically focused on decision-making reasoning processes, and the data management strategy to be employed as a means of tracking my attempts to fuse horizons with the identified texts.

### *Purpose*

The purpose of this study was to explore how my previous exposure to moral philosophy and medical ethics affected my understanding of ethical decision-making processes as discussed in the MFT literature. In philosophical hermeneutic terms, it extended in a new way a conversation I had been participating in through my reading of a wide variety of ethics literatures. Consistent with ontological hermeneutics, it is important to clarify that I was not attempting to identify, with any sort of definitive authority, what the authors of the articles examined were “really” saying. Instead, my goal was to discover what new understanding of MFT ethical decision-making may arise when articles are viewed from a perspective that includes but is not limited to critical consciousness of western moral philosophy

and medical ethics, and how might my reading the MFT literature alter my understanding of moral philosophy and medical ethics.

#### Text Identification Procedures and Outcomes

Articles published between January 1984 and April 2004 in *The Journal of Marital and Family Therapy (JMFT)*, *The American Journal of Family Therapy (AJFT)*, *Contemporary Family Therapy (CFT)*, *Family Process (FP)* and *Family Relations (FR)*

were searched using the Web of Science computer database. First, the database was searched for all articles published by each of these journals. Second, results were obtained by searching the entire database for the following key words: ethics, moral, law, legal, and all grammatical derivations of these terms. Third, the results of the key word searches were combined separately with results from each of the five journals; thereby identifying ethics articles in each journal. A total of 247 articles were newly identified for this project in this way (67 in JMFT, 45 in AJFT, 32 in CFT, 30 in FP, and 73 in FR).

JMFT, AJFT, and CFT are generally recognized as top MFT journals, while FP and FR are likewise acknowledged as top family studies journals, which also publish MFT related works. Furthermore, in a previous study of the MFT ethics-related literature, Mowery and Gale (2002) reviewed nine MFT journals across 13 years, and the five journals listed above contained the majority of ethics-related articles previously identified.

#### Screening

There were two phases of additional screening of articles for inclusion in the study. The first phase involved examining articles based on titles and abstracts. All non-articles (e.g., book reviews and letters to the editor) were automatically excluded. As the journals *Family Process* and *Family Relations* have a broader family science focus than strictly family therapy, titles and abstracts from these two journals that did not explicitly make reference to therapy or treatment were excluded from further consideration. Remaining articles from all five journals were then assessed for perceived relevance to the topic of ethical decision-making in MFT. In other words, as I read the title and abstract of each article, did it seem like it would inform my search for a deeper understanding of how we talk about the *process* of

ethical decision-making? Specifically, the appearance in the title or abstract of action-oriented words and phrases such as *choose, decide, decision, guidelines, approach, ways to resolve, process, dilemmas, negotiate, issues that should be considered, adhere, justification, and privileging* guided my choice of which articles to include in this study.

Next, a rank was assigned to each article based on the title and abstract according to the perceived level of relevance to the study: 1= strongly relevant, 2= relevant, 3= somewhat relevant and 4= only marginally relevant. The more the article appeared to focus on elucidating ethical *reasoning processes* and *evaluation procedures*, not just identifying variables for consideration (i.e., focusing more on *how* rather than *what*), the more relevant it was considered. In other words, if the main thrust of the article appeared to be identifying ethical issues without offering substantial guidance on how to reason about, prioritize, or evaluate those issues, or how to choose between justifiable alternative ethical actions, it was not considered very relevant. Only articles receiving a rank of two or higher proceeded to phase two of the screening process. Phase one identified 53 articles (23 in JMFT, 10 in AJFT, 8 in CFT, 5 in FP, and 7 in FR). It should be noted that this total contained three sets of three articles that were linked as an original article, a commentary and a rejoinder.

In phase two, the full text of each article was skimmed and ranked once again based on the four point scale described above, and only those articles ranked two or above (i.e., relevant or strongly relevant) received in-depth hermeneutic analysis as part of this study. Such iterative and inductive sampling procedures help keep the data set manageable, and are consistent with the focus on depth rather than breadth as is common in qualitative inquiry (Coffey & Atkinson, 1996; Creswell, 1998). Across five journals and 20 years, only 13 articles were perceived as sufficiently focused on ethical decision-making processes to meet the criteria for analysis in this study (4 in JMFT, 0 in AJFT, 3 in CFT, 2 in FP, and 4 in FR which includes one commentary and a rejoinder). This result was consistent with the findings of Mowery and Gale (2002) that the vast majority of the MFT ethics literature focuses on assertions of *what* is ethical rather than on processes describing *how* to reach these considered judgments. Nevertheless, though not entirely unexpected, it was shocking to see exactly how little attention this topic has received

in the literature during the last 20 years, in spite of its being ranked number one on Figley and Nelson's (1989) list of most important skills for family therapists.

### *Screening Outcomes*

To aid the transparency and accountability of these procedures, all 53 articles identified in phase one of the screening process are listed in the reference section with at least one asterisk. The 13 articles receiving in-depth hermeneutic analysis are identified by two asterisks in the reference section, but are also listed here:

Brown, R., & Strozier, M. (2004). Resisting abuse at what cost? The impact of mandated reporting laws on the process and content of therapy. *Contemporary Family Therapy*, 26(1), 45-60.

Burkemper, E. M. (2002). Family Therapists' ethical decision-making processes in two duty-to-warn situations. *Journal of Marital and Family Therapy*, 28(2), 203-211.

Butler, M. H., & Gardner, B. C. (2001). Ethics and the ideal helping relationship: Response to Hill and Mamalakis. *Family Relations*, 50(3), 209-214.

Green, S. L., & Hansen, J. C. (1986). Ethical dilemmas in family therapy. *Journal of Marital and Family Therapy*, 12(3), 225-230.

Haverkamp, B., & Daniluk, J. C. (1993). Child sexual abuse: Ethical issues for the family therapist. *Family Relations*, 42(2), 134-139.

Hill, M. R., & Mamalakis, P. M. (2001). Family therapists and religious communities: Negotiating dual relationships. *Family Relations*, 50(3), 199-208.

Jankowski, P. J., & Martin, M. J. (2003). Reporting cases of child maltreatment: Decision-making processes of family therapists in Illinois. *Contemporary Family Therapy*, 25(3), 311-332.

Mamalakis, P. M., & Hill, M. R. (2001). Evaluating potential dual relationships: A response to Butler and Gardner. *Family Relations*, 50(3), 214-219.

Newfield, S. A., Newfield, N. A., Sperry, J. A., and Smith, T. E. (2000). Ethical decision making among family therapists and individual therapists. *Family Process*, 39(2), 177-188.

Russell, C. S., & Peterson, C. M. (1998). The management of personal and professional boundaries in marriage and family therapy training programs. *Contemporary Family Therapy*, 20(4), 457-470.

Schlossberger, E., & Hecker, L. (1996). HIV and family therapists' duty to warn: A legal and ethical analysis. *Journal of Marital and Family Therapy*, 22(1), 27-40.

Woody, J. D. (1990). Resolving ethical concerns in clinical practice: Toward a pragmatic model. *Journal of Marital and Family Therapy*, 16(2), 133-150.

Zygmund, M. J., & Boorhem, H. (1989). Ethical decision-making in family therapy. *Family Process*, 28(3), 269-280.

There were several themes that emerged from those articles not included in the final analysis. As noted, most articles were generally excluded because they primarily focused on what is ethical, not how to make such decisions. Two examples are Willbach (1989), who identified ethical issues related to case management of family violence, and Pais, Piercy, and Miller (1998) who, in their article entitled, *Factors related to family therapists' breaking confidence when clients disclose high-risks-to-HIV/AIDS sexual behaviors*, explicitly conclude: "Now that we have acknowledged that the elephant is there, perhaps we as a profession can discuss what to do with it" (p. 471). Some articles focused on clinical processes rather than ethical reasoning processes (e.g., Jory & Anderson, 1999; Jory, Anderson, & Greer, 1997), or included a secondary discussion of ethical issues as an adjunct to primary attention to clinical considerations (e.g., Yarhouse, 2003). Similarly some articles combined a clinical focus with legal considerations and therapist liability concerns, but did so authoritatively rather than explicating reasoning processes (e.g., Bray, Shepherd, & Hays, 1985; Woody & Perry, 1993).

### *Caveats*

Three caveats about the idiosyncratic nature of the text identification procedures used are worth noting. First, only the Web of Science database was used to identify articles for participation in this hermeneutic conversation. Using another or multiple databases may have produced a different original set of articles, possibly a more comprehensive set. Second, a different researcher may have ranked the articles differently (especially between rank 2, “relevant,” which was included in the study, and rank 3, “somewhat relevant,” which was not included), again leading to a different data set. The understanding produced through the fusion of horizons based on the identified articles will undoubtedly differ in at least some respects from those based on other articles. Philosophical hermeneutics does not consider this problematic because of its focus on the finitude of *any* interpretation (Gadamer, 1989; Richardson & Fowers, 1998).

The aim of Gadamer’s philosophical hermeneutics is to illuminate the human context within which scientific understanding occurs and to account for the necessity of repeated attempts at critical understanding. We can indeed gain critical awareness of our prejudices and correct them in our effort to hear what the text says to us. But this correction of prejudices is no longer to be regarded as the transcendence of *all* prejudices in the direction of a prejudice-free apprehension of the text or event ‘in itself’” (Linge, 1976, p. xviii).

Finally, there was no attempt to involve others in this selection process in order to establish inter-rater reliability, largely because the focus of this study is on how *my* pre-understandings of professional ethics discourses (e.g., moral philosophy and medical ethics) affect and are affected by *my* understanding of MFT ethical decision-making discourse(s). Because others would necessarily be ranking the articles based on *their* unique pre-understandings (which would need to be made transparent), this would actually confound the process rather than enhance the certainty of my rankings. It must be remembered that the *meaning and outcomes* of methodological procedures are interpreted differently from an

ontological hermeneutic perspective than with classical social inquiry (Richardson & Fowers, 1998). Any conclusions reached in this study are temporary, mere snapshots of understanding gained during the current trip around the hermeneutic circle. The point of this particular hermeneutic venture is to chronicle my encounter with MFT ethics texts, not combine it at this point with other people's encounters with the texts, though doing so would be an enriching next adventure.

### Analytic Procedures

#### *Coding*

Nearly all qualitative social inquiry uses coding of some sort to disaggregate the data through a process of constantly comparing and contrasting various segments of data and labeling these similarities and differences (Schwandt, 2001). Consistent with a hermeneutic perspective, Wolcott (1994) noted that to varying degrees coding is always an act of interpretation. The continuous movement between how codes and categories relate to each other, to the original text, and to other data or theoretical ideas (Coffee & Atkinson, 1996) can be conceptualized in hermeneutic terms as a systematic description not unlike the act of fusing horizons. "Ian Dey (1993) argues that categorizing enables one to think about the data in a new way. This is only the case if we move beyond the codes, categories, and data bits back to what the 'whole' picture is or may be" (Coffee & Atkinson, 1996, p. 46). Thus, as one shifts one's gaze back and forth between part of the data and the larger context, as well as between the different segments of data, a larger panorama of the topic being studied is possible than without such dynamic movement, thereby illustrating the dialogic nature of hermeneutic interpretation.

Schwandt (2001) describes three common approaches to coding in qualitative research, any or all of which may be combined. Codes may represent: (1) an *a priori*, content-specific scheme in which all categories are established based on the theoretical field and prior to the encounter with the text; (2) an *a priori*, non-content-specific scheme such that general typologies (e.g., who, what, where, when) are derived from common sense reasoning or a particular methodological framework; or (3) an *a posteriori*,



inductive, context-sensitive scheme based on the actual language of the text and modified and refined in relation to other segments of text.

Gadamer's reaction to each of these schemes might be to suggest that our prejudices are always creating *a priori* schemes like those described by Schwandt (2001) some of which we can be conscious of and intentional about, but not others, and that *a posteriori* schemes are the very product of hermeneutic dialogue with the text. Gadamer's opposition to such systematic categorization is most likely to come against the rationales justifying their use. A philosophical hermeneutic perspective would resist a modernist use of *a priori* coding structures to create subject-object distance, as well as a post-modern claim that *a posteriori* coding is somehow truer of the data itself. Hence, in this project I did not set out to *create* a definitive coding structure in advance of my encounter with the selected texts. Rather, it is acknowledged, that my pre-understanding of distinctions made in ethical theory, medical ethics, and the larger psychotherapy ethics literature provided the basis from which I could identify both the familiar and unfamiliar ideas presented by the texts being engaged. The point of providing so much detail in chapters three and four about my current understanding of ethical theory and methods of ethical analysis was to make explicit the *a priori* influences inevitably shaping my understanding of the texts. Doing so facilitated my maintaining a stance of openness to *a posteriori* coding of the ways in which the text challenged and transformed my thinking by making new information stand out in greater relief against old understanding. Thus, the codes used to track my understanding of the texts were derived both deductively from my current horizon, and inductively from fresh encounters of the texts themselves.

Numerous qualitative researchers discuss ways to work with coded data in the process of meaning-making. Dey (1993) suggested that categories of coded data may be split or combined, or even reassigned, but with an eye toward establishing pathways through the data. In the process of moving toward generalizing and theorizing from the data, one should look for patterns of similarities and differences (Coffee & Atkinson, 1996; Delamont, 1992). Similarly, tactics for data transformation suggested by Huberman and Miles (1994) include noting patterns of themes, counting occurrences of phenomena in the data, comparing and contrasting across data sets, and questioning the relations between

variables. In keeping with an ontological hermeneutic perspective, rather than turning these general strategies into prescriptive recipes—as Glaser (1992) has critiqued Strauss and Corbin (1990) for doing in grounded theory methodology—the process of coding in this study should be understood as the means by which I was conversing with the text, tracking what my pre-understanding had to say about the text, and what the text had to say about my pre-understanding. It is critical to reiterate that Gadamer (1989) does not see the use of specified methods as a means of establishing the validity and reliability of an interpretation, but according to Smith (1993) doing so is an appropriate means of organizing and managing the conversation.

Specifically, I created some codes based on categories used in moral philosophy and medical ethics (e.g., moral philosophy/normative ethics/deontological theory/Kantian ethics), while others emerged from the texts themselves (e.g., identifying how to decide ethics/comprehensive model/J. Woody model/5 bases/ base 2 professional codes of ethics; or professional codes/regarding AAMFT code/helpfulness of AAMFT code). Eight major descriptive categories (vs. analytically derived themes) eventually organized 274 codes deductively and inductively created through the iterative process of reading and reading the texts. The eight categories were: (1) Demographics of the article (e.g., author name, title, journal); (2) Moral Philosophy (A., meta-ethics; B., normative ethics; and C., applied ethics, which included implicit or explicit references to work by Beauchamp & Childress, Kitchener, and Graber & Thomasma); (3) Moral Development Theories (e.g., Kohlberg, Rest, or Gilligan); (4) Teaching ethics (e.g., explicit discussion of teaching or supervision implications); (5) How to Decide (which included comprehensive and topic specific models, as well as references to the quality and availability of decision-making resources in MFT, and the importance of consultation); (6) Descriptive ethics (i.e., empirical studies of decision-making processes and types of dilemmas encountered; uniqueness of systemic ethics); (7) Regulatory Concerns (i.e., legal considerations and professional codes); and (8) Clinical Concerns (i.e., self-of therapist issues, multi-cultural and religious values).

## *Data Management*

Increasingly, researchers are using computer software programs to manage the large volume of data typical of qualitative inquiry (Coffee & Atkinson, 1996; Fielding & Lee, 1998; Schwandt, 2001; Silverman, 2000; Weitzman & Miles, 1995). The logic behind most software packages mimics the procedures of manually coding and sorting segments of data, but does so with greater efficiency and comprehensiveness, thereby increasing the rigor of analysis (Coffee & Atkinson, 1996; Schwandt, 2001). Schwandt (2001) cautions, however, though computer-managed analysis is by definition more algorithmic, systematic and rigorous, its use does not eliminate the presence of philosophical assumptions in the study's design. John Seidel (1991), the developer of ETHNOGRAPH, one of the first computer programs for analyzing qualitative data, notes two dangers accompanying the benefits of qualitative software packages. First, because of the computer's ability to handle large volumes of data, there is risk of sacrificing the depth traditionally associated with qualitative inquiry for increased scope. Second, computers can aid in the reification of the relationship between the researcher and the data, ignoring the fact that the coded data is an artifact of a complex interpretive process shaped by theoretical and methodological assumptions.

These cautions are consistent with Gadamer's admonition that what is important is not so much whether or not particular methods are used, but the understanding the researcher has of *why* they are being used and what the end product of their being employed is assumed to be. With this distinction in mind, I used the qualitative data management software program created by QSR International known as N6 (2002) in order to *track* my conversation with the text, making it as transparent as possible. Such transparency—rather than being motivated out of a desire to neutralize my bias—allows other readers to have more entry points for merging their own horizons with the text I am producing here rather than only in the interpretation of results. In other words, transparency is not for replication or verification in the traditional sense, but rather for promulgation of the conversation via additional engagement with the hermeneutic circle.

The identified articles were scanned into an optical character recognition (OCR) program which allowed scanned images to be converted into plain text documents for use in the N6 program. This allowed each article to be coded in its entirety. As OCR programs do not produce error-free documents, each article was read a second time (the first during sample selection) and ‘typos’ corrected before they were analyzed. Reading all of the articles analyzed in this study twice created a sense of the “whole” prior to the detailed analysis of each individual article and is also in keeping with the reiterative nature of the hermeneutic circle.

The categories/codes noted above served descriptive purposes for tracking my conversation with the text more than as a primary mechanism for generating new understanding. As such, the codes themselves played a minor role in the analytic process beyond initially orienting me to the MFT texts. Once all articles had been categorized and initially coded, ideas and possibilities for new understanding were tracked through the use of N6’s memo function rather than trying to refine the coding structure. N6 allowed me to record ideas as memos as they occurred to me while reading texts and link them to specific text units or the document as a whole. The emphasis on memos rather than codes was somewhat unexpected, but necessitated by the small sample size and the disparate nature of the article content (as will be discussed in depth in the next chapter). I found the use of memos more helpful than codes as they kept possibilities for new understanding open and expanded (a primary aim of ontological hermeneutic analysis) rather than requiring a distillation of concepts (the goal in traditional social science research). As ideas emerged while reading one article, I would then go back and review other articles for how they related to the new idea and attach new memos to each document. By repeating this hermeneutic process of alternating reflection on an individual article and the collection of articles, I was able to track the ways in which my pre-understanding of moral philosophy and ethical theory informed my new understanding of these texts, and how new ideas illuminated the limitations of my previous understanding.

Recall that for Gadamer dialogical understanding consists of an interplay between ‘openness’ and ‘application,’ between having our beliefs and prejudices challenged by the text and listening for what our

old understandings reveal about new texts. My use of N6 allowed me to code and attach memos to segments of text (i.e., paragraphs), using general strategies described above, both for how my pre-understandings affected my reading of the text and how the text itself challenged my thinking. This is not completely unrelated to a process in qualitative research Silverman (2000) refers to as “abduction,” the combination of ‘top-down’ and ‘bottom-up’ analysis.

### *Evaluation Criteria*

It is vital to clarify that although Gadamer downplays the role that careful attention to methodology has traditionally played in the social sciences, this does not in any way imply that he is not interested in quality of thinking or that any interpretation of data will do. Remember that Gadamer is a realist who believes that there is a world which is understandable; but because understanding is historically and linguistically constituted, what Gadamer challenges is the *degree of certainty* that the social sciences have presupposed is possible through the application of methodological procedures.

Philosophical hermeneutics considers the product of social inquiry to be the formation of a comprehensive horizon from which real understanding is possible. But such understanding is not a representation of a separate reality (as presumed in positivism) which ignores the role of the interpreter; nor is it the nihilism or relativism of postmodernism which often suggests that because there is no foundation from which to justify knowledge, no understanding is more valid than any other.

But now the question arises as to how we can legitimate this hermeneutical conditionedness of our being in the face of modern science, which stands or falls with the principle of being unbiased and prejudiceless. ... [Science] always stands under definite conditions of methodological abstraction and that the successes of modern sciences rest on the fact that other possibilities for questioning are concealed by abstraction (Gadamer, 1976, pp. 10-11).

As it is ontologically assumed that all influential factors constituting one’s horizon can never be fully known at any given time (because the act of making them known changes the horizon), horizons that yield more possibilities for making influential factors manifest are preferable to the fusion of horizons

that limit such possibilities. This criterion of perpetuating openness is in stark contrast to the Enlightenment quest for closure and certainty through carefully controlled methodology.

A second criterion Gadamer uses to evaluate the quality of interpretations is derived from his rehabilitation of Aristotle's concept of *praxis*, or practical wisdom. Gadamer shares Habermas' critique that modern society's over-emphasis on technical capacity has led to the neglect of our ability to reason about the quality of the ends our technology allows us to produce. Thus, for Gadamer, genuine understanding always includes an inseparable ethical or moral component. The understanding of what 'is' that includes reflection on what 'ought to be' is considered more worth knowing than the understanding of either 'is' or 'ought' alone can produce. In other words, interpretations that facilitate our ability to act in ways that promote "the good" (even pluralistic definitions of "the good") are considered superior to those interpretations that fail to acknowledge the ends they implicitly or explicitly promote. Thus, philosophical hermeneutics rejects modern society's sundering of theory and practice, facts and values, explanation and purpose (Kane, 1998).

