FAMILY THERAPISTS' ETHICAL DECISION-MAKING PROCESSES IN TWO DUTY-TO-WARN SITUATIONS

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This quantitative study investigated the ethical decision-making process of 177 Missouri members of the American Association for Marriage and Family Therapy using two in-session duty-to-warn scenarios of child abuse and HIV transmission. The components of the critical-evaluative level of ethical decision making include the lower-level decision components of personal/therapeutic response, professional ethics, and legal considerations/laws of the State, and the components of the higher-level decision base, the meta-ethical principles, which are nonmaleficence, autonomy, beneficence, fidelity, and justice. Statistical results indicated that in the child abuse scenario, professional ethics and legal considerations/laws of the State were considered most important, whereas in the HIV scenario, professional ethics were the preferred lower-level decision base. Across scenarios, the preferred higher-level decision base was nonmaleficence. There were differences across the child abuse and HIV scenarios in the perceived significance of the remaining lower-level decision base items as well as differences in perceived significance and ordering of the remaining meta-ethical principles. Limitations are discussed.

Family therapists make ethical decisions. An ethical dilemma presents the therapist with two or more good reasons to make two or more reasonable decisions. When therapists are asked why they made a specific decision, they will tend to concentrate the answer by making one or two broad points. However, the realm of possibilities, or why they made the decision, can be expanded to thinking and speaking about the decision in a more detailed manner. The explanation can be broken down into the concepts and language underlying the decision. This can provide family therapists a common language with which they can address their concerns about, and resolution of, the dilemma. Kitchener's (1984) model of ethical decision making can expand the conversation by breaking down the ethical decision from a broad discussion to more exact and universal detail.

The purpose of this exploratory study was to elicit a basic understanding of the ethical decision-making processes of marriage and family therapists (MFTs). The standards of conduct that govern professional MFT are operationalized in Kitchener's (1984) model of principle ethics. The dilemma of concern was that of protecting client confidentiality when there was a perceived and/or actual legal mandate of duty to warn. The decision to protect client confidentiality or to reveal information to authorities was examined in response to scenarios of child abuse and of HIV transmission to unsuspecting sex partners. This study examined the order of importance of the lower-level ethical decision-making base of personal/therapeutic response, professional ethics, and legal considerations/laws of the State in each scenario as well as differences across the two scenarios of these lower-level decision base components. This study also examined the order of importance in ethical decision making of the higher-level decision base of the meta-ethical principles of nonmaleficence, autonomy, beneficence, fidelity, and justice in each scenario, as well as differences across the two scenarios of the higher-level decision base of these meta-ethical principles.

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BACKGROUND

The principle-ethics model of decision making proposed by Kitchener (1984) provides the components of the ethical decision-making process in this study. Kitchener drew from Beauchamp and Childress (1979) in proposing an ethical decision-making process composed of two levels of moral thinking. The first level of moral thinking, the intuitive level, involves considering ordinary moral sense in reaction to the facts of the situation resulting in a knee-jerk reaction, an initial personal (and, in this study, therapeutic) response. Hare (1991) describes this intuitive level as a joining of prior ethical knowledge and experience in an immediate, prereflexive response. This intuitive response may detect dissonance (Festinger, 1962) between competing values and may not be able to find resolution of the ethical dilemma.

When the first level of moral reasoning fails to find the necessary resolution of the dilemma then one moves to the critical-evaluative level of ethical justification. This level contains three clusters of components: The lower-level decision base of rules, professional codes, and laws, the higher-level decision base of the meta-ethical principles of nonmaleficence, autonomy, beneficence, fidelity, and justice, and ethical theory.