Whoever wants to learn a science has to learn to master its methodology. But we also know that methodology as such does not guarantee in any way the productivity of its application. Any experience of life can confirm that there is such a thing as methodological sterility, that is, the application of a method to something not really worth knowing, to something that has not been made an object of investigation on the basis of a genuine question. ...The real power of hermeneutical consciousness is our ability to see what is questionable (Gadamer, 1976, p. 13).

#### Summary

For Gadamer, a genuine question is one that is worth finding an answer to, one that promotes practical wisdom and continued investigation and dialogue. Underneath my research question—*How can ethical decision-making as discussed in the MFT literature be understood in light of previous exposure to ethical theory and medical ethics?*—is the larger quest for an understanding of how it is we decide what is good practice in marriage and family therapy. In so far as the top three skills needed by family therapists,

as identified by Figley and Nelson (1989), had to do with ethical analysis and behavior, I believe my research question has been a “genuine question.”

My study has not been a search for intended meanings, or even hidden presuppositions of the authors of the articles under examination; nor is it merely a literature review. With some irony, my study can be likened to a chemistry experiment—a one-time “naturalistic” experiment that is non-replicable, because I was changed by the experiment and other factors will influence future readings. Chapter 6 reports the results of my fusion of horizons by discussing what happened when what I brought to the text (i.e., my current understanding of ethics) was mixed with the text itself (i.e., a new comprehensive reading of articles related to MFT ethical decision-making). I do not purport to produce a definitive end product, but rather one that can serve as a catalyst for future experiments of understanding (i.e., the criterion of openness) and helps facilitate movement toward “the good” (i.e., the criterion of praxis). Thus, in chapter 7, I conclude this project by discussing the implications my current travels around the hermeneutic circle have for future “fusions of horizons” by others.

## CHAPTER SIX: RESULTS OF FUSION OF HORIZONS

### Introduction

This project represents an amalgam of empirical and philosophical methods employed to achieve a hybrid goal: understanding that promotes praxis, or practical wisdom. As previously discussed, this goal is neither explanation, nor pure description in the traditional social science sense. Published ideas were the data, rather than newly collected responses to investigator stimuli (e.g., survey or interview questions). The experiment in its essence explored what happened when one set of ideas collided with another. What happened to the old ideas when they interacted with new ideas, and what happened to the new ideas when they were exposed to old ideas? Transparency has been the measuring tool with which I have added the old and the new ideas into the container of my mind. N6 was the tool used to separate and blend the ideas together, and this chapter is the presentation of my results.

Recall that Gadamer's concept of the "fusion of horizons" requires us to test the limits of what we can understand from our current vantage point by seriously considering the truth claims derived from other points of view "as having potentially valid and important things to say to us" (Fowers & Wenger, 1997, p. 166). This chapter reports on my attempt to fuse horizons shaped by the philosophical ethics and medical ethics fields, and the MFT ethical decision-making literature. The aim was to open up additional new possible interpretations for others, and in so doing, perpetuate the conversation, the goal of inquiry within an ontological hermeneutic framework.

The features of the landscape shaping my newly fused horizon are categorized as mountain peaks, foothills, and valleys. Mountain peaks are those results from the hermeneutic analysis that dominate my new understanding and are briefly reviewed in the first part of this chapter to serve an orienting function for the rest of the results. Mountain peaks include:



- (1) The role of professional and legal regulations;
- (2) The role of Karen Kitchener's seminal model of ethical decision-making for psychotherapists; and
- (3) The role of Graber and Thomasma's models of ethical analysis.

Foothills and valleys, though briefly outlined here, are discussed most explicitly in the summary at the end of this chapter. Foothills are important considerations arising out of this fusion of horizons, but are not as prominent as the mountains; they include:

- (1) The importance of reflecting on self-of-therapist issues from the moral point of view as well as a clinical perspective;
- (2) The suggestion that self-awareness and differentiation may be understood as profession-specific virtues; and
- (3) The need to account for the delimiting role of stress and anxiety in ethical decision-making.

Valleys are moral considerations that seem conspicuously missing in the set of articles on MFT ethical decision-making analyzed in this study; these included:

- (1) The lack of discussion of multicultural issues from the moral point of view, not just a clinical perspective;
- (2) The lack of recognition that the split between ethics and religion reflects a strong western bias; and
- (3) The lack of exposure to larger philosophical and theoretical ethics literatures, and the use of secondary sources appears to have contributed to the perpetuation of conceptual and theoretical errors within the MFT ethical decision-making literature.

Following an overview of the most prominent results of this study (i.e., the mountain peaks) and the ways they may relate together, the remainder of the chapter is devoted to an in-depth chronicling of

my hermeneutic engagement with each MFT article, and a comprehensive summary of results. Insofar as this project records an on-going conversation, the presentation and discussion of results is largely one and the same. Implications and recommendations based on these efforts are presented in the final chapter.

### *Caveats*

Before reporting results of this hermeneutic process, however, two caveats are worth raising at the outset. First, as previously mentioned, I was surprised, upon closer inspection of the MFT literature during the screening process, by how few articles actually addressed ethical decision-making *processes*. Only 13 articles across five MFT journals in 20 years had decision-making procedures as an explicit central focus, and three of those 13 represented a unit comprised of an article, a commentary and a rejoinder. Whereas some exciting possibilities for new understanding emerged, it quickly became apparent during the process of reading and rereading articles that such a small number of items limited making many cross comparisons or summary types of conclusions. A recognized limitation of document analysis is that texts studied were not originally generated with the research question in mind.

Although all articles addressed the common theme of ethical decision-making processes, they did so from very diverse perspectives and with ostensibly unique goals. In addition, there was very limited cross-citations between the authors of these texts. Thus, from the outset (assuming that the text selection procedures used identified at least the bulk of this sort of MFT literature), it appears fair to say that our professional discourse about ethical decision-making processes in MFT remains extremely scarce and fragmented.

Reading these 13 articles, I felt like I had been given 13 random pieces of a 1000-piece jigsaw puzzle (with only the three pieces published together clearly linked), with the goal of describing the picture on the cover of the box (even while recognizing that more than one “box” was possibly

represented). Yet the sense that I was working with a 1000-piece puzzle (vs. a 15 or 20 piece puzzle) was likely based on my pre-understanding of the depth and breadth of moral philosophy, which raises the second important consideration. Despite earnest attempts to be genuinely open to what new information the texts had in store for me, I encountered just a few genuine surprises in the course of reading and rereading the MFT texts, meaning that many of the ideas they contained were already incorporated into the presentation of my then-current horizon in chapters one, three and four.

There are two possible explanations for this. One, I have simply become so absorbed in philosophical ethics that I could not escape its gravitational force, so to speak; thus hindering my ability to recognize novel points of comparison. A second explanation, and I would claim a more likely one, is that I have been engaging this topic in the hermeneutic circle for years. I came of age as a family therapist in 1994, when I finished clinical training in my MFT masters program and began work as a full-time family therapist. Thus, my presentation of ethical theory and medical ethics in chapters three and four already incorporated my previous understanding of MFT ethics and the socialization of 13 years in the family therapy field (1992-2004). Of course, this is the hermeneutic circle in its essence. As Gadamer asserts, just as my pre-understanding makes a new understanding of MFT ethics possible (i.e., the goal of hermeneutic analysis), it also inevitably limits it, thereby requiring additional critical inquiries into the topic.

## Overview of results

### *Introducing the texts*

Five of the 13 articles reported empirical studies about how family therapists *do* make ethical decisions, while the remaining 8 articles were theoretical discussions about how family therapists *ought* to make ethical decisions. Green and Hansen (1986) used quantitative methods to identify the types and frequency of ethical dilemmas faced by MFTs, and assessed the usefulness of the 1984 AAMFT code of ethics in dealing with ethical dilemmas. Newfield, Newfield, Sperry, and Smith (2000) conducted a quantitative study assessing whether therapists used justice or care based reasoning when faced with

ethical dilemmas. Burkemper's (2002) quantitative study assessed perceived importance of different components of Kitchener's (1984) model of ethical decision-making when faced with dilemmas related to HIV and child abuse. Brown and Strozier (2004) quantitatively examined the impact mandated reporting of suspected child abuse had on family therapists' consideration of systemic treatment issues. Jankowski & Martin (2003) used mixed qualitative and quantitative methods to identify six themes/factors relating to the process and outcome of therapists' decisions to report or not to report child maltreatment.

Of the eight normative discussions of MFT ethical decision-making, seven focused on models. Zygmund and Boorhem (1989) summarized Kitchener's (1984) entire model and then demonstrated its general applicability to family therapy. Haverkamp and Daniluk (1993) focused on Kitchener's (1984) five moral principles, while adding a sixth, the principle of self-interest, and how they are applied to sort through dilemmas associated with child abuse. Hill and Mamalakis (2001) worked within Kitchener's (1984) model to create a "sub-model" for assessing the appropriateness of entering into dual relationships in religious settings. Butler and Gardner (2001) presented their concerns about Hill and Mamalakis' model, while Mamalakis and Hill (2001) provide a rejoinder to this commentary. Russell and Peterson (1998) relied on Kitchener's (1988) application of role theory as a foundation for their "check-up" model for supervisors to assess dual role relationships with students and supervisees. Only Woody (1990) presented a completely original comprehensive decision-making model for use specifically by family therapists when faced with ethical dilemmas. The final article examined in this study, Schlossberger and Hecker (1996), provided an excellent example of the relationship between legal and ethical analysis of the duty to report when working with HIV-positive clients.

### *Orienting Features*

As noted above, the small number of articles in the MFT literature explicitly focused on ethical decision-making processes, and the diversity of approaches to the topic that the authors of these papers presented made cross comparisons and generalizations difficult. Among the myriad issues raised in the presentation of individual articles below, as noted above, three considerations seem to particularly stand out in relation to MFT ethical decision-making processes: (1) the role of professional and legal

regulations; (2) the role of Karen Kitchener's (1984, 1988) work (including as it relates to ethical theory); and (3) the role of Graber and Thomasma's (in press) models of ethical reasoning. How these considerations related to each article is summarized in Table 1 below.

These should be thought of as higher peaks in a mountain range of ideas forming a contrasting horizon, rather than a distillation of meta-themes as one might expect to find in most qualitative studies aimed at description. Consistent with a philosophical hermeneutic frame, it is ultimately the shape of the entire horizon as a whole, with all of its peaks and valleys—tall and small—that is of interest, which is why the detailed analysis of each article is also included below. Nevertheless, from this initial vantage point, specifying the peaks dominating the landscape will serve an orienting function during the rest of the hermeneutic journey.

#### *The Role of Professional and Legal Regulations*

Across the entire 20-year span of literature, it was generally observed by the authors of the examined articles that little attention has been given within MFT to ethical decision-making processes, and, except for Butler and Gardner (2001), there was a strong consensus that more guidance was needed than was or could be provided by the AAMFT code of ethics. In particular, the lack of available guidance for decision-making and scant reliance on decision-making models was emphasized by Burkemper (2002), Hill & Mamalakis (2001), Jankowski & Martin (2003), Mamalakis & Hill (2001), Newfield, Newfield, Sperry, & Smith (2000), Woody (1990), and Zygmund and Boorhem (1989). Furthermore, four articles discussed the limitations of a legal perspective as it relates to ethical decision-making: Burkemper (1998), Haverkamp & Daniluk (1993), Hill & Mamalakis (2001), and Schlossberger & Hecker (1996). Finally, the need to clarify the relationship between moral principles and the AAMFT code of ethics emerged from three articles (Butler & Gardner, 2001; Haverkamp & Daniluk, 1993; Schlossberger & Hecker, 1996).

### *The Role of Karen Kitchener's (1984) Seminal Model of Ethical Decision-Making for Psychotherapists*

While I had previously been aware of the seminal nature of Kitchener's (1984) article, I was unprepared for how dominant a role it played in the MFT ethical decision-making literature. Six articles focusing on decision-making models either based their work entirely on Kitchener's (1984) model (e.g., Hill & Mamalakis, 2001; Mamalakis & Hill, 2001; Zygmund & Boorhem, 1989), part of it—mostly her presentation of moral principles (e.g., Burkemper, 2002; Haverkamp & Daniluk, 1993), or used it to evaluate their own efforts (e.g., Jankowski & Miller, 2003).

Only Schlossberger & Hecker (1996) and Woody (1990) addressed ethical theory without using Kitchener as a primary source. Schlossberger & Hecker (1996) directly discussed the original work on moral principles by Beauchamp and Childress (1983, 1989). Woody (1990), as previously mentioned, relied on a flawed presentation of ethical theory by Hare (1981). The other seven articles that have any sort of connection to ethical theory do so through Kitchener's model. Kitchener, as discussed previously, escapes the especially troublesome aspects of Hare's (1981, 1991) model by merely borrowing his formal distinction between intuitive and critical thinking. She maintains conceptual clarity (and credibility) by substituting Hare's problematic definitions of these levels with Beauchamp and Childress' discussion of ordinary morality and principlism.

It must be remembered, however, that Kitchener is adapting one model from within medical ethics and Beauchamp and Childress have adapted moral principles first articulated in the context of research with human subjects. While the model Kitchener (1984) has chosen (i.e., principlism) has dominated medical ethics for the last twenty years, it is not without its limitations and critiques as noted by Graber and Thomasma (in press) and Tong (2001). It is as though Kitchener largely is seen by the authors in this study as the one and only source of ethical theory.

### *The Role of Graber and Thomasma's Models of Ethical Analysis*

Perhaps most exciting, were the possibilities created by reflecting on the MFT ethical decision-making literature through the lens of Graber and Thomasma's models of ethical reasoning, which were

reviewed in depth in chapter four. The work of Graber and Thomasma (in press) appears to offer a conceptual framework for understanding decision-making processes that has been lacking in the psychotherapy literature. Specifically their models facilitate the identification of mechanisms used in weighing or prioritizing conflicting moral considerations. By combining features of these models, the possibility of truly systemic procedures for ethical decision-making emerges more clearly, in contrast to the linear models currently in the literature.

It must be acknowledged that in applying what I take to be the main thrust of these philosophers' ideas outside the medical humanities context (i.e., philosophical medical ethics), I am taking liberties of which Graber and Thomasma may or may not approve. In other words, I am loosely applying in somewhat vague and unrefined ways, distinctions carefully articulated by Graber and Thomasma, and in doing so may introduce distortions of philosophical rigor. Furthermore, it is important to note that these reasoning models are present in traces only, hinted at, and largely operating, I would venture to guess, outside the awareness of the authors of the MFT articles. Nevertheless, I would argue that becoming fluent in the language of ethical theory as described in chapter three and the models of ethical reasoning described by Graber and Thomasma, offers much promise for evaluating, analyzing, synthesizing and expanding upon current MFT ethics discourse.

Describing the insights I gained into Kitchener's (1984) model of ethical decision-making by viewing it through the lens of Graber and Thomasma's (in press) models serves as an example of how I am applying the reasoning models, as well as a critical foundation and point of comparison for the presentation of the fusion of horizons below. The analysis of Kitchener's model actually originated in the midst of reviewing the article by Hill and Mamalakis (2001), when it first dawned on me that maybe Graber and Thomasma (in press) were functionally describing a series of tools available for sorting and weighing moral considerations and that some tools might be preferred to others depending on the nature of the task at hand. This led me to not only go back and re-read Kitchener's article in this light, but the other MFT articles as well. In so doing, the enthusiasm with which I considered the utility of Graber and Thomasma's work for understanding MFT ethical decision-making snowballed.

Table 1: Peak Considerations in Relation to Ethical Decision-Making Processes

Articles	Topic	Role of Kitchener	Role of Regulations	Role of Ethical Theory
Green & Hansen 1986	Quant study of ethical dilemmas encountered & usefulness of Code	None	Empirical support of limits of 1984 code	None
Zygmund & Boorhem 1989	Applied Kitchener's comprehensive model to MFT	Heavy Entire basis of article	Viewed as necessary but not sufficient	Heavy Via Kitchener's model
Woody 1990	Developed original comprehensive model	None But relies on 2 main Kitchener sources	Two of five bases for decision-making	Considered 1 of 5 key bases, but presents confusing description based on Hare, 1981
Haverkamp & Daniluk 1993	Applied Kitchener's comprehensive model to child abuse	Heavy Uses Kitchener's moral principles; adds self interest	Viewed as necessary but not sufficient	Moderate Does not go beyond principlism
Schlossberger & Hecker 1996	Conducted legal and ethical analysis of HIV and reporting	None But references Beauchamp/Childress	Law & ethics seen as related, but not equated	Heavy Uses own list of principles
Russell & Peterson 1998	Developed framework for assessing boundaries	Heavy Uses Kitchener's work re: roles, not 1984 model	Acknowledges code's rule re: dual relationships	None
Newfield, Newfield, Sperry, & Smith 2000	Quantitative study of justice vs. care based ethical reasoning	Indirect Via feminist model; main sources are Kohlberg & Gilligan	Questionably assumes all codes based on justice reasoning	None Uses moral development theory instead
Hill & Mamalakis 2001	Extended Kitchener's model to address dual roles in religious settings	Moderate Expands Kitchener's hierarchical reasoning procedures	Recognizes that codes must be interpreted & clarity is limited	Ostensibly light, but implicitly heavy reliance on Kitchener's model
Butler & Gardner 2001	Commentary on Hill & Mamalakis (2001); suggests code is sufficient	Light Critiques H & M for deviating from Kit., but doesn't use either	Code is clear so no need for interpretive guidance	Light Brief reference to Kitchener's principles
Mamalakis & Hill 2001	Rejoinder to Butler & Gardner (2001) commentary	Light Focus is on analyzing guidance offered by Code's prohibition	Emphasizes importance of code, but assert interpretation	Light
Burkemper 2002	Quantitative study of Kitchener's levels of critical evaluation re: reporting child abuse, HIV	Heavy Components of Kitchener's model are basis of study	Where codes are clear, people will use; where not, will use moral principles	Moderate Via Kitchener
Jankowski & Martin 2003	Mixed methods study of reasoning processes re: child abuse reporting	Moderate Relates results from inductive study to Kitchener's model	Describes factors influencing reporting	Moderate Via tertiary source, e.g., Burkemper, (1998)
Brown & Strozier 2004	Quantitative study of affects of duty to report on systemic considerations	None Relies on Bowenian and Psycho-dynamic theories	Concludes laws shift focus off of systemic considerations	Light Indirect when discussing rationale for reporting laws



*Models of ethical reasoning exhibited in Kitchener (1984).* Kitchener (1984) offered guidance on how to think through ethical decisions by prioritizing different types of ethical considerations as identified by Hare (1981), authors of professional codes, Beauchamp and Childress (1979), and deontological and teleological ethical theorists. Kitchener's model is helpful because it tells us what to consider and when. In other words, Kitchener's (1984) model is comprised of the following components, which she hierarchically arranged: (1a) facts of the situation, (1b) ordinary moral sense, (2) professional codes, (3) moral principles, and (4) ethical theory. Prior to this fusion of horizons, I thought of these components as "things," but the cognitive schemas for ethical reasoning described by Graber and Thomasma (in press) exposed the opportunity to think about some of these components in process terms, not merely content terms; for using these "things" when making decisions implicitly implies "using" them in certain ways.

For instance, professional codes are typically collections of prescriptive and proscriptive rules developed by members of the profession that essentially function as moral policies for that profession. These organizational policies may take on the form of social policies if they are incorporated into laws. Thus, when relating codes of ethics and laws to professional practice, validation model reasoning (Graber and Thomasma, in press) is likely, but not exclusively, being employed (i.e., an action is validated as ethical or unethical if the policy says it is). The moral principles component of Kitchener's (1984) model is a direct importation of the reasoning methods Beauchamp and Childress (1979) use, which Graber and Thomasma (in press) classify as an example of mediation model reasoning. Regarding the ethical theory component of Kitchener's model, she talks about directly applying the principles of universalizability and balancing, which seems to suggest the purely deductive sorts of reasoning described by Graber and Thomasma (in press) in the application model. Finally, the ways in which Kitchener (1984) talks about the intuitive level of her model (i.e., facts of the situation combined with ordinary moral sense) tentatively suggests a very loose form of origination model reasoning (Graber and Thomasma, in press). This last association requires more speculation, because as previously critiqued, Kitchener (1984) fails to provide much substantive detail about what she means by the "facts of the case." Nevertheless, it is provisionally linked to origination model reasoning (Graber and Thomasma, in press) precisely because informal

casuistry (i.e., case study or analogous reasoning) is associated with day-to-day reasoning. In sum, Kitchener prioritized and ordered the types of reasoning tools she recommended for thinking about ethical dilemmas as follows: (1<sup>st</sup>) loose origination model, (2<sup>nd</sup>) validation model, (3<sup>rd</sup>) mediation model, and (4<sup>th</sup>) application model. Thus, as a result of this fusion of horizons, the possibility has been opened for thinking about Kitchener's model not just in terms of "what to think about, when," but "how to think about what, and when."

There are definite pragmatic benefits to Kitchener's ranking. Certainly when pressed for time, reaching for the most obvious resolution that seems reasonably ethical may make sense, and if bright, well-informed and well-meaning others have invested the time and effort to create a guideline, why "reinvent the wheel?" But there are limitations to this pre-prioritized approach to ethical reasoning. Graber and Thomasma (in press) articulate the strengths and limitations of each model, including ways in which these reasoning processes may incorporate fallacious assumptions (e.g., the naturalistic fallacy), or may readily go astray. Kitchener suggests that if a dilemma may be resolved at a lower stage of the model, there is no need to advance to other stages. But this approach gives little consideration to the types of errors and limitations Graber and Thomasma discuss, and its linear procedure offers no opportunity for simultaneous checks and balances across reasoning processes being employed in any single stage.

Additionally, Kitchener's (1984) model may presuppose more deductive relations between components than exist in reality. For instance, she suggests that if provisions in a code of ethics conflict, resolution may be found by evaluating the moral principles upon which the code's provisions were presumably based. This makes great sense if the axioms and rules found in codes were clearly deduced from moral principles. But as Kultgen (1988) observed, most professional codes are formulated as ad hoc reactions to complaints, not logical reasoning about what rules coherently follow from moral principles (though the code of ethics for the Canadian Psychological Association may be an exception). Also, both moral and non-moral considerations may have gone into the formation of the code's rules, which as Graber and Thomasma (in press) point out is part of the strength and utility of validation model

reasoning; thus evaluating moral principles may not fully account for the important non-moral considerations contained in the code.

Much caution is warranted with this analysis. My intention is to present the possibility of theoretical links as they occurred to me during this fusion of horizons. More rigorous analysis, ideally using raw data, would be needed to confirm whether the conceptual relationships presented in this analysis bear the fruit of increased understanding (e.g., creating a coding structure using these theoretical models and then coding transcripts of therapists' describing the decision-making process they used when faced with a tough moral choice). This is true not only regarding the Kitchener (1984) article, but all of the articles explored in this study. Table 2 notes the types of reasoning processes I explored as being present in the MFT articles; the full narrative of these ideas is found in the discussion of individual articles.

Table 2: Graber & Thomasma's (in press) Models of reasoning appearing in MFT articles

1st Author	Application	Mediation	Validation	Determination	Origination	Virtue
Green			X			
Zygmund	X*	X*	X*		x*	
Woody	x	X	X	X	X	X
Haverkamp		X*	X*			X
Schlossberger		X	X		X	X
Russell				X		X
Newfield						
Hill	X*	X*	X*	X	X	X
Butler	X					
Mamalakis	X	X	X			
Burkemper		X*	X*		x*	
Jankowski		X	X	X	X	
Brown		X	X			X

\* Via Kitchener's (1984) Model  $x$  = loosely applied

### Chronicling the Fusing of Horizons within Each Article

It is important to note, the process of writing this chapter itself was another hermeneutic cycle, another interpretation of each individual article in light of the understanding produced by reading all of the articles. Some insights that technically "originated" during the reading of later articles are here presented with earlier articles, because my understanding of these early articles is now colored by the

insights gained while reading the later articles. Likewise, how I presented the early articles in this chapter led to additional new insights into later articles during the writing process itself. Thus, although articles are discussed chronologically, the insights discussed with each article did not necessarily develop chronologically or in the linear manner in which they are presented. Without bearing in mind this cyclical interpretive process in the development of understanding, it would be easy to assume that what follows is merely a review of the literature rather than the results of careful hermeneutic analysis.

[1] Green, S. L., & Hansen, J. C. (1986). *Ethical dilemmas in family therapy*. *Journal of Marital and Family Therapy*, 12(3), 225-230.

The empirical study by Green and Hansen (1986) examined the types of ethical dilemmas therapists faced and how helpful the 1984 AAMFT Code of Ethics was with these dilemmas. Using a five point scale labeled from “frequently” to “never,” subjects were asked to indicate how often they “faced a dilemma with...” and then were given a list of 31 dilemmas derived from the code of ethics and another 10 identified in the literature, but not by the code. They found that family therapists were facing dilemmas not addressed by the code significantly more than those included in the code. For those dilemmas covered by the code, the professional standards were considered helpful. This study provided empirical support for limits of the 1984 code.

Green and Hansen’s (1986) article was ranked as relevant to the current study, but not strongly relevant, in that it offered an analysis of the utility of using a code of ethics during reasoning about ethical dilemmas, but did not unpack the reasoning process itself. I found the insight this article provided to this investigation limited by its brevity, in that it was only three pages long plus a one and one half page-length table. Upon careful review of the article, I primarily was struck by how vaguely many of the dilemmas were worded (e.g., “treating the entire family,” “training or qualifications,” sharing values with clients,” “personal problems that impair your work performance”). It was not clear if this was an artifact of publication or if indeed this was the wording used in the study. If the later, it raises the question of whether shared understanding can be presumed about the moral issues raised by each circumstance, in a research study in particular, but also in practice more generally. For instance, what exactly are the moral

problems created by sharing values in therapy; and are all values shared in therapy equally problematic? This was the oldest article reviewed in this study, and is a good example of the historicity of our understanding of ethics in MFT; it was written at a time when therapist neutrality was assumed to be the most ethical stance. It also illustrates the need for more nuanced ethical language in order to rigorously assess decision-making processes.

[2] Zygmund, M. J., & Boorhem, H. (1989). *Ethical decision-making in family therapy*. Family Process, 28(3), 269-280.

With this article, Zygmund and Boorhem (1989) can be credited with introducing Karen Kitchener's (1984) model of ethical decision-making to family therapists, by summarizing her model and supplying examples of how to apply it in family therapy and in supervision. They grounded their discussion in the AAMFT code's prescription to advance the welfare of families and individuals, noting that the needs of individuals and families often conflict. They explicitly acknowledged that although numerous MFT articles examined such issues as confidentiality, privileged communication, family secrets, use of paradoxical techniques, and the role of therapists' values within the treatment context, "*none* has offered family therapists useful guidelines that enable them to evaluate their clinical decisions" (Zygmund & Boorhem, 1989, p. 269, emphasis added). With their central focus on decision-making, this article was given the highest ranking (i.e., strongly relevant) for inclusion in this study.

Zygmund and Boorhem (1989) noted that the use of ethical decision-making models was not commonplace among family therapists and clinical models were used instead as sources of moral guidance.

In the family therapy field, the accepted practice is to rely on acknowledged schools of family therapy. This practice has promoted conflict between family therapists about the most effective treatment approach.... We believe that various family therapy approaches, if used appropriately, can promote the welfare of families and individuals. However, it is important to teach students and supervisees that relying solely on a therapeutic approach may result in unethical decisions. We are all aware of situations in which our actions or

our colleagues' actions were based on accepted therapeutic approach, yet they produced harmful consequences for the family or some of its members. By teaching students and supervisees to evaluate their clinical decisions, using Kitchener's model of ethical justification, they can examine their clinical decisions from an ethical perspective (Zygmund & Boorhem, 1989, p. 270).

In this way, the authors made a clear distinction between a clinical perspective and an ethical perspective, between clinical issues and ethical issues, while suggesting that the difference was not readily recognized in the field. It still may not be well understood, even to this day. As discussed below, this issue appears again in Woody's (1990) model of ethical decision-making, and more recently in the model proposed by Hill and Mamalakis (2001). In the late 1980s when this article was written, debate over treatment effectiveness was largely theoretical and ideological; now it has assumed an empirical focus. It is worth considering whether in the fervor to empirically validate the effectiveness and efficacy of family therapy the distinction between clinical concerns and ethical concerns continues to get lost.

Furthermore, by emphasizing the need to provide tools for therapists to "examine their clinical decisions from an ethical perspective" Zygmund and Boorhem (1989) introduced the evaluative and reflective nature of ethical reasoning. Implicit in their advocacy of Kitchener's multifaceted model of decision-making, seemed to be the view that an ethical perspective involves more than a rote enactment or avoidance of behaviors prescribed and proscribed by a professional code of ethics. It may be reasonable, therefore, to suggest that perhaps Zygmund and Boorhem would have agreed that when it comes to training students to be ethical practitioners attention must be given to reflective judgment as well as clinical technique; in other words, ethical praxis.

The bulk of Zygmund and Boorhem's (1989) article is devoted to summarizing and applying Kitchener's (1984) model. It is notable that these authors gave careful attention to each level of Kitchener's model in their examples, not just stopping with the second critical-evaluative level of ethical principles or dramatically minimizing their discussion of the third level, ethical theory, as other authors

have while presenting Kitchener's model (e.g., Burkemper, 2002; Haverkamp & Daniluk, 1993; Hill & Mamalakis, 2001). As the strengths and weaknesses of Kitchener's model have been previously discussed, they will not be repeated here. Kitchener's (1984) seminal work brought much order to the chaotic world of ethical dilemmas in counseling psychology, and Zygmund and Boorhem (1989) aptly communicated this order to the field of family therapy. But as Gadamer teaches us, all understanding is finite, even Kitchener's understanding of ethical decision-making, which the fusion of horizons created by the works of Kitchener and Graber and Thomasma described above bring more clearly to our attention.

[3] Woody, J. D. (1990). *Resolving ethical concerns in clinical practice: Toward a pragmatic model*. *Journal of Marital and Family Therapy*, 16(2), 133-150.

Like Zygmund and Boorhem (1989), Woody (1990) identified the MFT ethics literature to date as lacking a focus on process:

In the past 10 years, professional position statements have finally started focusing on key ethical issues that marital and family therapists face in practice...Such discussions serve a valuable purpose in increasing awareness of ethical and legal aspects of therapy, but they do not adequately address the processes through which therapists manage the routine, pervasive ethical dimensions of clinical work as well as resolve the complex ethical problems (p. 133).

In this article, Jane Woody (1990) presented the only fully original comprehensive model of ethical decision-making (i.e., not topic specific) identified in the current review of literature that was published in an MFT journal. While Volker Thomas (1992) also created a comprehensive decision-making model for family counselors, it was published in a counseling psychology journal. While I did not base my own approach to ethical decision-making (i.e., The 7 Ps) on Woody's model, they are similar in their recognition of the multidimensional (but not necessarily hierarchical or linear) nature of ethical decision-making. Woody (1990) asserted that ethical decisions should be based in five types of considerations, what she called decision bases, with the first being used to assess the other four: (1) theories of ethics; (2)

professional codes of ethics; (3) professional theoretical premises; (4) the sociolegal context; and (5) the therapist's personal/professional identity. The article focused on explaining each base and then applying the model to five actual cases. As with Zygmund and Boorhem (1989), with Woody's explicit attention to decision processes, this article received the highest ranking (i.e., strongly relevant) for inclusion in this study.

In Woody's (1990) pragmatic model, ethical theory is considered a "foundation decision base" (p. 137) which is used to provide a check on one's thinking about a problem. Woody used Hare's (1981) model of psychiatric ethics as a primary source for her discussion of ethical theory. As previously discussed, Hare's presentation of ethical theory is problematic and Woody's reliance on Hare's work perpetuated conceptual difficulties. Woody also spent considerable time describing Rawlsian contract theory. It was unclear if she used John Rawls' (1971) book, *A Theory of Justice*, as a primary source or if she described Rawls' contract theory via Hare's interpretation. In either case, Rawls himself acknowledged that his theory of justice, though highly influential was narrow in scope, and was never intended to serve as a comprehensive ethical theory in the same way as Kantian deontological ethics, or Bentham or Mill's utilitarianism (Rawls, 1993, in Rest, et al., 1999). Thus, Woody's presentation of Rawls' theory as one of two major categories of theories is misleading. Certainly Rawls (1971) assumes a deontological stance (even an absolutist stance) when he asserts that each person possesses an inviolability founded on justice that cannot be bargained away in the quest for the greatest good for the greatest number, but his narrow focus on justice issues, while neglecting other moral principles, makes for an anorexic representation of the full scope of ethical theory. With ethical theory as foundational to her model, I would suggest that Woody has been terribly handicapped by her reliance on Hare's (1981) confusing conceptualization of ethical theory and her misrepresentation of Rawls' theory of justice as a general ethical theory.

As a related issue, since the feminist critiques of systems theory in the 1970s and 1980s, there has been increased attention to social justice issues in family therapy, and sensitivity to these issues no doubt strengthens the field. Indeed, some MFT training programs are promoting their social justice emphasis. I



suspect this has more to do with the larger feminist discourse in the field than Woody's single justice-focused presentation of ethical theory in this article. Nevertheless, the same concern that applies to Woody's (1990) article—namely that justice is not the only moral consideration—also needs to be raised in relation to training programs that privilege a justice orientation over other moral orientations. How do these programs account for other moral considerations and what was the moral reasoning process used to reach the conclusion that justice issues should carry more moral weight in family therapy than other moral considerations? My view is not that justice should not be emphasized, but rather that attention to social justice is one of many important *prima facie* ethical duties of which family therapists need to take notice, and the decision to privilege one moral issue needs explicit justification.

The distinction between *prima facie* duties and absolute duties is also blurred in Woody's (1990) discussion of the second decision base, professional codes. An absolute duty cannot be overruled, whereas a *prima facie* duty is one that carries a binding obligation, but may be overturned in the face of other competing moral considerations. This is where viewing the items of a code as *prima facie* is much more realistic. Confusingly, Woody (1990) referred to principles in the code as being "absolute," but went on to acknowledge the non-absolute nature of codes of professional ethics. This was somewhat of a surprise to me based on her later work (e.g., Woody & Woody, 2001).

Professional codes of ethics appear to offer "absolute" rules and principles for proper professional conduct; but the terms used are, in fact, general and subject to definition and interpretation. The meaning of terms...will seem arbitrary in the face of a dilemma. In addition, the codes do not acknowledge that some of their guidelines encompass what can become conflicting obligations for the therapist; nor do they indicate how to weigh the importance of duties when they conflict....The therapist's judgment will be required to weigh and evaluate such situations (Woody, 1990, pp. 137-138).

In discussing the interface between professional codes and the socio-legal context (the fourth decision-base), Woody made two comments that served as effective checks on my own thinking. First, as professional codes of ethics are increasingly incorporated into licensure laws, Woody noted concerns by

some therapists that this results in the view that ethics gets reduced to simple technical maneuvering for avoiding lawsuits. To see this worded so starkly caught me short. Is this the essence of my own critique of my perceptions of current AAMFT practices with its emphasis on compliance and legal risk management? Yes and no. Indeed, I am convinced for reasons articulated in chapters one and four that the dominant discourse in the MFT ethics literature features a legal perspective to the neglect of other ways of talking about ethics, and this is problematic. Yet I also believe that the MFT profession is full of sophisticated thinkers who may rely on legal discourse more from the lack of familiarity with other languages (e.g., ethical theory), than a genuine sense that avoiding lawsuits is all that ethical practice entails. Indeed, MacIntyre (1981) observed that in the face of fragmented moral traditions and languages, we tend to resort to procedural and legal discourse. Could the legal emphasis in MFT relate to the old adage, “If all you have [or are aware of] is a hammer, everything looks like a nail”?

Second, Woody (1990) went on to say, “This view [i.e., ethics as technical maneuvering] ignores the fact that therapy occurs in a social context and that, increasingly, codes of ethics are *reflecting societal and legal interpretations* of ethical conduct” (p. 138, emphasis added). The ontological hermeneutic framework that is the basis of this study requires me to risk my own deeply cherished views being altered by the texts I am reading; thus, I must acknowledge that this rejoinder by Woody helped me to see more clearly an important limitation of my current horizon. Although my view that a legal perspective when interpreting codes is a necessary, but insufficient component of ethics education has not changed, bumping up against Woody’s statement brought to the surface the recognition that while I have developed some sophistication in thinking about ethics, I most likely have a fairly unsophisticated understanding of the intricacies of law’s function as one of society’s primary moral institutions. This is not saying I am unfamiliar with laws relevant to family therapy, but rather the *institution* of law itself and its interpretive practices (i.e., the means by which it both shapes and is shaped by society’s moral values) are currently rather foreign to me. Understanding the institution of law better will likely further enhance my understanding of ethics.

Woody (1990) included clinical theoretical premises as a third decision base, stating that these can affect how codes of ethics are interpreted. She noted that embedded in every therapy theory are values assumptions about what is considered healthy or unhealthy, and what is expected to benefit clients; these assumptions will affect one's interpretation of words typically found in codes of ethics, such as therapist's knowledge or competence, integrity, and client welfare. Thus, noted Woody (1990), moral guidance comes not from the clinical theories themselves, but the moral assumptions embedded within them, though rarely are these clearly extrapolated and articulated.

While this is the thrust of the content of Woody's message, it is worth looking directly and carefully at exactly how she talks about this issue for clues about reasoning processes being employed. Doing so provides an opportunity to explore the possible insights afforded by an understanding of Graber and Thomasma's (in press) models of reasoning processes.

A given theory will focus only on certain dimensions of human behavior of particular interest to the theorist; this narrowing of scope results precisely because of the intent to focus on elements omitted in previous theories.... It is necessary to remember that theories of therapy are merely maps, not the territory itself. Yet practitioners often apply them as if they embody the 'truth' of the human condition when, in fact, they are largely unvalidated hypotheses (Woody, 1990, p. 139).

Though perhaps a bit of a stretch, and at the risk of conceptual distortion, it may be worth toying with idea that those who are looking to clinical theory for moral guidance, especially those that mistake the "map" for the "territory" may be engaging in a misguided attempt to use determination model reasoning (Graber & Thomasma, in press). In other words, determination model reasoning suggests that different clinical practices may be the source of different ways of weighting moral considerations. The danger in determination model reasoning is that the clinical context (i.e., the map) gets mistaken for the source of moral authority itself (i.e., the territory), rather than as a source for normative rules for prioritizing moral considerations. Thus, in feminist based practice, for example, feminist clinical theory cannot be a direct justification for ethical behavior (or the lack of it), but it can provide the rule that determines *privileging*

the moral principle of justice. Woody makes approximately this same argument, of course not using these terms, but by implicitly promoting alternative approaches to ethical reasoning instead.

[The] abstract theoretical debates about the validity of various therapeutic approaches are not particularly helpful in resolving a given clinical [ethical] dilemma. These discussions typically assume the primacy of theory in the conduct of therapy. The advocates also tend to argue their favored position without clearly defining their assumptions and values about universal moral principles, their interpretations of professional ethical guidelines, their sensitivity to the social reality (including the sociolegal context), and the relevance of their own personal histories and identities (including the evaluation of their personal/professional consciences) (Woody, 1990, p. 140).

Woody (1990), seems to be advocating a mediation model approach to ethical reasoning whereby the moral principles involved need to be clearly articulated. Her focus on the sociolegal context hints at a more straightforward and rigorous usage of determination model reasoning, and her inclusion of personal histories and identities imply both origination (i.e., narrative ethics) and virtue models of moral reasoning.

The forth decision base in Woody's (1990) model, sociolegal context, involves three facets: social values, legal realities (which have already been discussed), and the organizational context in which therapy takes place. In her brief discussion of social values, Woody argues that the values of therapists and clients as well as their personal histories emanate from the sociocultural context, and this context is often in a tremendous state of flux (e.g., changes in sexual values over time). Though Woody does not go in this direction explicitly, her recognition that values change over time, reminded me of the utility of Volker Thomas' inclusion of Bronfenbrenner's (1989) ecological theory as a frame for thinking about ethical issues. Where therapists and clients are in their own lifespan development and the larger historical events that have shaped their views likely play significant roles in the development of moral sensitivity (Rest, 1994) and understanding of ethical considerations. More recent attention to increasing multicultural sensitivity by therapists would also readily fit with Woody's discussion. Likewise, Woody's recognition of institutional context would also be consistent with an ecological framework.

Interestingly, Woody's (1990) article was one of only four in this study that addressed systemic considerations beyond the level of the family, with the others being Brown and Strozier (2004), Hill and Mamalakis (2001), and Jankowski and Martin (2003).

Woody's (1990) final decision base was the personal/professional identity of the therapist. At the time of this article, debate was raging between clinical theories that promoted the idea of therapist neutrality and those who challenged this view; thus she defended her inclusion of this base with the view that the therapist is present in the therapy room both as a person and as an expert.

And it is a person who does the critical thinking and makes the choices that resolve a dilemma. The clinician can draw from many sources to fortify critical thinking, but the personal/professional identity ultimately chooses on the basis of a vision or beliefs about life, reality, and one's own character, that is, the kind of person one is or wants to be through this choice.... [One] of the factors that the therapist must additionally process and weigh is his or her own knowledge, competence, and integrity relevant to a give dilemma. We expect a well integrated personal/professional identity that can carry out these functions; yet the lack of an integrated identity may impair the whole judgment process and may, in fact, trigger or contribute to a clinical dilemma (Woody, 1990, p. 144).

In this exemplar of Woody's thinking, there is clear evidence of virtue model reasoning (Graber & Thomasma, in press). In particular, Woody and Graber and Thomasma appear to agree that ethical decisions are made by embodied persons and the quality of the reasoning process cannot not be affected by the qualities of the person making the decision.

In the discussion of virtue theory, it was observed that lists of virtues recommended for therapists largely are personal character virtues, not strictly professional values or skills, honesty, trustworthiness, and courageous for example. Yet in this process of fusing horizons, reading and rereading the 13 articles, it occurred to me that perhaps there are explicitly professional virtues that are emphasized in training and in the MFT literature, but are not thought about in terms of virtues. In particular, I would argue that self-

insight, or self-awareness, instinctively is revered as a professional virtue in the mental health professions more so than even other health care fields. Though Woody (1990) was not the original source for this idea, she does offer an excellent example of this view of self-insight as a professional virtue:

Helping professionals are expected to have considerable insight and be able to evaluate themselves without excessive distortion. They are supposed to monitor their competence in terms of knowledge and skills for working with given client problems, and, perhaps even more importantly, to be aware of self, personality structure, emotional needs, and life stresses that can interface with sound professional practice (Woody, 1990, p. 144).