The rules, professional codes, and laws are often ritualized and concrete, but when these are considered inadequate for dilemma resolution, one must consider the interaction of the meta-ethical principles in the decision. The meta-ethical principles provide a base for refining moral decisions and intuitions and imply a hierarchical process for resolving ethical dilemmas (Kitchener, 1984). Autonomy implies that individuals are able to make decisions and have the right to make those choices. Nonmaleficence is understood as “above all do no harm” (Beccar, Beccar, & Bender, 1982) and implies that one must consider possible competing choices and avoid possible harm arising from clinical action. Beneficence implies that one will do good and promote the welfare of the client. Fidelity conveys the idea that one will be trustworthy and keep one’s promises. Justice implies that one will treat individuals equally. Kitchener (1984) defers broad discussion of the ethical theory except to recognize Western philosophical thought.

Kitchener’s (1984) critical-evaluative level of moral reasoning begins by noting the rules, professional codes and laws that govern behavior. This implies that the person of the therapist is relying on his/her reading and understanding of these guidelines to develop a further understanding of the ethical dilemma. In this study, and unlike Kitchener’s model, the person of the therapist (personal/therapeutic response) is directly incorporated into consideration at the critical-evaluative level of ethical justification. This was done for two reasons. First, Kitchener assumes that the person of the therapist is indeed present in the process of ethical decision making. Second, the ethical dilemma presented by the scenarios in this study concerns the concept of duty to warn. Incorporating the concept of use of self, personal and professional, at this level could provide information concerning the tensions between self preferences and the professional codes, rules, and state laws.

The influential Tarasoff decisions introduced into law the concepts of duty to warn and duty to protect (1976). The State of Missouri mandates reporting of child abuse (Child Protection and Reformation Act, 1996). The Missouri case of first impression of Bradley v. Ray (1995) imposes a clear duty to warn in cases of child abuse, though it omits duty to protect. The vast majority of jurisdictions in the United States have considered the issue of duty to warn and have accepted the rule set out in Tarasoff. However, numerous jurisdictions have strictly applied the three elements of Tarasoff, which include serious danger or harm, foreseeability, and a readily identifiable victim (Stenger, 1996). In Missouri, there have been only two cases since Bradley v. Ray that deal with Tarasoff’s duty to warn. Matt v. Burrell, Inc. (1995) stands for the proposition that the holding of Tarasoff will not be extended to the general public (as opposed to just one readily identifiable individual). The 2001 case Robinson v. Health Midwest Development Group is the most recent Missouri look at Tarasoff and as yet is undecided as to whether or not there is a duty to warn the general public. There is no specific law in Missouri that requires psychotherapists to report transmission of HIV; however, it is against the law for a citizen to risk infecting another with HIV (Health and Welfare Act, 1996). The common themes of these two scenarios are the potential of harm/danger, the foreseeability of the harm to another readily identifiable human being as the result of a therapist’s client’s actions, and the client revealing this information to the therapist (a special relationship).
The duty-to-warn precept is in direct opposition to the pure professional value of confidentiality. The Code of Ethics of the American Association for Marriage and Family Therapy (AAMFT) states that "Marriage and family therapists do not disclose client confidences except by written authorization or waiver, or where mandated or permitted by law." (AAMFT, 2001). Violating client confidences when "mandated by law" appears to be straightforward except for the potential ambiguity of the interpretations concerning what exactly is the type of injury or the magnitude of injury that is reportable to authorities. Definitions of clear and immediate danger are not explicit (Totten, Lamb, & Reeder, 1990) and may be construed differently by different therapists (Millstein, 2000; Pais & Pierce, 1998). For instance, what is the extent of harm to a child that should be reported? Is a spanking harmful? If so, what degree of force makes it reportable? Is a maple switch on a child's bottom child abuse? Is a paddle worse? Is an individual absolutely going to be infected with HIV by having unprotected sex with an infected individual? Sorting through these situations may be somewhat similar to several people seeing the same car accident. Each person sees the accident from a different angle or perspective and believes that his or her version/personal response is the absolute truth. However, although some facts may likely remain the same for the group in general, the conclusions that they draw may be different concerning fault, specific details, and timing. The broad perspective is clear. There was an accident. However, each witness to the accident will identify different details of what happened that reflect his/her personal response. It is fair to state that clients expect their discussions with a MFT to remain confidential. The duty-to-warn exception presents therapists with the dilemma of honoring and keeping client confidences (fidelity), or violating client confidences (duty to warn) by speaking about client confidences outside the therapy session.