The significance of translating our emphasis on self-insight and other self-of-therapist issues (e.g., boundaries and differentiation, as discussed below) into virtue terms is that doing so accesses language that opens up possibilities for enhanced ethical perspective in addition to the clinical focus we usually associate with self-of-therapists concerns. Recall that Graber and Thomasma (in press) argue against a view of virtues that are motivated by fears of external social or legal sanctioning; a virtues view of self-of-therapist issues gives us language to emphasize the importance of self-insight or boundaries, for example, beyond their compliance-oriented functions.

In concluding the presentation of her five decision bases, Woody (1990) stated, “In the final analysis we are left with the messy reality that clinical decision making consists of an unpredictable mix of intuition and rationality” (p. 144). Although ethical decision making is certainly messy, by virtue of the inherent ambiguity in moral dilemmas, I would suggest that Woody offered more potential tools for navigating the “mess” than she may have realized. In this article, Woody demonstrated traces of most of the moral reasoning models described by Graber and Thomasma (in press). Thus, more than any other author in this study, apart from Kitchener, Woody comes closest to Graber and Thomasma’s (in press) recommended multidimensional approach to ethical reasoning. While there is little evidence in this article to suggest that Woody conceived of her model as offering a collection of distinctive reasoning processes—after all she

used nouns (i.e., “decision bases” and “information sources”) to describe them—this may be the unrecognized, and to date unfulfilled, promise of her approach. I find in Woody’s reasoning processes about ethical issues in MFT, embryonic translations—from the medical to the family therapy context—of Graber and Thomasma’s carefully articulated schemas for ethical deliberation. While Kitchener’s (1984) presentation of the varied types of ethical reasoning is certainly more tidy, and in some respects more “generic” than Woody’s implicit usages, I suspect the breadth engendered in Woody’s five decision bases (especially if her ethical theory base is expanded), in the long run, opens more possibilities for comprehensive understanding of MFT ethics than Kitchener’s (1994) approach alone.

[4] Haverkamp, B., & Daniluk, J. C. (1993). *Child sexual abuse: Ethical issues for the family therapist*. *Family Relations*, 42(2), 134-139.

The article by Haverkamp and Daniluk (1993) used a principlism approach to examine ethical dilemmas faced by marital and family therapists when child sexual abuse is disclosed or suspected that may not be clearly addressed by professional codes or legal statutes. The dilemmas discussed related to informed consent and disclosure, mandated reporting of abuse, and therapeutic treatment of abuse. The authors relied on Kitchener’s (1984) definitions of five moral principles (i.e., autonomy, fidelity, justice, beneficence, and nonmaleficence), and an additional principle, self-interest, described by Thompson (1990). Careful attention was given to which moral principles apply to a given situation and the rationales that justified which principles were given the most weight. For this reason, it was ranked as strongly relevant for inclusion in this study.

Supplementing Kitchener’s framework, Haverkamp and Daniluk (1993) included the principle of self-interest in their analysis of ethical dilemmas related to child abuse.

The principle of self-interest reflects the moral and ethical responsibility of self-knowledge, self-improvement, self-protection, and self-care. When therapists fail to attend to their own legitimate interests or are unaware of their beliefs and limitations, their needs and values may indirectly interfere with their treatment decisions. Ethical

decision-making is enhanced when therapists are explicitly aware of their personal needs and motivations. Owing a duty to self is an extension of the imposition of all ethical duties and is embedded in Section 3 of the AAMFT (1985) code (Haverkamp & Daniluk, 1993, paragraph 12).

The idea of a moral principle of self-interest was new to me prior to reading this article. I realized I had tended to think of moral principles as guidelines for our relationships with others, but it is interesting to consider that our obligations to ourselves have moral weight, the neglect of which can lead to moral harm. The authors, following Thompson (1990), simply asserted that we have a “moral and ethical responsibility of self-knowledge, self-improvement, self-protection, and self-care.” Just as it may be worth future contemplation of self-insight as a therapy specific moral virtue, it may be important to further unpack the role of self-interests in therapy ethics, especially in light of the finding by Smith, McGuire, Abbott, and Blair (1991) that personal and practical considerations can lead to doing less than what we know our professional standards tell us we ought to do. This relates too, to Kultgen’s (1988) admonition that as most professions are made up of persons of ordinary conscientiousness and moderate good will, professional standards, to be effective, should not require heroic efforts. While it is fundamental to being a professional that the well-being of our clients outweigh our self-interests, as personal and practical factors inevitably already are playing roles in the ethical decision-making process, it behooves us to think more carefully about the legitimate role they should play (i.e., make the covert, overt).

Consistent with the works discussed above, Haverkamp and Daniluk (1993) found professional codes of ethics helpful, but limited, and gave an especially succinct and helpful representation of the ways in which professional regulations (i.e., codes or laws) are related to but distinct from ethics.

Behavior may be ethical and yet illegal (e.g., choosing not to report suspected child abuse due to the risk of physical reprisal for the child), unethical and illegal (e.g., failure to report or pursue suspected child abuse, based on a lack of knowledge regarding reporting procedures), or unethical yet outside of legal jurisdiction (e.g., working with families in



which abuse has occurred, without specific training and/or supervision in sexual abuse intervention). In cases where law and ethics suggest contradictory action, the therapist must choose between two conflicting, yet legitimate loyalties (Haverkamp & Daniluk, 1993, paragraph 4).

The authors suggested these sorts of conflicts as illustrative of the types of circumstances in which one would resort to the second level of critical-evaluative reasoning in Kitchener's (1984) model, moral principles.

Unlike other authors in this study utilizing Kitchener's model, Haverkamp and Daniluk (1993) were the only ones to explicate their understanding of how moral principles are related to the AAMFT code of ethics. It is important to note, however, that they talked about the principles of autonomy, fidelity, justice, and so forth as "embedded" in various sections of the 1985 AAMFT code; the exact nature of this embedded relationship was not made clear. As discussed above, Kitchener's model implies that the rules contained in professional codes are directly deduced from the list of moral principles she articulates, but according to Nichols (in Mowery, Becvar, Carlson, Gale & Nichols, 2004), Kitchener's particular list of principles were not ostensible guides in the formulation of the AAMFT code. This, of course, does not preclude the sorts of connections Haverkamp and Daniluk (1993) identify.

I would argue, however, that post-hoc assertions about the mere presence of a relationship between moral principles and the AAMFT code of ethics is ultimately insufficient for careful analysis of decision-making processes, both those we currently use and those we would normatively prescribe. We either need to identify and articulate the precise nature of the moral and non-moral considerations that make up our current code of ethics, or, more realistically, include more intentional considerations of the roles being played by moral principles and other moral and non-moral factors in future revisions of the AAMFT code.

Such distinctions are necessary, because interpretations of codes of ethics tend to engender validation model reasoning (Graber and Thomasma, in press), while the principlism used in Kitchener's

(1984) model seems to rely on mediation model reasoning. In mediation model reasoning, only moral considerations may determine which moral principle is given priority, whereas in validation model reasoning, policies that provide direction for actions can be derived from both moral and non-moral factors. Haverkamp and Daniluk (1993) give examples of both types of reasoning throughout their article in the rationales they use to justify their recommendations for resolving ethical dilemmas related to child abuse.

For example, in the AAMFT code of ethics, written consent is required for breaches of confidentiality. Informed consent, as required in the code of ethics, is a legal construct used as a *mechanism* to promote the moral principle of autonomy; alone, the concept of informed consent holds little or no moral force. Justifying an action (e.g., reporting suspected abuse) because it is legally required or because a disclosure statement signed by a client gave advanced notice that this action was possible, is an example of validation model reasoning: the action was valid because it followed a policy. However, violating a professional or social policy (i.e., a provision in a code of ethics or the law) may be justified as ethical using mediation model reasoning.

For instance, a therapist may choose not to report based on the primacy of the moral principle of non-maleficence, having assessed the risks of harm to the child (based on knowledge of the family's strengths and weaknesses as well as known strengths and weaknesses of the specific social service agency involved) if reporting were to take place. Of course in this example there are additional clinical scenarios possible and other steps that may or may not mitigate the circumstances, but the imperfect nature of families and social service agencies makes this a realistic possibility. The relevant point here, however, is how critical it is, especially for those in positions to adjudicate ethics complaints, to recognize that different methods of reasoning may lead to different ethical actions, and that mediation reasoning may produce morally justifiable behaviors that violate professional policies.

Recall, too, that in Kitchener's (1984) model, she privileges mediation model reasoning over validation model reasoning by representing the evaluation of moral principles as a higher order function

of critical-evaluative thinking than consideration of the code of ethics. This is less problematic for codes more overtly and conscientiously derived from fundamental moral principles (e.g., the Canadian Psychological Association Code of Ethics) than the current AAMFT code (whose “principles” are more accurately viewed as middle level axioms than fundamental moral principles).

Understandably, the idea of actions that violate a profession’s code of ethics legitimately being justified as ethical may be extremely uncomfortable for leadership of a professional organization and those whose task it is to enforce the code, and who may give primacy to validation model reasoning. This makes perfect sense in light of Kultgen’s (1988) distinction between the social and human functions of a code. When considering the human functions of a code for guidance at the level of an individual case, if the code is insufficient, it is comforting to the practitioner to know that guidance at the level of moral principles exists. However, when considering the social functions of a code as core to the profession’s identity and public status, the idea of “morally justifiable violations” of the ethics code is something of a non-sequitor, if not downright threatening at the public relations level.

This, then, is a moral dilemma for ethics committees who must find ways of reconciling conflicts between the legitimate social and human functions of their codes. If a therapist commits an act that can arguably be justified as morally permissible, but that violates a policy or law, how ought an ethics committee respond in order to reconcile both policy-level and moral-level claims? What would it be like to include a provision in the code itself (perhaps in the preamble) that somehow recognizes the interpretive nature of all codes (i.e., based on differing models of moral reasoning), acknowledges that exceptions to provisions may be morally permissible under extreme circumstances, and therefore requires (not merely recommends in these cases) consultation with the ethics committee? This would be a possible antidote to the “allness” stance (as discussed in chapter four) of the current AAMFT code noted by William C. Nichols (in Mowery, Becvar, Carlson, Gale & Nichols, 2004), but would thereby necessitate ethics education, and not merely ethics training (Cohen, 2001) for ethics committee members as well as general members of the profession.

To be absolutely clear, this analysis is in no way *advocating* violations of the AAMFT code of ethics or relevant laws. Rather, the point to be pressed is that for those in positions of evaluating the *ethical* nature of an act, there must be sophisticated understanding that different methods of ethical reasoning will lead to different justifiable conclusions. This was made evident in how Haverkamp and Daniluk (1993) use various methods of reasoning in their examples. Of course in these situations, therapists may still be held *legally* liable and face possible legal sanctions, but additional moral or ethical condemnation or sanctioning by the profession may or may not be appropriate. Thus, ethics committees need to be clear of the purpose of their sanctioning: protecting the public (i.e., a human function of the code was violated) or protecting the profession (i.e., a social function of the code was violated); both are legitimate tasks of an organization's ethics committee, but protecting social functions must not be masked as protecting human functions.

[5] Schlossberger, E., & Hecker, L. (1996). *HIV and family therapists' duty to warn: A legal and ethical analysis*. *Journal of Marital and Family Therapy*, 22(1), 27-40.

While the distinction between legal and ethical considerations was embedded in Haverkamp and Daniluk's (1993) article, it was the central focus of the article by Schlossberger and Hecker (1996), as they presented separate legal and ethical analyses of therapists' duty to warn when working with HIV-positive clients. Careful discussion of the California Tarasoff case and subsequent legal decisions made clear that legal and ethical analyses can lead to both similar and different conclusions. In their legal analysis, the key issue for these authors seemed to be centered on whether the questionable behavior (i.e., having unprotected sex when one is HIV-positive) is proscribed by law; since having sex is not against the law, the authors concluded that the duty to report does not apply. Legally, therapists only have a duty to report those behaviors that are against the law. Thus, therapists are not legally required to report HIV client behavior, but there remain ethical (e.g., non-maleficence) and clinical reasons (e.g., problems with "secret-keeping") why a therapist may still feel compelled to do so. Schlossberger and Hecker (1996)

focus on the use of carefully constructed disclosure statement as a practical solution for addressing gaps between law and ethics.

While numerous articles in MFT include a legal perspective, this article appears to be somewhat unique in its focus on understanding the law from a moral point of view, not strictly a behavioral one. Careful attention is given to a) the difference and the relation between ethical and legal analysis, b) how moral principles relate to legal principles, and c) justifying conclusions explicitly, rather than merely relying on authoritative assertions. For these reasons, while the content of this article was ranked as strongly relevant to the current study for its focus on reasoning processes, the structure of the article itself was also very enriching to my fusion of horizons.

Schlossberger and Hecker (1996) clearly exhibited validation model reasoning (Graber & Thomasma, in press) in their recommendation that therapists need to formulate personal policies when faced with legal gray areas, and disclose them to potential clients at the start of therapy. The idea of personal policies is important in its implicit recognition that not all moral issues can (or perhaps) should be resolved at the professional association level. Thus, validation model reasoning includes resolving moral conflicts through the creation of personal policies, as well as those at institutional, professional, and societal levels.

Breaking confidentiality and keeping “guilty” secrets both have ethical and therapeutic drawbacks. Therapists considering disclosure must decide, for a given type of case, which is the least bad option. In making this decision, therapists should identify relevant ethical considerations, evaluate the importance of these considerations, and arrive at an ethically sound decision. A list of relevant ethical factors might include four significant considerations: respecting autonomy, maintaining integrity, benefiting clients, and fostering responsibility....Therapists must formulate clear disclosure policies, preferably in the form of written statements distributed to clients before therapy begins. Clients’ understanding of the policy should be reinforced with oral discussion of the limits of confidentiality.... Finally, every alternative to disclosure should be explored....

Interventions designed to modify the client's behavior or prompt the client to warn partners are preferable to breaking confidentiality. When the therapist's duty, says Melton (1991), "is understood to be a duty to protect rather than to warn third parties, the dilemmas presented by possibly dangerous behavior of clients may be resolved by clinical creativity in responding to such behavior" (Schlossberger & Hecker, 1996, pp. 35, 37).

During the course of their legal and ethical analyses, Schlossberger and Hecker (1996) discussed that therapists may have a duty to protect, but not necessarily to warn, leaving open numerous clinical options not just issuing a verbal warning. This raises the possibility of what I would call, "ethical equifinality," which simply means that there may be more than one way to reach an ethical goal. I would argue that a critical lesson illustrated by Schlossberger and Hecker (1996) is the importance of careful ethical analysis in pinpointing the exact nature of ethical obligations rather than relying on superficial global ethical notions. Doing so allows for more tailored interventions to benefit all therapy stakeholders, rather than taking the most conservative means possible to reduce possible therapist liability. This is where origination model reasoning may play a supplemental role to validation model reasoning. "Clinical creativity" may include the ethical sensitivity engendered by narrative ethics, i.e., given the specific histories of the people and institutions involved, what is needed in this case at this particular time in order to best meet policy obligations? Careful ethical analysis also helps to prevent the creation of secondary ethical conundrums in the process of reacting to an initial ethical dilemma.

As viable a solution as disclosure statements are, it is necessary to recognize the limitations of policy approach; for not all clinical situations will lend themselves to policy solutions every time. Given the complexity and ambiguity of many ethical issues, policy makers need to anticipate the need to allow exceptions to any rule they create. As noted by Graber and Thomasma (in press), few ethicists think of moral principles as absolute, considering them *prima facie* instead (i.e., they may be overridden at times under certain circumstances), and few think purely deductive moral reasoning from those moral principles is possible; thus there is innumerable variation possible. This is also why Graber and Thomasma (in

press), in their bioethical hermeneutics, emphasize probabilistic certitude (i.e., under certain conditions, there is a greater probability that one value will be prioritized over another) instead of absolute certainty in normative ethics.

[6] Russell, C. S., & Peterson, C. M. (1998). *The management of personal and professional boundaries in marriage and family therapy training programs*. *Contemporary Family Therapy*, 20(4), 457-470.

Russell and Peterson (1998) discussed the various roles involved in student/teacher and supervisee/supervisor relationships, and this perspective on roles became the basis of their recommended procedures for assessing possible exploitation in multiple relationships. Once again the work of Karen Kitchener was used to provide a theoretical framework, but instead of her 1984 model of ethical decision-making, Russell and Peterson relied on Kitchener's (1988) application of role theory to the topic of multiple relationships. The authors presented a framework (related to self-care, student-care, and care of the professional group) for assessing the degree to which one's relationships with students and supervisees fits professional expectations.

Early in the analysis process, this article created a moment of methodological panic, as I pondered whether or not I had made a screening error by including it in the study. During both phases of the screening process I had viewed the series of questions presented by Russell and Peterson for use as "personal check-ups" as clearly focused on decision processes, and had even given this article a ranking of "strongly relevant" to this study. Then, after analyzing the five articles discussed above, with their overt discussions of moral principles and the complete absence of references to moral principles in the Russell and Peterson (1998) article, I found myself reconsidering whether this article should have rightfully been categorized as a "what" article rather than a "how" article. With additional careful deliberation, it dawned on me that this article could perhaps be an example of determination model reasoning (Graber & Thomasma, in press), whereby the context of the training program determined the roles and the roles contained normative expectations. The experience with this article made me pause, however, and reflect on the possibility that perhaps my text selection overall included a bias toward more

abstract, deductive processes, and I was ranking those articles that possibly presented more inductive reasoning processes as less relevant to the current project. With this possibility in mind, I re-evaluated all 53 articles identified after phase one screening, but concluded that I could still justify the exclusion of those other articles using rationales described in chapter five.

My initial analysis of Russell and Peterson's (1998) article was as follows. Determination model reasoning (Graber & Thomasma, in press) was especially apparent in a concluding comment. "[The] principles underlying decisions regarding permeability of boundaries between the personal and the professional are the same: care for the student imbedded in a clearly bounded professional system where the faculty are respectfully connected to one another" (Russell & Peterson, 1998, p. 469). Yet it should be remembered that the primary danger in determination model reasoning is mistaking the professional context as the source of moral force in decision-making, rather than viewing it as the determining factor mediating between moral principles (Graber & Thomasma). Russell and Peterson (1998) appeared to be making this error. The professional norms (i.e., professional boundaries) in place in training programs are designed to mediate the duties of instructors and supervisors to promote the welfare of students and prevent harm (i.e., principles of beneficence and nonmaleficence). Moral force comes from these principles, and boundaries are the mechanism by which these moral principles are enacted. The evaluative schema offered by Russell and Peterson (1998) is useful in assessing the degree to which one is meeting professional expectations, but they do not actually offer guidance for how to navigate situations in which the professional norms themselves may be in conflict.

Having reconfirmed the appropriateness of including this article in the study, during the reiterative hermeneutic process of shifting between individual articles and the collection of articles as whole, an alternative understanding occurred to me that focused not on the contexts determining the role expectations, but the roles themselves. Russell and Peterson (1998) summarize their "check up" as follows.

Because boundary violation is part of a process rather than a single event, and because we are all less likely to notice "red flags" when we are isolated and/or under stress, we are



recommending a regular “check up” for evaluating vulnerability to boundary infringement. The three major areas of the evaluation are: Self Care, Student Care, and Care of the Professional Group. Self Care includes an assessment of progress on life goals, losses, life cycle transitions, and the possibility of unmet, yet legitimate adult dependency needs. Questions within the Student Care section focus on the clarity of the educational contract with the student or supervisee and keeping that contract visible and up-to-date. The third section, Care of the Professional Group, directs attention to the institutional context in which supervision occurs. Questions in this section focus on the modeling of appropriate professional behavior, availability of consultation, and sensitivity to the evaluative power of supervisors (Russell & Peterson, 1998, p. 463).

Russell and Peterson’s (1998) model of assessing professional boundaries relied on a series of self-questions, not unlike the model by Hill and Mamalakis (2001), discussed below, and dependent on the “virtue” of self-insight discussed above. Seeing Russell and Peterson’s (1998) article as an example of virtue model reasoning opened up the possibility that this article had more in common with other articles than I realized at first, particularly Woody’s (1990) inclusion of personal/professional identity in her decision-making model. Furthermore, Russell and Peterson’s (1998) emphasis on self-care as a means for preventing boundary violations seems to resonate closely with Haverkamp and Daniluk’s (1993) discussion of the principle of self-interest.

In spite of mid-process apprehension about the inclusion of this article in this fusion of horizons, in the end, Russell and Peterson (1998) opened my horizon to the possibilities of looking at the role of therapist, and assumptions of what it means to a therapist as a source for mediating ethical decisions, i.e., are there ways we justify ethical behavior because that’s what good clinicians/supervisors do? Virtue theory may be a theoretical aid in thinking through this approach to justifying moral behavior, but it requires careful analysis to avoid superficial circular reasoning and collapsing the distinction between what is clinical and what is ethical.

[7] Newfield, S. A., Newfield, N. A., Sperry, J. A., and Smith, T. E. (2000). *Ethical decision making among family therapists and individual therapists*. *Family Process*, 39(2), 177-188.