The duty-to-warn scenarios were selected to provoke obvious duty-to-warn thought. Although child abuse is the most often considered duty-to-warn possibility (Corey, Corey, & Callanan, 1998) the extension of duty to warn in the HIV scenario implies the same Tarasoff-like mandate. The child abuse duty to warn is mandated by law. HIV transmission between sex partners is not mandated as reportable by psychotherapists. The discussion in the literature about duty to warn with HIV transmission continues to be a more open question as to the actions a therapist should take given the absence of a clear legal mandate (Stenger, 1996). Few individuals would wish to contract HIV and may feel that they should be informed of their sex partner's positive HIV status.

The literature addressing the issue of protecting client confidentiality and the legal duty to warn is of two principal types: Theoretical discussion of the issues involved in duty to warn and research examining particular reasons for professional ethical decisions. First, there is ample theoretical discussion of the issues involved in duty to warn (Ericson, 1990; Krajewski, 1990; McGuire, Neri, Abbott, Sheridan, & Fisher, 1995; Oppenheimer & Swanson, 1990; Schlossberger & Hecker, 1996; Totten, et al., 1990). These general discussions, though helpful in sorting through issues, lack specificity as to the actual decision-making processes concerned in making an ethical decision. This lack of specificity limits the in-practice utility of this literature. Conversely, Stanard and Hazler (1995) specifically address the importance of the meta-ethical principles in Tarasoff-like decisions. Their discussion implies that the law and principles set forth by this legal decision should provoke consideration of the meta-ethical principles. Hendrix (1991) and Lynch (1993) agree that Kitchner's (1984) principles should be carefully examined and are a strong defense of careful consideration of all the potential issues involved when considering breaking confidentiality.

The second type of literature is research concerning particular reasons for professional ethical decisions. This literature is not as voluminous as the theoretical discussions of the issues concerning duty to warn. Two studies, though, point to the need for further investigation in the area of ethical decision making (Smith, McGuire, Abbott, & Blau, 1991; Wilkins, McGuire, Abbott, & Blau, 1990). This research identified the psychotherapist's knowledge of the ethical components of a decision, the "should" choice, and the psychotherapist's ability to act in that way, the "would" choice. The psychotherapist's action, the "would" choice, reflected lower-level decision bases, such as intuition and personal values. The "should" choice concerned congruence in action to the formal codes of ethics. These studies suggest that research in ethical decision making should be concerned with higher order decision-making processes, specifically the meta-ethical principles. Only Brown and Newman (1992) in their research of program evaluators attempted to apply the meta-ethical principles to the standards developed by the Joint Committee on Standards.
METHOD

Sample
Each of the Missouri members of the AAMFT received a mailed packet. The response rate was 41%, (n = 177), an adequate response rate for this type of research (Pies & Pirocy, 1998). Seventy-seven percent of the participants were clinical members, 27% associate members, 11% student members, and 2% affiliate members. The gender distribution was 63% female and 37% male. Ninety-six percent were Caucasian, and 3% were African American.

Educational level was reported as: 41% doctoral degree, 57% master degree, 6% medical degree, and 1% bachelor’s degree. Thirty percent worked in private practice, 55% in public agencies, and 15% in other settings. The respondents reported their years of practice experience as: 0–5 years (12%); 6–10 years (21%); 11–15 years (19%); 16–20 years (20%); 21–25 years (18%); and 25+ years (9%).