In an empirical study, Newfield and colleagues (2000) conducted structured interviews with both individual therapists and family therapists using two hypothetical ethical dilemmas (one involving an individual client and the other with a family client) and one personal dilemma elicited from the research participants. The authors claimed that there is an apparent disconnect in family therapy between systemic theoretical considerations and the individual rights focus of available models of ethical decision-making, to the neglect of relational considerations. Recognizing that codes of professional ethics are a primary decision-making tool for therapists, they further suggested that codes of professional ethics are based on individual rights and Kohlberg's (1984) justice model of moral reasoning. A content analysis was conducted evaluating results of interviews for evidence of justice reasoning versus the relational-care reasoning articulated by Gilligan (1982). Results suggested that both individual and family therapists rely more on care-based reasoning than justice-based reasoning, especially in their personal dilemmas. Based on their central focus on decision-making processes, this article was ranked as strongly relevant for inclusion in this study.

In the process of fusing horizons with the horizon presented in this article, I found the authors' line of reasoning, as they sought to justify their study, confusing. Particularly confusing were their discussions of individual rights, the justice based reasoning underlying codes of ethics, and their reliance on the Kohlberg's justice reasoning compared with Gilligan's care reasoning regarding therapy cases. First, claims about individual rights were broad and made quickly with little supporting discussion: "Existing ethical models used by mental health professional organizations focus on individual rights, a perspective associated with Cartesian dualism and traditional individual psychology (Becvar & Becvar, 1996)" (Newfield, et al., 2000, paragraph 2). It is not uncommon for rights to be thought of in individual terms. A more formal and comprehensive understanding of rights, however, as discussed in chapter three, is actually very systemic in that if one person has a right, another person as a corresponding duty in response to that right. Admittedly though, there is often little thought to the implications for duties

imposed on others in the loose bantering of rights language often seen in the professional literature and this society generally.

Second, a major limitation of codes of ethics is that the rationales or reasoning processes used to justify their provisions are rarely if ever articulated, so it is difficult to tell how Newfield and colleagues reached the conclusion that “the ethical codes of professional organizations emphasize a justice ethic” (Newfield, et al., 2000, paragraph 41). The reasoning processes used to interpret the codes may be either care based or justice based. However, to the extent that codes, as formal policies, are by nature written in abstract, impartial language, explicitly or implicitly deriving moral force from abstract principles, then yes, one can see how the link to Kohlberg's justice model can be made, for it too operates at a higher level of moral abstraction, and Gilligan's model relies on less abstract reasoning that focuses on concrete specifics. This leads to the third and most troublesome aspect of this article.

Newfield and colleagues (2000) sought to determine whether the reasoning used by therapists to make decisions about dilemmas faced in clinical practice related more to Kohlberg's justice model of reasoning or Gilligan's care based model of reasoning. This premise fails to account for the fact that Kohlberg himself, in his later writing, agreed with Gilligan that his moral theory did not cover all of morality, particularly relational dilemmas (Rest, Narvaez, Bebeau, & Thoma, 1999). Thus, the finding by Newfield, et al. (2000) that therapists, regardless of individual or systemic theoretical orientation, relied primarily on care reasoning rather than justice reasoning when dealing with dilemmas in clinical cases is no surprise and is entirely predictable based on the personal nature of relationships that exist in all therapy settings.

Nevertheless, Newfield and colleagues (2000) are to be applauded for incorporating moral development literature in their study; only rarely is this literature referenced in MFT ethics discourse, including my own. Thus, this article, in spite of conceptual difficulties, greatly aided my fusion of horizons by highlighting another limitation in my current thinking. While most of my attention has been on incorporating normative theory into MFT ethics research as a means of conceptualizing how we

*should* reason about ethics, Rest and his colleagues (1999), and other moral development researchers and theorists have much to facilitate our understanding of how we *do* reason about ethics.

For instance, Rest, et al. (1999) make a helpful distinction between macromorality and micromorality that would have aided Newfield and colleagues in their study, and that holds promise for helping the MFT profession sort through its own moral challenges.

Macromorality concerns the formal structures of society that are involved in making cooperation possible at the society level (in which not just kin, friends, and long-known acquaintances are interrelated, but strangers, competitors, and diverse clans, ethnic groups, and religions are as well)....On the other hand, micromorality concerns developing relationships with particular others, and with an individual's creating consistent virtues within him- or herself throughout everyday life.... In micromoral issues, what is praiseworthy is characterized in terms of unswerving loyalty, dedication, and partisan caring to special others. On the other hand, in macromorality, the praiseworthy response is characterized in terms of impartiality and acting on principle, instead of partisanship, favoritism, or tribalism. Both macro- and micromorality concern ways of constructing and enriching the web of relationships--one through the structures of society, and the other through personal, face-to-face relationships. To be sure, there is tension between macromorality and micromorality, and there are many interconnections between the two (Rest, et al., 1999, pp. 2-3).

Though it is beyond the scope of the current project to do so now, Rest and colleague's (1999) distinction between micro- and macromorality opens possibilities for analyzing reporting issues such discussed by Schlossberger and Hecker (1993) about HIV-positive clients. At what point does a moral issue shift from micro to macro and do we think differently or should we think differently when this sort of shift occurs? It may be, too, that this distinction illumines further the social and human functions of codes of ethics, and knowing more about how we think about macromorality or micromorality may factor into our interpretations and evaluations of codes. Finally, as AAMFT, as a professional organization, is

increasingly involved with social policy formation, and our code of ethics expects members to be as well, awareness of micro and macro distinctions may be important in formulating and evaluating policy.

[8] Hill, M. R., & Mamalakis, P. M. (2001). *Family therapists and religious communities: Negotiating dual relationships*. *Family Relations*, 50(3), 199-208.

Hill and Mamalakis (2001) presented a model for making decisions about whether or not to enter into a dual relationship within religious settings. They maintained the hierarchical reasoning process presented by Kitchener (1984). Like Kitchener, Hill and Mamalakis (2001) suggested first reviewing codes of professional ethics and legal guidelines, and if they provide clear-cut direction, additional reasoning processes are unnecessary; the decision should be to abide by the regulations. In the case of dual relationships, however, these authors argued that guidance at this first level is not always clear. They noted that while there is consensus in the field about always avoiding sexual relationships with clients, views about non-sexual dual relationships are less homogenous.

They further asserted there are specific conditions within a religious context that may mediate the decision-making process (i.e., factors related to (a) the therapist, (b) the client, (c & d) within and between the therapist-client relationship(s), (e) the religious community, (f) the relationship between the therapist and the religious community, and (g) the relationship between the client and the religious community). The bulk of the article was devoted to articulating these factors, and giving an example of how they are to be considered in decision-making. Given their explicit focus on decision-making processes, this article was ranked as strongly relevant to this study.

At first it appeared that Hill and Mamalakis (2001) were altering the content of Kitchener's model such that attention to clinical theory replaced her second level emphasis on moral principlism, and reflection on contextual and relational factors substituted for her versions of deontological and teleological ethical theory. This is part of how Butler and Gardner (2001, discussed below) interpreted the article, and how I initially understood the text too. However, though difficult to discern except through extremely careful re-reading of the text, in fact, Hill and Mamalakis (2001) seemed to be operating primarily *within* Kitchener's second level of principles, by suggesting that clinical theory, and

the contextual and relational factors they discuss are to be employed in evaluating conflicting principles. Part of the confusion engendered by this article is that due to space constraints, their case study focused only on one moral principle, non-maleficence; though they acknowledged the need to attend to the other principles in Kitchener's model (i.e., autonomy, beneficence, justice and fidelity).

Part of my earlier critique of Kitchener's (1984) model was that she did not elucidate what she meant by "facts of the situation" in the intuitive level of her model; nor did Kitchener fully account for the methodology of "specification and balancing" that governed Beauchamp and Childress' (1979, 2001) theory of principlism (i.e., the process by which principles are evaluated and weighed), which she implicitly imported. Once it is clarified that Hill and Mamalakis (2001) were operating within Kitchener's adaptation of principlism, the possibility emerged of understanding their contribution to the ethical decision-making literature regarding dual relationships as clarifying the "facts of the [religious context] situation." Or in Beauchamp and Childress' terms, Hill and Mamalakis (2001) were actually adapting the process of "specification and balancing.

Graber and Thomasma (in press) classified Beauchamp and Childress' (1979, 2001) principlism approach to normative ethics as exemplifying mediation model reasoning in that "specification" entails articulating exactly how different moral principles are manifest in a particular situation and then these moral considerations are balanced one against another. Consistent with mediation reasoning, *only* moral considerations are part of the decision-making equation in Beauchamp and Childress' model. In their long, detailed litany of factors, Hill and Mamalakis (2001) included both moral and non-moral considerations, thereby appearing to variously evoke determination, origination, and virtue model (Graber & Thomasma, in press) reasoning.

For instance, their emphasis on the contextual features of religious communities as contributing to the evaluation of moral principles was a clear and accurate example of determination model reasoning. Their attention to the particular relationships between a specific therapist and a specific client and their respective interactions within the religious community was an excellent example of narrative ethics, or

origination model reasoning. Finally, their considerations of individual therapist and client factors provided traces of virtue model reasoning.

As noted above, Kitchener (1984) largely relied on deductive methods of reasoning in her model of ethical decision-making, while the methods of reasoning used by Hill and Mamalakis (2001) were much more inductive in orientation. Graber and Thomasma (in press), in their unity theory of biomedical hermeneutics repeatedly stressed the need to incorporate both deductive and inductive reasoning. It is exciting to recognize that Hill and Mamalakis (2001) effectively embedded inductive reasoning into Kitchener's deductive model as applied to the specific topic of dual relationships in religious settings; for in so doing, they modeled the type of complex reasoning about ethics that I believe will genuinely advance the profession. Unfortunately, because the relationship between their model and Kitchener's (1984) model was not made clear the significance of Hill and Mamalakis' (2001) contribution is easy to overlook.

[9] Butler, M. H., & Gardner, B. C. (2001). *Ethics and the ideal helping relationship: Response to Hill and Mamalakis*. *Family Relations*, 50(3), 209-214.

Butler and Gardner (2001) offered a commentary on the presentation by Hill and Mamalakis (2001) of their model for deciding whether or not to participate in dual relationships within a religious context. The tone of their remarks was one of alarm, which is a remarkable contrast to my own optimistic appraisal of Hill and Mamalakis' efforts. They seemed very disturbed by the lack of attention given by Hill and Mamalakis (2001) to the AAMFT code of ethics, and perhaps most bothered by the implication that the profession's ethical codes has been portrayed as offering insufficient guidance. Many of the critiques made by Butler and Gardner (e.g., the limited discussion of codes) are answered in a careful reading of Hill and Mamalakis' article (e.g., they focused their discussion in the article on contextual factors and on the principle of nonmaleficence in particular, not because first level considerations such as the code of ethics are to be minimized, but because such discussions were pervasive in the extant literature).

Butler and Gardner raise some very important concerns not mentioned by Hill and Mamalakis about the risks to therapists, clients and their respective families when dual relationships go awry. Certainly these were credible justifications for extreme caution when entering into dual relationships. I suspect Hill and Mamalakis would have supported such caution and in fact the point of their model was to explicate a reasoning process that facilitated caution and careful analysis prior to entering into a dual relationship, but stopped short of the absolute prohibition Butler and Gardner (2001) seemed to advocate as the only appropriate manifestation of caution.

Butler and Gardner (2001) began with the view that codes of ethics present definitive descriptions of ideals, rather than establishing baseline requirements for minimally acceptable ethical standards. They argued that departure from these ideals must be justified. This represents confusion between enforceable standards, which AAMFT has explicitly focused on in its code of ethics, and aspirational ethical ideals, which as previously discussed, AAMFT has not included in its code. They asserted that the code of ethics represented a definitive and conclusive consensus of the profession and there was no need for independent evaluation of its contents. Furthermore, Butler and Gardner (2001) appeared to view codes as necessary to compensate for deficiencies in the decisional capacities of most therapists, rather than as aids to therapists of ordinary conscientiousness and moderate good will (Kultgen, 1988) who are facing complex moral situations.

We must remember also that the focus of a code of ethics is resolved on those exact circumstances where a professional's independent judgment is most likely to be clouded and impaired. Ethical codes provide guidance and rules for professional conduct in high-risk circumstances....With this in mind, we should understand that any proposal introducing or increasing independent and subjective judgment in high-risk ethical situations initiates momentum exactly opposite that intended by the code of ethics....Indulging independent, subjective judgment in high-risk circumstances is like removing all signal lights and stop signs from a four-lane intersection and relying on each individual driver both to know the rules of the road and to follow them without either



inadvertent or intentional error.... Every therapist can identify a [dual relationship]; however, therapists are not always very good at assessing their own 'personal propensity and readiness to exploit clients.' Further, the person who possesses such a propensity is also the very one least likely to do anything about it. Thus the ethical code opts for a rule rather than a subjective application of principle because the former approach is operationally tenable whereas the latter is operationally dubious (Butler & Gardner, 2001, paragraphs 2, 3, 8).

These comments seem to imply a purely deductive use of ethical codes in the absence of any sort of mediating reasoning processes, suggesting that Graber and Thomasma's application model reasoning is being deployed. Given Butler and Gardener's driving analogy, are they suggesting that no reasoning processes are necessary for application of the code of ethics to concrete situations? For this to be the case, the provisions of the code of ethics must be seen as moral principles in and of themselves, and although it is not uncommon to find this sort of language in the ethics literature published by AAMFT, it represents faulty logic and a misunderstanding of ethical theory. As previously discussed, the provisions in the AAMFT code of ethics are more accurately classified as middle level axioms and rules, because their normative force must actually be derived from higher order moral principles such as beneficence, nonmaleficence, autonomy, justice, and fidelity.

Whether or not a rule applies in a concrete situation is always a matter of interpretation, though some applications have become more obvious (e.g., the prohibition of sexual relationships) than others (e.g., whether non-sexual dual relationships are inherently exploitive). Thus, few professional ethicists would agree with Butler and Gardner's assertion that independent and subjective judgment is incommensurate with the application of codes of ethics. It is precisely the recognition of the interpretive requirements of moral principles that lead them to question whether purely deductive moral reasoning is even possible.

From the perspective of application model reasoning (Graber & Thomasma, in press), Butler and Gardner (2001) are without options for the wide variety of justified moral reasoning used by professional

ethicists. Thus it makes sense that they would see alternatives as operationally dubious. Butler and Gardner (2001) seemed to suggest that moral reasoning skills and moral virtues are static rather than dynamic (a view not supported by moral development research), and in their efforts to protect clients from those who possess poor reasoning skills or insufficient virtue, all therapists must presumably accept the interpretation of the code of ethics offered by Butler and Gardner (2001) as authoritative and in need of no further analysis. One might surmise from this that these authors would see ethics training that is compliance-focused (Cohen, 2001) as sufficient and ethics education, which includes attention to reasoning skills and moral justifications, as unnecessary.

Subjective exception to [dual relationships] proscription presumes an impressive level of consistent and ongoing conscientious reflection, on-target analysis, and uncanny prescience among all members of a profession. This assumption seems unreasonable to us. Hence, the profession affirms ethical codes and encourages near universal adherence thereto, with exceptions prudently undertaken only in consultation with the ethics committee (Butler and Gardner, 2001, paragraph 9).

The assumption described in this quote that Butler and Gardner dismissed out of hand certainly is not consistent with an ethics training perspective (Cohen, 2001). Even with more comprehensive ethics education as advocated in the current paper, it is unlikely that every single member of the profession will make the right and best decision every time in every circumstance. Nevertheless, the assumption may serve as an appropriate aspiration for the profession. I would argue that the absence of such an aspiration eliminates any motivation to equip therapists to improve their reasoning skills or intentionally try to eliminate vices. Furthermore the view expressed by Butler and Gardner (2001) appears to give more power and authority to members of the ethics committee (who may or may not be familiar with the extant professional ethics literature) than may be warranted, especially from a clinical systemic perspective (which so often seeks to empower every member of the system). It is confusing that a profession that so often seeks to flatten hierarchies and has largely rejected the notion of therapist as expert, maintains such an active commitment to an authoritative stance when it comes to ethics.

At this point I must pause and explicitly acknowledge my own bias against application model reasoning, at least in the form seemingly being utilized by Butler and Gardner. Like Graber and Thomasma (in press), I believe that a pure deductive application of moral principles to concrete circumstances is not possible. The strength of my pre-understanding of professional ethics and moral philosophy coming into this project is limiting my ability to genuinely open myself up to the sort of absolutist thinking demanded by application model reasoning. Perhaps if Butler and Gardner were referring to genuine moral principles I could be more open to the stance they are taking, but their misattribution of provisions of the AAMFT code of ethics as moral principles rather than lower level axioms and rules is, I believe, a fatal flaw in their line of reasoning.

[10] Mamalakis, P. M., & Hill, M. R. (2001). *Evaluating potential dual relationships: A response to Butler and Gardner*. *Family Relations*, 50(3), 214-219.

This article was a response to Butler and Gardner's (2001) concerns, and as such was primarily a clarification and defense of their model. In support of the decision-making process they are advocated, Mamalakis and Hill (2001) offered four reasons why the AAMFT code alone is insufficient guidance regarding multiple role relationships in religious settings. First, dual relationships in the 1991 AAMFT code were not clearly defined. Second, there was not consensus in the profession as to whether all dual relationships are necessarily harmful and are, therefore, to be assiduously avoided at all costs. Third, reliance on casebook examples related to dual relationships by clergy had not been sufficient to clarify the intent of the code in this setting. Fourth, rationales beyond authoritative prescriptions or proscriptions were needed to better equip therapists when talking to clients about the limitations of dual relationships.

The elucidation of their model provided by the authors in this rejoinder article hermeneutically stimulated the analysis presented above in connection with the Hill and Mamalakis (2001) article; therefore, there is little separate analysis to report here. My first reaction to Mamalakis and Hill's rejoinder was thinking that they were back peddling in the face of the application model reasoning presented by Butler and Gardner in their critique. Certainly they missed their opportunity to clarify their linkage with Kitchener's (1984) comprehensive and readily justified model of ethical decision-making.

Yet Mamalakis and Hill (2001) may have simply fallen prey to the exclusive role the AAMFT code plays in MFT ethics discourse, and code-driven discourse is simply not equipped to wrestle with the sorts of special considerations Hill and Mamalakis presented (e.g., the use of determination, origination, and virtue model ethical reasoning). As demonstrated above, including understanding of the breadth of ethical theory and accessing applied ethical models via medical ethics provides language for making the strengths of the Hill and Mamalakis (2001) model more accessible.

[11] Burkemper, E. M. (2002). *Family Therapists' ethical decision-making processes in two duty-to-warn situations*. *Journal of Marital and Family Therapy*, 28(2), 203-211.

In this empirical study, marriage and family therapists were asked to rank order the importance of subcomponents of Kitchener's (1994) model of ethical decision-making as they related to two hypothetical dilemmas, one regarding child abuse and the other regarding unprotected sex by an HIV-positive client. Burkemper (2002) found that for both scenarios, professional ethics were prioritized over laws and self-of-therapist considerations. For the child abuse scenario, the priority was identified as follows: nonmaleficence, beneficence, justice, fidelity, and autonomy. For the HIV scenario, nonmaleficence was the highest ranked principle, followed by fidelity, justice, autonomy, and beneficence. Rationales for these rankings were not included in the study. Burkemper stressed the value in being able to break decision-making into its component parts.

Burkemper (2002) presented a straightforward study. It is difficult to evaluate, however, because insufficient detail was provided about the instrument she used or the definitions she gave key constructs. This was particularly troublesome because of some conceptual errors present in the article. For instance: "The standards of conduct that govern professional MFT are operationalized in Kitchener's (1984) model of principle ethics" (Burkemper, 2002, p. 203). This statement reflected a lack of understanding of the conceptual relations between codified professional standards and moral principles. Burkemper (2002) had the levels of abstraction reversed (i.e., standards are operationalizations of higher order moral principles).

Also, Burkemper (2002) refers to nonmaleficence, beneficence, autonomy, justice and fidelity as “meta-ethical principles,” though nowhere does Kitchener (1984) do this. This mis-representation is further perpetuated by Jankowski and Martin (2003), who use Burkemper’s version of Kitchener’s model to discuss moral principles and evaluate their study, rather than referencing Kitchener (1984) directly. In Kitchener’s model, moral principles are presented at a higher level of abstraction than the “principles” listed in codes of ethics, so in this sense, Burkemper’s adaptation of terminology is understandable. It is problematic, however, in relation to the larger professional ethics and moral philosophy literatures, particularly because there is an entire domain in the study of ethics known as meta-ethics which is very different from the principles discussed by Burkemper.

Kitchener’s source for her discussion of principles is Beauchamp and Childress (1979), who are philosophers and who explicitly refer to their principles as “middle-level” principles in order to distinguish them from the more abstract and higher order normative principles such as Kant’s deontological principle of universalizability (which Kitchener modifies, but keeps the term in her third level of critical-evaluative reasoning) and Mill’s teleological principle of utility (which Kitchener refers to as balancing), and the more concrete, lower order “principles” found in codes of ethics. Graber and Thomasma (in press), as previously mentioned, understand “principles” found in most codes of ethics as more properly classified as axioms and rules. The casual usage of the term “principle” hides the various levels of abstraction that are at play in moral reasoning, and may perpetuate difficulty in translating the larger philosophical ethics literature into a form usable by MFTs.

The significance of the terminology issue is the lack of theoretical context that seems to be rampant in the MFT ethics literature. There is little evidence in Burkemper’s (2002) article that Kitchener’s work is understood as a doorway to larger theoretical frameworks and additional sophisticated thinking about moral and ethical issues in psychotherapy. Instead, Kitchener’s (1984) model largely seems to be taken as a destination, a decontextualized end in itself. This view of Kitchener was consistent across the articles in this study that presented all or part of her model. Thus, while

Burkemper's apparent enthusiasm for the component structure of Kitchener's model is well placed, systemic considerations for theoretical context should not get lost.

[12] Jankowski, P. J., & Martin, M. J. (2003). *Reporting cases of child maltreatment: Decision-making processes of family therapists in Illinois*. *Contemporary Family Therapy*, 25(3), 311-332.

Jankowski and Martin (2003) report on their mixed methods empirical study on decision-making processes and outcomes concerning child maltreatment. They presented a sample of marriage and family therapists with ten hypothetical scenarios (three each regarding neglect, physical abuse, and sexual abuse, and one regarding emotional abuse), and asked them to rate on a four-point scale how likely they were to report concerns to a child protective services for each scenario. Participants were then asked to provide a written narrative of their decision-making process, which was analyzed using a grounded theory methodology that incorporated a hermeneutic approach (i.e., "a process of self-reflexivity in which new understandings were consistently juxtaposed with pre-existing ideas," p. 317). Participants were also asked to indicate a time they decided not to report and describe their rationales. Finally, a variety of demographic data were collected and an assessment of philosophical worldviews (i.e., contextual vs. mechanistic) was included. Due to the explicit attention given to decision-making processes, this article was ranked as "strongly relevant" to the current study.

Granted, the article by Jankowski and Martin (2003) is one of the most recent in this study; still it provided some of the most comprehensive and sophisticated thinking about ethical decision-making of any of the articles examined. These authors noted the lack of attention to ethical decision-making processes, and rightfully, I think, grounded this situation in the dearth of literature related to MFT clinical processes generally, and especially clinical decision-making processes. Further, they observed that most of the empirical literature on ethical decision-making does not include family therapists. Jankowski and Martin (2003) hypothesized that this may be due to paradigmatic differences between systemic thinking and the extant literature that considers decision-making a linear, sequential process, and neglects the role of context and interactional factors. This view is consistent with much that I have already discussed during this fusion of horizons.

Jankowski and Martin (2003) reported that the results of their qualitative analysis of narratives revealed three decision-making themes associated with reporting. First, the “developmental level” theme noted that the younger the child, the more likely a report was made. Second, the “categorical” theme focused on whether the facts of the situation fit definitions and the requirements of being a mandated reporter. Third, the “cautious” theme emphasized the possibility that abuse had, was, or could happen. There were also three themes associated with the decision not to report. First, the “conditional” theme included the need for a future requirement to be met prior to reporting taking place. Second, the “situational” theme required other criteria to be in place, and third, the “intervening” theme viewed some sort of clinical intervention as being more helpful than reporting. Jankowski and Martin (2003) evaluated their results in light of Kitchener’s (1984) model, as presented by Burkemper (2002), justice and care based reasoning as discussed by Newfield, et al. (2000), and the feminist decision-making model of Hill, Glaser, and Harden (1995). Additionally, they reflected on their findings in terms of contextual or mechanistic worldviews. Jankowski and Martin (2003) suggested that decisions to report theoretically might be associated with use of Kitchener’s (1984) first critical-evaluative level (i.e., codes and laws), justice reasoning (as described by Newfield, et al.), and a mechanistic worldview, while themes associated with decisions not to report seemed to imply the use of Kitchener’s (1984) second critical-evaluative level (i.e., moral principles), Newfield and colleagues’ (2000) discussion of care based reasoning, and a contextual worldview.

It is interesting to use the perspective of Graber and Thomasma’s (in press) models of ethical reasoning to speculatively consider the themes that emerged from Jankowski and Martin’s (2003) study, and the theoretical linkages they made. By design, reporting laws focus on the moral principle of non-maleficence and the prevention of harm to children. The “developmental level” theme focuses on the child’s degree of vulnerability to neglect due to age and seems to entail mediation model reasoning in which a normative priority rule is used (i.e., the younger or more vulnerable a child is, the more important it is to report). The “categorical” theme implies the use of Graber and Thomasma’s (in press) definitional mediating consideration whereby the decision is based on whether certain definitions are met: “The

incident is ‘reportable as defined by the mandated reporters act’ (Jankowski & Martin, 2003, p. 321). The third theme associated with the decision to report suspected child abuse, the “cautious” theme, could be related to validation model reasoning in that a policy exists about what to do if abuse is suspected: “If there is any suspicion of abuse I would make a report so an investigation can be made” (Jankowski & Martin, 2003, p. 321). Each of these methods of reasoning is largely deductive, which seems to be consistent with Jankowski and Martin’s linkage of “to report” themes with a mechanistic world view (i.e., what to do can mechanistically be deduced).

Relating the “not to report” themes to Graber and Thomasma’s (in press) models of ethical reasoning is a bit more challenging, but still worth considering. The “conditional” theme, in which a future condition needs to be met before a report is made, seems to be a loose example of the third type of mediation model reasoning whereby “exemptions” mediate the decision. The excerpt used by Jankowski and Martin (2003) to represent the “situational” theme—“It would depend upon the explanation given for how the child received the bruise and/or if other marks were visible” (p. 322)—implies the use of origination/casistry reasoning. In other words, is the explanation similar to those most likely to raise suspicion of abuse?

Likewise, the excerpt illustrating the “intervening” theme suggests determination model reasoning: “Instead I’d work on ways of dealing with her acute stress, identify support services and possible home visits for mother” (Jankowski & Martin, 2003, p. 322). In this example, the clinical context, established by the types of services in place or available, helps determine whether or not to report. Jankowski and Martin associate “not to report” themes with the contextual worldview, and indeed, except for the first “not to report” theme, the models of reasoning that seem to be used in deciding not to report are largely inductive. Such a tentative split between decision-outcomes based on deductive or inductive reasoning is, I would strongly assert, reason to emphasize combining reasoning processes as a means of providing checks and balances in the evaluative process.

[13] Brown, R., & Strozier, M. (2004). *Resisting abuse at what cost? The impact of mandated reporting laws on the process and content of therapy*. *Contemporary Family Therapy*, 26(1), 45-60.



This article by Brown & Strozier (2004) is the last one included in the current study. The authors presented both a theoretical analysis of the role mandated reporting of child abuse has in decision-making and the results of an empirical study that examined differences in family therapists' clinical choices when reporting is or is not an issue in treatment. Given this explicit focus on decision making, this article was ranked as strongly relevant for inclusion in this study.

Brown and Strozier (2004) noted the ethical rationale for mandated reporting as: "lawmakers have placed a higher value on the protection of children than they have the protection of therapeutic confidentiality ...although the latter remains a professional and ethical responsibility of therapists" (Brown & Strozier, 2004, p. 48). In their empirical study, family therapists were presented with a vignette related to the disclosure by a client of past abuse. They were first asked to identify from a list of nine possible treatment concerns the issue they thought was the most critical to address in therapy. Next, they were asked to choose again, but this time from the same randomized listing of possible issues to which mandated reporting had been listed as a tenth option. Results indicated without the mandated reporting option a variety of clinical concerns were rated as most critical (presumably based on differing clinical theoretical conceptualizations of the case), but that when reporting was listed as a consideration, most therapists changed their responses to prioritize reporting. Interestingly, even given the option, not everyone chose reporting as most critical and there was a significant difference in that therapists with less experience were more likely to report than those with greater experience (i.e., over ten years). This appears consistent with Jankowski and Martin's (2003) finding that legal requirements are not always given the highest ethical weighting.

Perhaps the big shift from clinical considerations to regulatory considerations observed by Brown and Strozier (2004) represents a shift in the reasoning tool used by therapists to weigh the competing interests in this case. The options from which participants had to choose in determining their top clinical priorities represented priorities espoused by various theoretical approaches to therapy (e.g., power as a key focus in feminist approaches, and unconscious impulses as a key focus of psychoanalytic approaches). It may be that the individual clinician's theoretical orientation provided the mediating

mechanism to weigh options. However, theoretical orientation is not usually seen as having sufficient normative force to outweigh the mediating mechanisms provided by socially sanctioned laws. Thus, once different mediating mechanisms were presented as options, the one seen as having the most normative force was selected.

Using constructs provided by Graber and Thomasma (in press), it would be interesting to think of clinical theories as articulating policies for how to reason about clinical issues. Doing so would put us in the camp of validation model reasoning with its accompanying strengths and weaknesses. Law then, can be seen as a higher order policy than clinical theory, thereby creating more normative force. Law can also be considered from a mediation model standpoint as offering a normative priority rule such that society has decided that in the event of suspected child abuse, the principles of beneficence and nonmaleficence (i.e., protecting the child from harm by reporting) are to be privileged over the principle of autonomy (i.e., maintaining client confidentiality).

Brown and Strozier (2004) also presented an interesting use of Bowenian theory to discuss the moral conflict between protecting children (i.e., nonmaleficence), and confidentiality (i.e., respecting autonomy). They considered the role that anxiety plays in decision-making and the need to reduce anxiety through triangulation. In other words, when therapists become triangulated between a client and the legal system, they must find ways to manage their anxiety, maintain therapeutic relationships, and attend to both the legal and ethical requirements of the situation.

Bowen stated that, in periods of calm, the triangle works as a “comfortably close twosome and a less comfortable outsider” (1978, p. 199). At times of stress, there is movement within and outside the triangle, as each individual works to find a comfortable state of equilibrium. When tensions are high (as when issues of abuse arise), the family system triangulates in people from outside; “successful externalization of the tension occurs when outside workers are in conflict about the family while the family is calmer” (Bowen, 1978, p. 199). . . . Furthermore, a systemic view of mandated reporting leads to the hypothesis that the involvement of the legal system in treatment serves to relieve the

anxiety of managing actual or suspected abuse by triangulating with an outsider. If mandated reporting did not exist therapists would be forced to involve some other mechanism or agency to relieve our anxiety (Brown & Strozier, 2004, p. 51).

The use of Bowenian theory to conceptualize ethical decision-making was a brand new thought for me and helped to expand my horizon by further emphasizing the role of affect, particularly anxiety or stress, in ethical decision-making. This opened the possibility that perhaps part of the regulatory focus in MFT ethics discourse has to do with the function that concrete rules and procedures have in reducing the inherent anxiety of decision-making when faced with morally ambiguous situations, and that merely introducing new cognitive approaches to understanding ethics will be insufficient.

The concept of triangulation also stimulated a new understanding of the role of supervision and consultation in ethical decision-making. Throughout the MFT ethics literature consulting with others is emphasized, and in the current set of articles, by Hill and Mamalakis (2001) in particular. I have always understood the role of supervision as improving ethical decision-making; though in light of recent research, this assumption is questionable. However, this may not exactly be the case.

In an empirical study using written scenarios involving ethical dilemmas (Bowers & Pipes, 2000), doctoral students in professional psychology were asked to either make decisions about what they would do after seeking consultation or without any consultation. Results suggested there is only limited evidence that consultation makes a difference in the decision-making process, raising questions about long cherished assumptions regarding the role of ethics consultations. The authors note, however, that written scenarios are much less salient than real life dilemmas (Bowers & Pipes, 2000). The saliency of real life dilemmas may have to do with increased anxiety and it may be reasonable to think that the usefulness of consultation is as much or possibly more affective than cognitive. Recall that research on decision-making under stress indicates that the more cognitive stress we experience, the fewer variables we are able to evaluate and manage in the formation of our decision (Janis, 1993). Thus, triangulating in a supervisor may mitigate anxiety, and thereby increase our capacity for thorough ethical analysis.

While triangulation is Bowen's understanding of how we manage anxiety externally, his theory suggests that differentiation is the internal management of anxiety (Kerr & Bowen, 1988). According to Bowen, chronic anxiety may result when we are undifferentiated and maintain heightened "fight or flight" responses in the face of stressful situations. Bowen considered the process of differentiation of self to be improving one's ability to contain these instinctual responses (which lead to externalized anxiety management in the form of triangulation), and this is contingent on developing higher order ways of thinking that can counterbalance them. It is essential to have enough conviction about an alternative way of thinking and being that one's instinctual "fight or flight" responses to anxiety do not automatically dictate one's actions (Kerr & Bowen, 1988). From this perspective, the need for sophisticated ways of thinking about ethics is reinforced, not in neglect of affective considerations, but precisely because of them.

As therapists, are we differentiated enough to live with the inherent tensions of an ethical dilemma long enough to fully reflect on its complexities and ambiguities, or do we seek the prompt response, the simplified formula, the rule not because it automatically leads us to the best, most morally praise-worthy solution (though it certainly may, and well-constructed codes ideally facilitate this), but because relying on a rule decreases our anxiety? Undoubtedly there are situations in which prompt responses are absolutely necessary, but given the fact that the presence of anxiety usually fosters an increased sense of urgency, it may well be that we could find more time to reflect than we think we can, if only we were motivated to do so. The word "motivation" conjures thoughts of virtue theory, with its attention to habituated patterns of character. Recall that in his research on moral development, Rest (1994) talks about the ability to deal with moral ambiguity and its concomitant anxiety as a critical part of moral character. Might differentiation of self be another profession-specific virtue (along with self insight/self awareness, which is a prerequisite of differentiation) and the lack of differentiation, with its reliance on impulsive "fight or flight" responses, be a vice when it comes to ethical decision-making? From the perspective of this fusion of horizons, I am convinced these are questions worthy of additional time and attention by our field.

## Summary

A primary goal in ontological hermeneutical analysis is the elucidation of multiple possible venues for increased understanding. Thus, the aim in articulating such a comprehensive chronicle of my attempt to fuse the horizons created by the moral philosophy, medial ethics, and MFT ethics literatures was to facilitate for others as many ports of entry into the topic of MFT ethical decision-making as I could. The down-side in this process is that the sheer volume of ideas generated can be overwhelming, thereby diminishing understanding rather than increasing it; thus some summary statements are in order. In providing such a summary, I do not claim to be objectively listing the most important, or even the most accurate, way of understanding MFT ethical decision-making; rather I list what stands out to me as this fusion of horizons becomes my new “pre-understanding” in preparation for my next hermeneutic venture. This is not to say that the relevance of this project extends no further than changes in my thinking. Rather I am acknowledging that based on the pre-understandings others bring to their reading of this text, they may see additional or different issues as being most significant. All of the next chapter is devoted to implications of this project for therapists, educators, researchers, and the profession at large. Having been as transparent as possible about my process, what would I choose to focus on as the most prominent features in my newly landscaped horizon?

### *Mountain Peaks*

*Role of Graber and Thomasma’s models of ethical reasoning.* Without a doubt, the work of Graber and Thomasma (in press) is the tallest peak, offering the broadest vista in my new horizon. I believe their models of the various ways of relating ethical theory to practice offer a conceptual framework for understanding decision-making *processes* that has simply been lacking in the psychotherapy literature. Gadamer talks about language being a constituting or limiting factor in our understanding; quite simply, it is hard to understand something without words to do so. The language of professional codes of ethics allows us to accomplish some aims, but prevents us from pursuing other goals in the quest for understanding of MFT ethical decision-making. Talking in terms of application, mediation, validation, determination, origination, and virtue models of reasoning gives us the language

with which to examine how we currently reason about ethical decisions in family therapy, as well as reflect on how we ought to reason about the moral dilemmas we face.

As a result of fusing Graber and Thomasma's (in press) work with the MFT literature, I find myself now thinking more clearly in terms of "mechanisms." What mechanisms do we utilize to first identify the morally relevant features of a situation, and then what are the mechanisms by which we evaluate and prioritize our options? I think written documents such as disclosure statements and informed consent forms, and maintaining interpersonal boundaries can be more clearly understood as mechanisms that facilitate our being ethical, they are not in and of themselves sources of moral force. Understanding this primes us to look creatively for additional mechanisms or tools to assist our being ethical, or to be willing to use the tools we have more flexibly. Likewise, personal, professional, and social policies are mechanisms for helping us decide how to be ethical. Clinical theories and empirical findings can also serve as mechanisms for ethical decision-making, but they too are not sources of moral force. Thinking in terms of mechanisms helps me avoid confusing descriptions of what is ethical with procedures for how to decide what is ethical.

Another benefit to merging Graber and Thomasma's view of clinical ethics with the MFT ethics literature is the example they set for a multi-modal approach to ethical decision-making that they provide in their original model of biomedical hermeneutics. No doubt, one strength of the field of marriage and family therapy is its contextual emphasis. Long ago Wendorf and Wendorf (1985) called for a systemic view of family therapy ethics. While many have contributed to identifying systemic factors affecting ethical decisions, none have articulated truly systemic procedures for ethical decision-making in family therapy. By conceptualizing ways to incorporate both deductive and inductive moral considerations, Graber and Thomasma (in press) provide us with building blocks to develop our own systemic processes tailored to the unique needs of marital and family therapy.

*Role of Kitchener's seminal work.* The second highest peak in my new horizon is formed by the work of Karen Kitchener. I suspect for most therapists (either explicitly or implicitly through other authors), her model has provided the broadest panorama available for reflecting on the process of ethical

decision making. This is rightfully so, for her model is well organized, practical and comprehensive, though there remains areas where supplementation is needed. For instance, though not family therapists, feminists Hill, Glaser, and Harden (1995) advocated the addition of a feeling-intuitive component to Kitchener's (1984) cognitive model. Newfield and colleagues (2000) similarly suggested the need to also add considerations of relational care concerns to the model, while Hill and Mamalakis (2001) can be understood as contributing inductive guidance to Kitchener's vague reference to the process of identifying the "facts of the situation."

Jane Woody (1990) offers the only completely original model of ethical decision making within the MFT literature, but her work is not referenced at all by any other writers in this sample. Woody's reliance on Hare's confusing portrayal of ethical theory may contribute to the lack of others building on her model, with Kitchener's presentation being much more accessible conceptually (though there is evidence—e.g., Burkemper, 2002—to suggest that most maintain only a superficial understanding of theoretical depth Kitchener is presenting). It is truly unfortunate that more attention is not given to Woody's model because it offers a systemic and ecological focus that is absent in Kitchener's work (i.e., attending to institutional and societal considerations).

Finally, Jankowski and Martin's (2003) discussion of ethics within MFT, in my opinion offers some of the most promise in that it gives rise, if only implicitly, to the need to consider both deductive and inductive modes of ethical reasoning, whereas Kitchener's model is very deductive in nature. Of course, in contrast to Kitchener's (1984) general normative model, Jankowski and Martin (2003) presented a research study that described how therapists are currently reasoning about hypothetical dilemmas in one specific area of clinical practice. Whether or not descriptions of how we do reason should become models for how we ought to reason is another question, for certainly there are those who would object to the rationales given by those who would choose to not report child maltreatment.

*Role of professional and legal regulations.* This gives rise to the third peak in my newly landscaped horizon: the role of professional and legal regulations in MFT ethical decision-making. This aspect of my horizon was not so much altered as confirmed. I found in the texts of these articles on MFT

ethical decision-making echoes of my own call in chapter one to expand our focus on ethics compliance to ethics empowerment (Cohen, 2001). Zygmund and Boorhem (1989) and Woody (1990) both discuss the debate in the field at that time over the ethical issues involved in prioritizing the family system's needs over the needs of the individual client. I believe the distinction Kultgen (1988) makes between the social functions and human functions of professional codes, and the micro- versus macro-morality distinction made by Rest and colleagues (1999) are useful means of clarifying isomorphic tensions that may arise in attending to the moral priorities of the profession versus the individual practitioner. While there is professional utility in developing a code of ethics that is readily incorporated into law, articles by Haverkamp and Daniluk (1993) and Schlossberger and Hecker (1996) emphasized the importance of understanding both the distinctive functions and close relations between law and ethics. Thinking about law and ethics variously using Graber and Thomasma's (in press) presentation of application, mediation, and validation model reasoning further illuminate that laws and moral principles can be interpreted differently, but justifiably, with different conclusions. I believe the AAMFT code of ethics can be strengthened by careful attention to moral theory as well as legal pragmatism.

### *Foothills*

*Self-of-therapist issues as moral imperative.* Finally, there are several foothills lining the moral horizon that are worth mentioning. Woody (1990) included personal/professional identity as one of the five ethical decision bases in her model. Haverkamp and Daniluk (1993) added the principle of self-interest to Kitchener's five moral principles, which encouraged me to think about self-care not just as a pragmatic necessity to avoid burnout but as a possible moral imperative. Russell and Peterson (1998) relied on Kitchener's understanding of role theory to evaluate our moral professional character, while Brown and Strozier's (2004) discussion of the Bowenian concept of triangulation prompted me to reflect on differentiation as a possible virtue. Thus, though discussed in different ways issues related to the person of the therapist seem to warrant increased reflection from the moral point of view.