Materials
The Ethical Decision Making Survey was developed, incorporating each discrete section of Kichener’s (1984) model including the lower-level decision base items (and adding personal/therapeutic response) and the higher-level items/meta-ethical principles. The components of the model were applied in two duty-to-warn dilemmas worded as follows:

Child abuse. In a therapy session, your client informs you that s/he has been disciplining her/his child with the buckle end of the belt that leaves welts on the child. The client will not contract to end her/his use of this form of discipline. The client will not authorize you to share this information with anyone.

HIV. In a therapy session, your client informs you that s/he is HIV positive and is engaging in unprotected sex with her/his uninformed mate. The client will not contract with you to stop having sex in this manner. The client will not authorize you to share this information with anyone.

Respondents were asked to rank order the lower-level decision base items of personal/therapeutic response, professional ethics, and legal considerations/laws of the State and the higher level decision base items/meta-ethical principles of autonomy, nonmaleficence, beneficence, fidelity, and justice for each scenario with 1 being the most important.

RESULTS

Lower-Level Decision Base
Research question #1. What is the order of importance for family therapists of the lower-level ethical decision-making base of personal/therapeutic response, professional ethics, legal considerations/laws of the State?

Child abuse scenario. Friedman $\chi^2$ analysis indicated that differences between personal/therapeutic response, professional ethics, and legal considerations/laws of my State were significant, $\chi^2(2, N = 177) = 48.33$, $p < .001$, suggesting that the lower-level decision bases were not seen as equally important. Professional ethics (mean rank = 1.70) and legal considerations/laws of my State (mean rank = 1.87) were perceived as more important than personal/therapeutic response (mean rank = 2.43).
TABLE 1
A Comparison of Lower-Level Rank Ordered Ethical Decision-Making Bases between Scenarios of Child Abuse and HIV

<table>
<thead>
<tr>
<th>Lower-level decision base</th>
<th>Child abuse</th>
<th>HIV</th>
<th>Wilcoxon signed rank test</th>
</tr>
</thead>
<tbody>
<tr>
<td>My personal/therapeutic response</td>
<td>2.43</td>
<td>2.19</td>
<td>-3.60***</td>
</tr>
<tr>
<td>My professional ethics</td>
<td>1.70</td>
<td>1.65</td>
<td>-1.08</td>
</tr>
<tr>
<td>Legal considerations/laws of the State</td>
<td>1.87</td>
<td>2.17</td>
<td>-4.41***</td>
</tr>
</tbody>
</table>

Notes. Lower rank or number indicates the most important consideration.
***p < .001

HIV scenario, Friedman χ² analysis indicated that differences between personal/therapeutic response, professional ethics, and legal considerations/laws of my State were significant χ²(2, N = 177) = 32.99, p < .001, suggesting that the lower-level decision bases were not seen as equally important. Professional ethics (mean rank = 1.65) appeared to be perceived as most important. There was a close rank ordering of legal considerations/laws of my State (mean rank = 2.17) and personal/therapeutic response (mean rank = 2.19).

Order of Scenario
Research question #2. Does the order of the lower-level ethical decision-making base differ depending on whether the family therapist is faced with the scenario of child abuse or HIV transmission?

A Wilcoxon Signed Rank Test was used to compare the mean ranks given to the three lower-level ethical decision-making bases of personal/therapeutic response, professional ethics and legal considerations/laws of my State between the child abuse and HIV scenarios (Table 1). Professional ethics were viewed as most important in both scenarios with no difference between mean ranks. However, personal/therapeutic response was ranked as significantly more important in the HIV scenario than in the child abuse scenario. Legal considerations/laws of my State was ranked as significantly more important in the child abuse scenario than in the HIV scenario.

Meta-ethical Principles
Research question #3. What is the order of importance for family therapists of the meta-ethical principles of autonomy, nonmaleficence, beneficence, fidelity, and justice?

Child abuse scenario, Friedman χ² analysis indicated that differences between nonmaleficence, autonomy, beneficence, fidelity and justice were significant, χ² (4, N = 177) = 269.65, p < .001, suggesting that the meta-ethical principles were not seen as equally important. Avoiding harm–nonmaleficence (mean rank = 1.27) appeared to be perceived as most important. The order of importance of the remaining choices in the child abuse scenario were the importance of doing good–beneficence (mean rank = 3.14), the importance of being fair to my client–justice (mean rank = 3.28), the client’s right to confidentiality–fidelity (mean rank = 3.42); and last, the individual’s right to decision making–autonomy (mean rank = 3.90).

HIV scenario, Friedman χ² analysis indicated that differences were significant, χ² (4, N = 177) = 194.50, p < .001. suggesting that the meta-ethical principles were not seen as equally important. The importance of avoiding harm–nonmaleficence (mean rank = 1.58) appeared to be perceived as most important. The order of importance of the remaining choices were the client’s right to confidentiality–fidelity (mean rank = 2.91), the importance of being fair to the client–justice (mean rank = 3.27), the individual’s right to decision making–autonomy (mean rank = 3.90).
TABLE 2
A Comparison of Meta-Ethical Principles between Scenarios of Child Abuse and HIV

<table>
<thead>
<tr>
<th>Rank order of meta-ethical principles</th>
<th>Child abuse</th>
<th>HIV</th>
<th>Wilcoxon signed rank test</th>
</tr>
</thead>
<tbody>
<tr>
<td>The importance of avoiding harm (nonmaleficence)</td>
<td>1.27</td>
<td>1.58</td>
<td>-3.62***</td>
</tr>
<tr>
<td>The individual’s right to decision making (autonomy)</td>
<td>3.90</td>
<td>3.59</td>
<td>-3.10**</td>
</tr>
<tr>
<td>The importance of doing good (beneficence)</td>
<td>3.14</td>
<td>3.64</td>
<td>-5.41***</td>
</tr>
<tr>
<td>The client’s right to confidentiality (fidelity)</td>
<td>3.42</td>
<td>2.91</td>
<td>-4.82***</td>
</tr>
<tr>
<td>The importance of being fair to client (justice)</td>
<td>3.28</td>
<td>3.27</td>
<td>-0.17</td>
</tr>
</tbody>
</table>

Notes: Lower rank or number indicates the most important consideration.
** p < .01; *** p < .001

making—autonomy (mean rank = 3.59), and last, the importance of doing good—beneficence (mean rank = 3.64).

Order of Meta-Ethical Principles

Research question #4. Does the order of importance of the meta-ethical principles differ whether the family therapist is faced with the scenario of child abuse or HIV transmission?

A Wilcoxon Signed Rank Test compared the mean ranks given to nonmaleficence, autonomy, beneficence, fidelity, and justice between the scenarios of child abuse and HIV (Table 2). The importance of doing good (beneficence) was ranked as more important in the child abuse scenario than in the HIV scenario. The client’s right to confidentiality (fidelity) is ranked as more important in the HIV scenario than in the child abuse scenario. The importance of avoiding harm (nonmaleficence) was ranked as more important in the child abuse scenario than in the HIV scenario. The individual’s right to decision making (autonomy) was ranked as more important in the HIV scenario than in the child abuse scenario. There was no statistically significant difference between scenarios of the importance of being fair (justice) to the client.

DISCUSSION

The results of this study provide family therapists and family therapy educators with some food for thought concerning discussion of ethical dilemmas within the context of Kitchener’s (1984) ethical decision-making model. The discrete elements of Kitchener’s model can provide therapists and educators with a “component” approach to incising difficult or thorny ethical dilemmas, especially duty to warn.

The whole point of this research was to identify potential hierarchic preferences in ethical decision making, given the spectrum of principle ethics components. Ethical decision making is often viewed as an abstract enterprise. This research should, however, provoke a sense of identifying and putting into words the possible components involved in ethical decision making. Discussion of the results of this survey must be viewed as only a relaying of the interpretation by the author given the stated scenarios. This research, though, can help practitioners and educators reduce the abstract into the realm of the more concrete, the
concrete being the attempt to sort through the various constructs as identified as components in ethical decision making.