*Profession-specific virtues.* There has been increased attention given to virtue ethics as a supplement to a strict principles approach (Doherty, 1995, Jordan & Meara, 1990; Meara, Schmidt, &



Day, 1996). These authors tend to apply lists of virtues generally associated with good moral character to professionals (e.g., trustworthiness, compassion, courage, and so forth). This seems to be a very fruitful deductive application of ethical theory to the therapy profession. New to me, however, as a result of this hermeneutic analysis, was the possibility of inductively identifying profession specific virtues. One need not be particularly self-aware or insightful to be a good person, but these characteristics seemed to be compellingly associated with being a good therapist. Is self-awareness a skill or a trait? Can it be taught or must it be nurtured? Likewise, is differentiation a virtue? Bowen suggests that we can only help others differentiate to the extent that we are differentiated ourselves. What role does differentiation play in ethical decision-making? Do folks who are less differentiated make worse ethical decisions? I do not have answers to these questions, but I find asking them intriguing.

*Accounting for stress and anxiety.* Closely related to differentiation is the other foothill that stands out on my new horizon, namely the role of anxiety and stress in ethical decision-making. Janis (1993), Russell and Peterson (1998), and Brown and Strozier (2004) note that stress negatively affects our ability to reason well about complex and ambiguous matters, particularly moral dilemmas, while Lageman (1993) and Rest (1994) both emphasize the importance of therapists building tolerance for moral ambiguity. Thus, it seems no model of moral ethical decision-making can truly be effective in practice if it does not account for the role of stress and anxiety that inevitably accompanies ethical evaluation and decision-making.

### *Valleys*

*Multiculturalism.* Lastly, having mentioned what stands out on my new horizon, the tall peaks and the smaller foothills, it is important to mention the gaps that also make up my view of MFT ethical decision-making. For all the attention directed at increasing our multicultural sensitivity as a profession, I was surprised that cultural considerations were not included more in discussions about ethical decision-making. Woody (1990) briefly addressed societal values in her socio-legal decision base, but did not fully account for the impact living in a pluralistic society may have on decision-making. It may be that we tend to think about multiculturalism in clinical terms, not ethical terms. Or it may be that culture is discussed

more in the MFT ethics literature that I have classified as the “what is ethical” literature. In other words, perhaps we are recognizing that culture is a factor in our understanding of ethics, but we have not yet focused on how it may affect our reasoning processes about ethics.

Certainly, culture is a critical issue in the meta-ethics domain in moral philosophy. Are moral issues created or discovered (Rae, 1994), and if they are created, by whom? Is it the nature of moral principles that they have universal application (e.g., is justice a universal principle or does it apply only locally), or are there criteria that limit the scope of moral principles? Even if, as Beauchamp and Childress (2001) assert, the principles of beneficence, nonmaleficence, justice, and respect for autonomy arise out of a “common morality” (a claim with which not all scholars agree), different cultures or subcultures often will privilege different moral principles. For instance, in Western cultures, we tend to privilege individualism and the concomitant moral principle of autonomy and individual notions of justice (i.e., rights). Other more communitarian cultures may privilege fidelity and beneficence as it applies to the group, not the individual. Thus, in a comprehensive understanding of ethical decision-making, we must make room for reflection of cultural meta-discourses and meta-ethics.

*Religion.* Another gap in the horizon, closely related to the cultural issue, is the need to attend more closely to religious understandings of ethics. It is uniquely western that ethics is seen so separately from religion; a sundering that has its roots in the Enlightenment quest to make ethics a science. Singer (1993) reviews non-western moral traditions, and almost all of them have deep ties to religious systems (e.g., Buddhism, Confucianism, and Hinduism). I noted that a limitation of my review of ethical theory was the absence of the natural law and non-western moral traditions. This is a limitation not only of my pre-understanding, but one that the current MFT literature also does not address. As therapists, we are increasingly creating a place for spirituality in our understanding of therapy; likewise, we need to include it in our understanding of ethics.

*Conceptual and theoretical errors.* The final gap in this fusion of horizons is one that I am both deeply troubled by and optimistic about. I think McIntyre (1981) is right: we do not know how to have moral discourse. There was repeated evidence in the articles reviewed that conceptual and theoretical

errors unwittingly plague our understanding of ethical decision-making. The use of only one or two sources to capture the whole of ethical theory is unrealistic. Reliance on secondary sources perpetuated misconceptions. We must break out of the psychotherapy literatures if ever we are going to develop more sophisticated understanding of ethics. I remain convinced that much is to be gained by incorporating ethical theory as a way to organize our thinking, but we must learn the language of ethical theory ourselves, from the “natives,” (i.e., professional ethicists) and not be dependent on a single translator or translation, including the review included with this project.

### Conclusion

The process of fusing horizons between the moral philosophy, medical ethics, and MFT ethical decision-making literatures has been a fascinating, and truly enriching process for me. My understanding of MFT ethics is not what it was and not what it yet can be. According to Gadamer, the fusion of horizons that yield more possibilities for making influential factors manifest are preferable to the fusion of horizons that limit such possibilities. This is the criterion of perpetuating openness, and I hope in this study, as many or more possibilities have been opened for others to understand MFT ethical decision-making in new ways as they have been for me. Gadamer’s second criterion for evaluating the fusion of horizons is the rehabilitation of Aristotle’s concept of *praxis*, or practical wisdom. The understanding of what ‘*is*’ that includes reflection on what ‘*ought to be*’ is considered more worth knowing than the understanding of either ‘*is*’ or ‘*ought*’ alone can produce. It is to this criterion that I turn my attention in the final chapter, as I explore implications of this fusion of horizons for therapists, supervisors, educators, researchers, and the profession of marriage and family therapy.

## CHAPTER SEVEN: PRAXIS IMPLICATIONS AND RECOMMENDATIONS

*[F]amily-therapy ethicists might profitably place systems theory in dialogue with ethical traditions in philosophy that attempt to deal with individual and relationship dimensions of human life....In the next decade, we should continue to hold our 'in-house' debates about ethics...but there should be new elements in the professional dialogue.... [One] new focus to be explored is the growing literature on applied professional ethics, particularly work in the field of bio medical ethics....These ethicists offer a rich grounding on which family therapists can develop more sophisticated approaches to ethics and values in the next decade....This dialogue cannot be limited to professional concerns alone, because the issues we face as family therapists go to the heart of the human condition. For this reason, we must not only talk with one another, but also learn to engage with ethical traditions from philosophy and religion, to access the deep veins of human wisdom found in art and literature, and to participate actively in the broader social debate about human welfare and family life in our times (Doherty & Boss, 1991, p. 634).*

Over a decade ago, the call went out from Doherty and Boss (1991) to stretch our horizons and engage other traditions in order to augment our understanding of the ethical issues that are core to our profession as well as those that “go to the heart of the human condition” (p. 634). One of these traditions, moral philosophy, has its roots in ancient times, when theory and practice were not seen as distinct, but understanding was inseparably tied to practice, practice was inseparably tied to reflection, and texts were examined for the primary purpose of gleaning practical wisdom; such was Aristotle’s understanding of praxis.

Thirteen articles, culled from five MFT journals across 20 years, were examined in this project using an ontological hermeneutic perspective in order to explore the ways in which an understanding of ethical theory and medical ethics might shape and be shaped by an understanding of ethical decision-making in marriage and family therapy. Many theoretical possibilities have been explored, the opportunity for expanded understanding presented, and numerous implications of this study have been discussed in previous chapters.

The purpose of this final chapter is to summarize 12 ways in which this journey has led to praxis, i.e., understanding that leads to practical wisdom, and recommendations for implementing some of the

ideas generated by this project. Specifically, what difference does thinking in new ways about ethical decision-making make in the practice of family therapy to therapists, educators, clinical supervisors, researchers, scholars, and the professional organization?

### Implications for Marriage and Family Therapists

*1. Fusing horizons among MFT, moral philosophy, and medical ethics provides new language for practitioners to identify and discuss the moral issues imbedded in therapy, including the ethical dilemmas faced by the client as well as the therapist.*

Lageman (1993) noted, “Practitioners sometimes miss significant moral issues because they define the issues in clinical terms and concepts. Implied and even hidden moral issues need to be brought to the surface” (p. iii). A major practical benefit of this project to clinicians, therefore, is that it serves to translate the often complex and jargon-laden language of moral philosophy into practical terms that can illuminate “hidden moral issues” (Lageman, 1993, p. iii) in clinical practice. With any language, fluency comes with exposure and practice. Kidder (1996) suggested we make two sorts of demands on moral language.

[Language] itself is poised between two opposite demands: the need for precision, and the desire for expansiveness.... We want words that don’t so much *define*—which means to limit or to set boundaries around—as *narrate*, words rich with the storyteller’s art, capturing the infinite nuances and fine-tunings of individual lives. ...What we need, then, are two sorts of language. The language we use to narrate our ethical dilemmas—the way we tell ourselves and others what’s going on in the world—is not necessarily the language we use to analyze and resolve those dilemmas. The former tends to be flexible, subjective, artistic. The latter tends to be firm, objective, even scientific. ...Ethics is at bottom, a verbal activity. And words are not always as clear as we would like....The more we work with these principles [i.e., ethical theory], the more they help us understand the world around us and come to terms with it. The metaphor is apt: We

*come to terms* by finding the terminology, the discourse, that helps give meaning to our lives” (Kidder, 1996, pp. 174-175).

I would argue that the two sorts of language Kidder referred to are represented in the inductive and deductive models of moral reasoning described by Graber and Thomasma. They can also be seen, for example, in Woody’s (1990) five decision bases and Kitchener’s (1984) intuitive and critical-evaluative levels of reasoning.

*2. This new language of ethical theory may also facilitate moral dialog between those who hold differing views.*

Nash (1996) devised a list of “ethical aphorisms” that he found facilitates moral conversation; some of these are as follows:

Do not force premature closure on the moral conversation. Genuine philosophical discourse rarely speaks in clear unambiguous messages. Beware of the tyranny of quick-fix moral directives and impatient “final” calls to action.... Find the truth in what you oppose. Find the error in what you espouse. Then and only then declare the truth in what you espouse, and the error in what you oppose.... Find and express your own voice, but also find the right time to lower your own voice so that others might find theirs. But speak we must! Language is the primary tool we have to make meaning together. ...There can be no conversation—moral or otherwise—unless people are willing to express their ideas... If you don’t stand for something, you’ll fall for anything. But know how to stand up for what you believe without standing over, or on, others (Nash, 1996, pp. 25-26).

I find in these “ethical aphorisms” echoes of Gadamer’s ontological hermeneutics (e.g., the emphasis on language as constitutive of meaning). Furthermore, as noted, each of us has moral presuppositions that contribute to debates in our field. It is unlikely that therapists will not at some point encounter a client, a colleague, or a supervisor with whom they have moral disagreement. Cicero has suggested that we have

no right to our own views until we can accurately and respectfully represent the views of those with whom we disagree.

According to Gadamer, language both facilitates and constrains our understanding, but a byproduct of fusing horizons is achieving a more sophisticated vocabulary (Richardson, Fowers, & Guignon, 1999). Thus, a benefit to therapists learning the language of ethical theory is that doing so equips them to articulate and evaluate the strengths and weaknesses of their own moral biases and those with whom they disagree. Given the diversity within the field of marriage and family therapy, and the pluralism in our society, it is imperative that we learn how to constructively engage in moral discourse.

*3. The process of fusion of horizons can serve as a model for addressing values differences between therapy stakeholders, thereby providing more guidance than the vague injunction to “not impose one’s values.”*

As a field we have made the shift away from viewing therapists as neutral experts, to one that acknowledges values as always being present in the therapy process. From an ontological hermeneutic perspective, we learn to take seriously the possible validity of another point of view and we open ourselves up to having our own viewpoint altered (i.e., the process of openness: what does the new say to the old?). At the same time, we apply our own perspective to see what difference it makes to the other perspective (i.e., the process of application: what does the old say to the new). In this way, our values, our thoughts, our emotions, our professional training, all of the components of our “prejudices” (to recall Gadamer’s provocative term), become the enabling conditions of therapy rather than something to be assiduously guarded against.

I would argue that clients come to therapy precisely because they recognize—or someone else recognizes, in the case of mandated treatment—that their current understanding of life is limited (i.e., the finitude of their current horizon), and is no longer generating the practical wisdom (i.e., praxis) needed for satisfying (appropriate, healthy, or good) relationships with others or even themselves. A goal of therapy is that when a client is safe enough to be open and share his or her (or their, in the case of a family) understanding of life, and merge it with the therapist’s understanding (i.e., the perspective generated

through one's values, training and knowledge of clinical theories and techniques), a new understanding emerges that facilitates practical wisdom in living (i.e., the fusion of horizons). It is important to note, that I conceive of this fusion of therapeutic horizons as not limited to cognitive understanding only. To the extent that affective and experiential factors are included in the processes of openness and application, they too may be included in the new understanding that emerges.

Seeing the therapy process itself as the fusion of horizons and the process of ethical decision-making as a fusion of horizons, generates a perspective from which therapists may be better equipped to deal with the moral issues presented by clients. For example, I believe being equipped to deal with our own ethical choices and the ethical choices faced by our clients is especially critical not only for family therapy generally, but also for the emergent specialization of medical family therapy. Given our aging population, rapidly advancing medical technology, shorter hospital stays, and increases in the need to manage chronic illnesses longer, families will be faced with ever more complex moral choices for which they will need support. I believe therapists who have sophisticated ethical reasoning skills in addition to their clinical expertise in family systems are in an ideal position to meet what I predict will be a growing need.

*4. The process-focused language of ethical theory and particularly that of Graber and Thomasma (in press) can help clinicians understand better the mechanisms available to evaluate and prioritize the many ethical considerations identified in the MFT literature and to justify their choices .*

In addition to relying on the concrete guidance of ethical codes, becoming well-versed in the expansive moral languages reviewed in this project equips therapists with rigorous means to reason about ethical dilemmas in order to make the best possible ethical decision, and language to justify the choices they make. Therapists who can articulate the reasoning process they used in formulating action in the midst of an ethical dilemma are in better positions to not only make the best choice, but to defend that choice if faced with being charged with an ethics violation or a law suit.

Reamer (1990) argues that just as we refer to a larger fund of knowledge and practice principles when developing a treatment plan, for instance for a depressed child, rather than solely relying on clinical



intuition, we should be no less satisfied with an intuitionist approach to ethical dilemmas, those we face as professionals, and those faced by our clients. This project introduces systems oriented clinicians to the larger body of knowledge and practice principles available to guide them in treatment planning for morally laden presenting problems and presents them with a systemic, rather than linear understanding of ethics.

#### Implications for MFT Education

*5. This project provides substantive content necessary for shifting MFT from ethics training (i.e., compliance focus) to ethics education (i.e., empowerment focus) by providing tools for ethics education and justification of decisions.*

Scant attention has been directed in the MFT ethics literature toward the reasoning *processes* that make observing professional ethics possible. Denton and Walsh (2001) made the case that the use of scientific evidence when making clinical treatment decisions is an ethical imperative and a matter of competence, the avoidance of which is a violation of our code's mandate to practice competently. I argue that this same reasoning applies to ethics. If it is an ethical imperative that we be competent in clinical methods that hold up to rigorous evaluation, then shouldn't we also be competent in methods of ethical reasoning that hold up to rigorous evaluation? If therapy is fundamentally a moral and ethical endeavor as some have suggested, I assert that we are mandated by our code's emphasis on competent practice to move beyond the limits of the code itself and make this shift toward increasing our competence in moral reasoning processes. Doing so requires a major paradigm shift from AAMFT's ostensible reliance on ethics training, with its primary focus on compliance to a minimum level of appropriate behavior, toward ethics education, which includes conformity to regulations, but also equips and empowers professionals with the skills to think through areas of discretion and justify moral choices (Cohen, 2001).

There was general consensus among the authors studied in this project that reliance on the AAMFT code of ethics is necessary, but by itself, is often insufficient for the resolution of moral dilemmas in marriage and family therapy. A significant utility of the extensive reviews of ethical theory and methods of ethical analysis in this project is that they provide educators with an introduction to the

variety of theoretical positions and analytic tools available beyond the MFT literature and resources strictly focused on the AAMFT code of ethics. As each of the user-friendly questions in my model, the Seven Ps of Ethical Reflection, is based on a class of ethical theories while also incorporating consideration of codes, laws, and other relevant systemic issues, it may serve as a pedagogical tool for organizing the vast ethical theory literature and structuring a syllabus for an ethics class.

*6. Just as students articulate their theory of therapy, so too should they articulate their theory of ethics.*

The use of ethical theory need not, (I would argue should not) be confined to a didactic classroom exercise. Jankowski and Martin (2003) made the explicit recommendation that educators require therapists to devise their own conceptual model of ethical decision-making, much like they are required to articulate a theory of therapy. In fact, as part of a graduate MFT ethics course I co-taught with Jerry Gale in 2000, we had students articulate their “theory of ethics” and students reported this was an enlightening exercise.

I also recall a helpful assignment from my MFT masters practicum. Listed on the form trainees used for writing case notes was a list of clinical theories; we were required to circle what theories we had used during a session. This became fodder for review during supervision. Often following live supervision my supervisor pointed out the ways in which I was using more theory than I realized, thereby making the theory-to-practice link more vivid. I would suggest including a similar list of ethical theories on case note forms to stimulate reflection and discussion of the moral and ethical nature of clinical practice, both from the perspective of the therapist and the client (i.e., the moral nature of the presenting problem). Just as this exercise and supervision discussion stimulated my clinical sensitivity, similar structured reflection on moral issues in therapy may help increase therapists’ moral sensitivity, a prerequisite for ethical behavior according to Rest (1994).

*7. There is research that indicates changes in moral reasoning skills develop best with sustained dialog about real life professional moral issues, which suggests that clinical supervisors may have a*

*greater impact on ethics education than classroom or workshop presenters; thus supervisors will need to be educated to be more than code enforcers.*

Research on the development of moral reasoning skills supports the recommendation that ethical reflection be tied directly to on-going real life professional experience. Longitudinal research with student teachers has suggested that training that includes *sustained dialogue* about ethical issues improves one's post-conventional moral reasoning and positively correlates with increased ethical practice (Reiman, 2001). Reiman agreed it is reasonable to suspect that similar correlations would apply to therapists, perhaps more so because of the regular on-going supervisory relationship that is already inherent in clinical practice (personal communication, 2001). Reiman's (2001) results further suggested that there is no quick fix if the goal is to significantly improve moral reasoning; "weekend workshops won't cut it." Kitchener (1986) notes, "although gains in moral judgment can be influenced by courses in ethics, the gains are not large nor do students end up using the most sophisticated forms of moral judgment" (p. 308).

Reiman's (2001) work with teachers in training, intimates that there may be a "*role-taking and reflection effect*" that contributes to improved moral reasoning and thereby increased ethical behavior. The five conditions Reiman identifies as necessary for such cognitive transformation are readily applicable to the clinical supervision and training of therapists. The first condition stresses role-taking as opposed to role-playing. It is important to pay close attention to the moral content during the *actual experience* of being in a new role while therapy students are in their first practicum. Therapists' being in a new complex role gives increased opportunities for new and complex moral thinking about the content of therapy. Apparently *role-playing* does not have the same impact. Clinical supervisors are then in a position to provide the second and third conditions, which include (2) a guided inquiry to produce reflection and analysis about the therapist's new role and (3) a balanced discussion between the process and content of the therapy experience. The fourth condition necessary for promoting increased moral reasoning involves supporting and challenging the therapist's zone of proximal development. In other words, supervisors need to capitalize on the disequilibria created by the therapist's being in a new role.

Finally, the supervision context is ideal for facilitating the last condition, which is continuity. Reiman's (2001) study suggested that this sort of experienced-based reflective dialog needs to be on-going for at least six months to a year in order to see a change or transformation of moral thinking.

Reiman (2001) stressed that dialog alone (i.e., in a classroom setting such as a separate ethics class) is insufficient. Rather, dialog must be intimately joined with experienced action; hence the ideal of using clinical supervision to facilitate gains in moral reasoning which then contributes to clearer ethical decision-making. "The results of this study suggest that the inclusion of a role-taking/reflection curriculum into teacher education programs (as well as other professional preparation programs) prompts future teachers to reason and respond to the many moral and ethical issues that arise in the context of their progressively more 'practice-based' experience (i.e., role-taking)" (Reiman, 2001, p. 12).

These recommendations necessitate the re-envisioning of how supervisors are educated to think about their role in promoting ethical practice. While they remain gate-keepers and promoters of compliance with the AAMFT code of ethics, we need to equip our supervisors with rigorous, theoretically grounded tools (e.g., the theories and methods described in this project) for reflecting on and making ethical decisions. This includes providing language for identifying and discussing morally relevant features of a case, as seen from the perspectives of both therapist and client that is not limited to legal language or those features sufficiently gross in size to evoke the language of the code of ethics. In the long run, given research on what facilitates moral development in professionals, I suggest it will be our supervisors, even more than our classroom educators who will promote enhanced ethical reasoning where I think it counts most, in direct service to clients.

Current and previous research studies have failed to support a significant positive correlation between counseling experience and level of ethical judgment (Zibert, Engels, Kern, and Durody, 1998). In other words, gaining clinical experience in and of itself has not been found to correlate with the use of higher order moral reasoning skills. Educators and supervisors who have not incorporated more complex moral reasoning processes into their own clinical practice will be hard pressed to teach it to others. We must make explicit effort to develop our moral reasoning skills.

Current accreditation standards for AAMFT doctoral programs do not require graduates of accredited masters programs to take an additional ethics course during their doctoral program. While the approved supervisor training course includes a section on ethics, the supervision ethics literature mirrors the compliance focus of the larger MFT ethics literature, including its emphasis on what is ethical, not reasoning processes for making ethical judgments. For these reasons, I would advocate accreditation standards for doctoral programs and approved supervisor certification to require an advanced ethics course that goes into the sort of depth about ethical theory and methods of ethical analysis introduced in this study for those planning to teach in MFT training programs or otherwise supervise MFT clinicians. Just as doctoral programs are increasingly promoting the development of research skills through advanced coursework so that we may empirically test our clinical models, I am suggesting that advanced courses in ethics likewise are needed to rigorously evaluate the ethical and moral nature of therapy. While there are many competing demands in graduate clinical programs, and I admit to being fairly naïve about the complexity of establishing accreditation standards, if ethics is as important and foundational as we ostensibly say it is, I would at least urge serious reflection on this proposal.

The shift from ethics training to ethics education represents a paradigm shift. According to Don Self (2001), *moral orientation* is the framework by which one determines and perceives a given situation to be a moral dilemma to be resolved. A more comprehensive effort is needed to shift the moral orientation of the marriage and family therapy profession. To make this shift, we need to cross more disciplinary boundaries. The world of professional ethics is seen as inherently interdisciplinary. In addition to attorneys, we need to talk to and learn from business ethicists, philosophers, and clinical medical ethicists; we need to read their literatures, invite them to be guest lecturers in ethics or practicum classes, divisional or chapter meetings, and be co-authors on our ethics articles (e.g., Schlossberger & Hecker, 1996).

Finally, a special report on teaching ethics in higher education and in the professions noted: Courses in ethics should respect the pluralistic principles of our society, acknowledging the variety of moral perspectives that mark different religious and other groups.

Indoctrination, whether political, theological, ideological, or philosophical, is wholly out of place in the teaching of ethics. Although students should be assisted in developing moral ideals and fashioning a coherent way of approaching ethical theory and moral dilemmas, the task of the teacher is not to promote a special set of values, but only to promote those sensitivities and analytical skills necessary to help students reach their own moral judgments” (Callahan & Bok, 1980, pp. 300-301).

Others may or may not agree with this approach. In my view, however, if an individual educator or a training program (or even the profession) is going to emphasize a particular moral position, whether based, for instance, on a feminist, religious, or another social justice perspective, it is important to prepare trainees to not only articulate moral justifications for their individual preferences, but be able to engage in respectful reflective moral dialogue with others (e.g., clients, supervisors, supervisees, colleagues, the general public) without either unduly compromising or imposing their considered moral judgments. I contend that the language of ethical theory facilitates this sort of ethics education.

#### Implications for Research and Scholarship

*8. The diffused and scattered character of the 13 articles used in this project helps us to identify the gaps in our current understanding of MFT ethical decision-making processes; it appears that the AAMFT code of ethics alone has been an insufficient framework for meaningfully connecting the available fragmented empirical and theoretical work.*

This collection of articles offered some confirmation of the preliminary observation made by Mowery and Gale (2002) that we seem to lack a coherent and consistent means of talking about ethics in MFT. It is hoped that the scholarship produced by the fusion of horizons chronicled in this project can fill in the gap by offering a broader theoretical framework for understanding MFT ethical decision-making.

The few empirical studies on MFT ethical decision-making processes were largely quantitative, and beyond Kitchener’s work, there was little theoretical guidance used by researchers; though the creative use of moral development theory (Newfield, et al. 2000) and Bowen theory (Brown & Strozier,

2004) is notable. The current effort discovered the potential utility of Graber and Thomasma's (in press) theoretical frameworks for understanding MFT ethical decision-making. More in-depth analysis of the literature is warranted using these models, and certainly researchers could use these theories in formulating research that collects new raw data. There remains, however, the caution against mistaking normative theory for descriptive theory, unless we are describing recommendations made by others for how we ought to reason.

It may be that the cognitive psychology literature on expert versus novice decision-making offers an existing empirically based theoretical framework for rigorously examining decision-making processes that we actually use. Additionally, the topic of MFT ethical decision-making is ripe for the sort of grounded theory qualitative inquiry conducted by Jankowski and Martin (2003). Once these processes are better identified, the normative theories presented here offer a point of comparison and evaluation between how we do and how we ought to reason. Using the hermeneutic criterion of praxis (i.e., understanding of the "is" that includes reflection of the "ought" is superior to either interpretation alone), I would recommend the use of normative ethical theory to discuss the implications of research findings in every empirical study that gives us descriptive information about MFT ethical decision-making.

Additional hermeneutic analyses of the MFT ethics literature are in order. Of the many "what" articles, are there areas of consensus and disagreement about what is ethical? Can reasoning processes be discerned from these articles? If so, are different reasoning processes leading to different conclusions about what is and is not ethical? Authors making future recommendations as to how to proceed ethically should give careful attention to articulating their rationales and the processes they used to reach their conclusion; doing so by using the language of ethical theory will enable us to make cross comparisons. Likewise, any future descriptions of factors for consideration in ethical decision-making need to include suggestions for how we are to evaluate and prioritize those factors. Classical, feminist, and postmodern normative ethical theories, and Graber and Thomasma's (in press) models of applied ethical theory give us names for some of the mechanisms and criteria professional ethicists recommend we use when making ethical decisions. It is also recommended that authors begin to acknowledge their own analytical

framework when presenting their considered judgments about what is ethical, and be prepared to account for the limitations that accompany their chosen methodology. For instance, those that seek to rely on deductive methods for weighing moral principles to justify their conclusions would need to also account for contextual features influencing their interpretations of those principles, and vice versa.

*9. Tjeltveit (1999) observed that therapy is made up of science and ethics. Just as we are seeking to empirically validate our clinical procedures and outcomes, so must we philosophically justify our moral reasoning procedures and our conclusions. Thus, there is a need for both empirical and non-empirical methods of analysis to address the scientific and ethical questions that pervade therapy.*

As professional [psychotherapists], either we are effective or we are not. If we are not effective, we had better close the shop. If we are effective, our work changes the human condition in some way, and every change moves those to whom we minister in some direction, for better or for worse. Like it or not, professional [psychotherapists] are moral agents. It is not enough to attend rigorously to the technical efficacy of our procedures, though we must discriminate critically in choosing techniques. It is not enough to examine the empirical credibility and heuristic power of our theories, though we must attend closely to the way we appraise, reject, sustain, and amend our theoretical constructions. It is not enough to probe and ultimately to vindicate the epistemic foundations of our scientific and professional inquiries, though we must examine deeply and comprehensively the ways of knowing upon which our formulations and actions are based. Beyond techniques, theory, and epistemology, we must be profoundly concerned about the moral basis of our work as professional [psychotherapists] (D. R. Peterson in Hoshmand, 1998, pp. 29-30).

It is important to consider the implications of this study on MFT ethical decision-making not just as they apply to clinicians or to the types of research questions to be pursued, but there are implications for researchers themselves. In the fervor to conduct clinical research in order to validate our clinical theories and techniques, we must be cognizant of the myriad ethical issues that arise in the conduct of



research with human subjects. Thus, the need for careful reflection and rigorous methods of ethical analysis in relation to clinical practice as described herein is readily translatable to the practice of research.

For instance, recall that informed consent is a mechanism for upholding moral principles, the written document itself holds no moral force, and is no guarantee that ethical practice is taking place. How the document is understood by the participant and the researcher may differ, there may be critical but subtle harms that current IRB regulations do not filter, forms that are so long and detailed may actually hinder understanding and do more to provide legal liability for the researcher than protect the human subject from harm, and there are moral limits on what we should ask others to consent to in the name of science (see the work of Jay Katz, 1987, 1996, for a fuller discussion of these sorts of issues). Informed consent alone does not resolve all ethical issues; assuming it does privileges the principle of autonomy over all other moral considerations.

Finally, I must consider the implications of my fusion of horizons for my own efforts to devise a comprehensive model of ethical decision-making. My model, the seven Ps of ethical reflection, as presented in chapter three, was developed prior to my exposure to the work of Graber and Thomasma (in press), but I believe there is much to be gained by reflecting on how to incorporate the distinctions and insights into moral reasoning processes presented by Graber and Thomasma (in press).

Furthermore, though it has received little attention in the field and only scant discussion in this project because it was outside the publications being sampled, Volker Thomas' inclusion of the ecological framework developed by Bronfenbrenner (1989) is especially important for articulating a truly systemic ethics. More attention needs to be given to the excellent theoretical and empirical advancements in moral development research, particularly Rest, et al's (1999) distinction between macro- and micro-morality, which could potentially fit nicely with Bronfenbrenner's (1989) framework. The cognitive science literature on expert vs. novice decision-making, too certainly seems important to consider. Theoretical and empirical literature on cognitive stress and decision-making (e.g., Janis, 1993) seems to hold promise for deepening our understanding, and would fit nicely with the conceptualization inspired by Brown and

Strozier (2004) about Bowen's triangulation and differentiation. Finally, as noted earlier, I find Gadamer's insights into the hermeneutic circle of understanding an important factor in any attempt to formulate a systemic understanding of ethical decision-making.

#### Implications for the Profession

*10. A revised code of ethics might benefit from careful consideration of aspirational goals, the distinction between law and ethics, the distinction between moral and non-moral consideration, and methods of prioritizing conflicting principles.*

I believe it is essential to have clear understanding of the links and distinctions between law and ethics, as well as the strengths and weaknesses inherent in professional codes of ethics. While the 2001 code was revised to make it more enforceable and more readily adoptable into law, all codes, as with all laws, must be interpreted. Within the AAMFT published ethics literature as well as within many journal articles, the AAMFT code is often presented as having one true meaning, though unlike the Canadian Code of Ethics for Psychologists, there is no list of definitions of terms, and no explicated mechanisms for prioritizing conflicting principles are included. Enforcement of the code of ethics must carry with it understanding of the interpretive nature of such a task.

I would like to see our code clearly distinguish between enforceable minimal standards and aspirational ideals, and it is my understanding that this goal is under serious consideration by the AAMFT leadership. I have previously mentioned my recommendation that the code include in its preamble some interpretive guidance, including considerations for weighting provisions when (not if) they come into conflict. Mentioned too, was the suggestion that future revisions of the code be made with conscious attention to moral principles (e.g., autonomy, non-maleficence, beneficence, justice, and fidelity), clarifying the relations between the code's axioms and rules, these middle-level moral principles, and higher order ethical principles such from deontological and teleological theories.

Furthermore, I would urge those involved in future revisions of the code to giving serious consideration to modeling the AAMFT code of ethics after the framework used in the Canadian Psychological Association Code of Ethics (available on-line through the professional association). This

code has received considerable attention in the literature for its clear links to ethical theory, its prioritization of higher order principles of normative theory, and its clear structural distinctions between aspirational ideals and legally enforceable mandates for therapists' behavior.

Interestingly, Hadjistavropoulos (1999) conducted a study using ethical theoretical analysis of each statement and functional grammar analysis to examine the implicit messages embedded within the Canadian Psychological Association's (CPA) code and compared it to the Canadian Medical Association's (CMA) code of ethics. Results suggested that "compared to CMA, the CPA document has greater educational value, is less authoritarian, provides a clear rationale for ethical behavior, and is more empowering to the decision-maker" (Hadjistavropoulos, 1999, p. 127).

In an empirical study comparing the Canadian code and the Code of Ethics for the American Psychological Association, Hadjistavropoulos, Malloy, Sharpe, Green, and Fuchs-Lacelle (2002) suggest that theoretical grounding in an ethics code can lead to better internalization of the decision-making process. In my own experience, I find this to be true. Having read the AAMFT code many times, and reading the Canadian code only a few times, I find the Canadian code easier to follow and grasp. Indeed, having spent five years intensively study ethics, and being more interested in the topic than probably most MFT clinicians, I still find the AAMFT code of ethics difficult to use, largely because I have trouble grasping the logic under-girding the list of rules. I do not take issue so much with the individual rules as with the organization of the code itself. Based on the results of the studies listed above and my own experiences, I suggest that revising the code to be more compatible with ethical theory, will increase its practical utility for clinicians (not just attorneys who may be more used lists of regulations), and will help facilitate the use of higher order reasoning processes in MFT ethical decision-making.

*11. Alternative ways of dealing with moral problems need to be created in recognition of the limitations of policy formation.*

Beyond suggestions for the content of the code, I would recommend increased attention be given by the profession about the variety methods of ethical reasoning that may be applied to understanding ethics in MFT. Based on the result of this hermeneutic analysis of the MFT ethical decision-making

literature, it appears that we are relying on application model reasoning or validation model reasoning (Graber & Thomasma, in press) in our use of the AAMFT code of ethics in decisions. From the standpoint of validation model reasoning, if a specific policy is covered in the code, then it makes sense to follow that first. But if there is no clear policy in the code, then it is legitimate to use other tools for reasoning through moral issues rather than trying to stretch codes to do more work than they legitimately are able to do.

Kultgen (1988) warns against the strategy of trying to codify all ethical guidance. Every codified rule hampers creativity and freedom, and while in many situations this is exactly what is desired, it is not unusual for policies to create as many or more problems than they solve precisely because it is impossible to comprehensively predict every future circumstance that may relate to a provision in the code.

I would encourage those involved with future revisions of the AAMFT code of ethics to carefully distinguish those types of moral issues that do and do not require the sorts of circumscription that codes create and the types of concrete guidance for which codes are well suited (e.g., don't have sex with clients). For those moral issues that do not lend themselves to policy solutions, rather than trying to create a policy, time and effort may be better directed at identifying another tool, articulating precisely what other mode of moral reasoning may be more helpful, e.g., perhaps a direct comparison of ethical principles (e.g., autonomy vs. non-maleficence), or perhaps the situation is unique enough that narrative ethics offer the most guidance.

The point is that first we need to be willing to invest our energies in becoming aware of what other modes of moral reasoning exist beyond those tied directly to codes of ethics. Second, we have to be willing to see these alternative approaches to ethical decision-making as legitimate and rationally justified. Third, we have to do the hard work of thinking through the sorts of circumstances and issues that may be best resolved by using each sort of reasoning, i.e., how do I know when mediation model reasoning or validation model reasoning, or determination model or virtue model, or application model reasoning is best? In short, we need to know when a hammer is the best tool during the construction of a house and when wrench would be best suited to the task at hand. This recommendation is consistent with

Graber and Thomasma's unitary theory of moral reasoning. I believe this will better facilitate a systemic approach to ethics than linear models like Kitchener's (1984) approach.

*12. I recommend the creating of a separate AAMFT committee to work toward an expanded view of ethics education, while working in conjunction with the current ethics committee, which would maintain its focus on code compliance. Just as an attorney advises the ethics code committee, so could a professional philosophical ethicist advise the ethics education committee.*

Cohen (2001) noted that making the shift from compliance-focused ethics training to empowerment-focused ethics education requires additional resources from the top of the professional organization. Maintaining careful enforcement of the code of ethics is a critical role that must be played by the professional organization. It makes sense to have those who are well versed in assessing ethics violations continue to be involved in compliance training. But what would it be like to have a separate AAMFT committee that focused its attention on the sort of ethics education I described above?

I contend that in trying to have a single committee attend to both sorts of issues is untenable, and sets up volunteer members, who inevitably are strapped for time, to default into prioritizing rote compliance over reflective ethics. It would be critical that the two committees work carefully together, and perhaps have rotating overlapping membership so that the legal focus and the ethics focus inform one another without either being excluded in the functioning of the organization. I believe this structure to be critical especially in the early days of trying to operate from the new paradigm I am envisioning based on this project

Furthermore, just as an attorney is available to provide ethics consultation from a legal perspective, I would recommend that AAMFT also contract with a professional ethicist for consultation to the "ethics empowerment committee." The field of biomedical ethics is exploding, and more and more graduate training programs in applied ethics are graduating masters and doctoral level ethicists; specialized focus on mental health care ethics is available. It is my understanding that attorney's are trained to be as efficient and pragmatic with their time as possible; thus, it is often more efficient and cost effective to simply give authoritative conclusive legal advice than to wade through the non-pragmatic

moral considerations that may equally well serve as rationales for advice. This could possibly set the organization up to privilege the social functions of the code over the human functions of the code (Kultgen, 1988) as previously discussed. But someone with advanced training in ethics will be able to do the ethical analysis from a moral point of view, thus providing cost effective and efficient attention to the human functions to the code.

To be clear, I am certain that attorneys attend to the moral point of view, just as philosophical ethicists attend to the legal point of view; sophisticated thinkers in both professions recognize the relevance of the other perspective. But I am suggesting that professional socialization will tend to equip each professional to weight moral and legal considerations differently, and this could be a “difference that makes a difference.”

Finally, it is worth reflecting on the topic of MFT ethical decision-making from an institutional perspective. For instance, what is the relationship between the institution of law and the institution of medicine/health care (which includes mental health), or the institution of the family and so forth; and from an ethicist’s perspective, what ought these relations look like? Are we looking to the institution that is best equipped to answer a given question? For example, are we asking the institution of law to address concerns better handled within the confines of the institution of the family or health care, or vice versa? Given that the profession of marriage and family therapy operates at the intersection of these institutions.

The distinction between micro- and macro-morality made by Rest and colleagues (1999) seems especially relevant from an institutional perspective. As professional marriage and family therapists are we to confine ourselves to micro-moral issues within personal relationships (i.e., couples and families) and rely predominantly on inductive/contextual and care based moral reasoning, or does attention to social justice issues, for instance, require a broader organizational or even institutional response based on deductive and more impersonal reasoning processes?

In recent public conversations within the MFT profession about the need for an organizational response to society’s debate about same-sex marriage, the AAMFT ethics code’s prohibition against discrimination was invoked as justification for the recommended response. Do we understand same-sex

marriage as a micro- or macro-moral issue? Was our code written to address micro- or macro-moral issues? Can it effectively address both levels as currently written, or are we asking it to do more work than it rightfully can do at the present? Are we confusing the social and the human functions of the code regarding this issue? Do the social and human functions of the code vary in response to micro- or macro-moral issues?

Is our apparent current reliance on application and validation model reasoning (Graber & Thomasma, in press) for our understanding of how the code applies in moral decision-making our best strategy for wrestling with both micro- and macro moral issues? Do we require different reasoning strategies for dealing with micro- versus macro-moral issues? Would different members of or different stakeholders in our profession answer these questions similarly enough to arrive at consensus? Or if, as emphasized in the previous chapter, different methods of moral reasoning can lead to different justifiable moral conclusions, are we equipped to engage in moral dialogue using Cicero's criterion that we be able to respectfully represent positions with which we disagree before asserting our own?

I ask these questions, not with ready answers, but rather with the recognition that it is a direct result of my fusion of horizons in the current project that makes asking these questions possible at all. I believe these are critical questions that we must address as a profession, but they were invisible to me prior to this project. Indeed, "the real power of hermeneutical consciousness is our ability to see what is questionable" (Gadamer, 1976, p. 13).

#### Toward the Exploration of New Horizons

This project has chronicled the evolution of my understanding of ethical decision-making in marriage and family therapy from a number of perspectives—clinical, philosophical, theoretical, empirical, and personal—and has done so using a philosophical hermeneutic framework. The territory has been vast, covering topics as diverse as marriage and family therapy ethics, psychology ethics, philosophy of science, moral philosophy, medical ethics, and moral development. I have endeavored to be as transparent as possible about all aspects of my journey so as to open for others as many possibilities as I could for understanding MFT ethical decision-making in new ways, trying to ask more questions than

I answered, and attempting to rehabilitate the link between ethical theory and practice in the quest for praxis. Karen Kitchener's work has dominated the landscape of psychotherapy ethics for the past 20 years. It is hoped that others will also find a loadstar in the work of Glenn Graber and David Thomasma.

Kitchener is often the only touchstone many writers in MFT ethics use when referring to ethical theory. Her contributions to psychotherapy ethics do indeed remain unparalleled and their significance can hardly be understated. She can be likened to Christopher Columbus in her discovery and introduction to others of the new world of ethical theory. But the new world was not unoccupied; there were others already present, just as the world of ethical theory has been and continues to be occupied by more than those to whom Kitchener introduced to us. Columbus proved that one would not fall off the edge of the earth by sailing beyond the edges of the horizon. Likewise, I would argue that expanding MFT ethics beyond the horizon of our professional code of ethics also is not as perilous a prospect as some who tend to take a strict legalistic and compliance view of ethics would lead us to believe.

If Kitchener (1984) is as Columbus in bringing us to the shore of ethical theory, Graber and Thomasma, (in press) can be likened to Lewis and Clark, for their attempts to map the expanse of territory associated with reasoning processes used in relating ethical theory to clinical practice. But as family therapists, we know that the map is not the territory. Indeed, the only way to fully explore the world of ethics initially opened up to us by Kitchener is for other pilgrims themselves to venture into the wilds of ethical theory and the larger discourse of professional ethics. And the only way to fully make ourselves at home with complex ethical reasoning is for other homesteaders to refine the maps Graber and Thomasma have provided and establish a genuinely systemic understanding of what it means to reason ethically, to act ethically, and to be ethical.

To the extent that my in-depth study of ethical theory and medical ethics represents an atypical path within MFT, the true value of this study may not reside in what new understanding I attained in this current project, for I have made many trips along the hermeneutic circle over the last few years thinking and writing about ethical theory and MFT ethics. The strength of this study, rather, may be the invitation to new understanding this project opens to others in marriage and family therapy for whom ethical theory



and medical ethics genuinely represent new horizons waiting to be explored for the first time. I eagerly await other hermeneutic adventurers to join me on this ever-evolving quest for understanding in MFT ethics.

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