The wording of the scenarios leaves open some questions. One question might be was the individual alone in session with the therapist? Was the situation, and results of the study, be different if a family member or the victim had presented the information to the therapist? In addition, the words used in the rank order question could be interpreted differently by each respondent. The point is that each clinical situation, once perceived as an ethical dilemma, must be approached in consideration of the specifics of the situation. This study, because of the possibilities of differences in respondent conceptualization of the scenarios as well as the wording used in the rank order question, is intrinsically flawed.

Although there was no difference between scenarios in the mean rank of professional ethics, there was a difference between scenarios of the perceived importance of legal considerations/laws of the State. In the child abuse scenario, professional ethics and legal considerations/laws of the State were considered most important. This may reflect the now professional understanding that ethics and the law are of one mind, at least in cases of child abuse. The differences in rank ordering between scenarios might reflect that the surveyed therapists carefully considered each scenario and therefore avoided “pat” responses to ethical dilemmas of this sort.

Professional ethics may reflect codes of ethics, spoken and unspoken rules of the profession, and/or professional standards and regulations. The fact that these therapists, three-fourths of whom had been in practice for 6 to 25 years, identified professional ethics in the child abuse scenario (Haas et al., 1988) as an important consideration would appear to provide support for the importance of professional education in ethical decision making (Welfel & Lipsitz, 1984).

Conversely, there was a similar rank order but difference in mean rank of the other two lower decision bases. Legal considerations/laws of the State was ranked as more important in the child abuse scenario than in the HIV scenario. This may reflect a stable, more entrenched perspective concerning legal considerations in the child abuse scenario (Kalisman & Craig, 1991). Personal/therapeutic response was ranked as more important in the HIV scenario than in the child abuse scenario, though in the HIV scenario personal/therapeutic response was closely ranked with legal considerations/laws of the State. This may reflect the lack of an entrenched legal stance, or therapist knowledge of State law, and resulting confusion concerning the violation of confidentiality in the HIV scenario (Stenger, 1996). This was supported by the comments written into the survey, for instance: “I think the issue of child abuse is more cut and dry than the issue of HIV and duty to warn.” “HIV has not been covered well in training.” “It took two times as long to answer the HIV scenario because the legal and ethical concerns are unclear.” This finding also supports earlier research pointing to the relationship between the ability to take direct action and having a codified or legal reason to do so (Haas et al., 1988). One implication may be that professional organizations and/or the state should take a stand on issues of this nature from which therapists may make decisions. This could take the form of precise professional guidelines, protocols, or statutory solutions (Bollas & Sundelson, 1995; Stenger, 1996).

Previous research was supported by the results of the Ethical Decision Making Survey. Legal considerations/laws of the State was ranked significantly more important in the child abuse scenario than in the HIV scenario and, alternately, that personal/therapeutic response was ranked significantly more important in the HIV scenario than in the child abuse scenario. The differences in mean rank of legal considerations/laws of the State and personal/therapeutic response may point to family therapists relying on personal feelings concerning the HIV dilemma (Pais & Piercy, 1998; Smith et al., 1991;) and, alternately, reliance on the law in the child abuse scenario (Haas et al., 1988).

Avoiding harm (nonmaleficence) held the primary position in both scenarios. The order of the remaining principles in the HIV scenario was fidelity, justice, autonomy, and beneficence. The first two choices reflect the dilemma of duty to warn in avoiding harm (nonmaleficence) and keeping client communication confidential (fidelity). These results substantially support literature that discusses the duty to warn in the HIV scenario pointing to the therapist’s knowledge that there is a dilemma that may lead to harm and that there is a potential duty to reveal confidential therapeutic information (Schlossberger &
However, as previously noted, the law of the State of Missouri does not at present support mandated reporting by counseling professionals of their clients' potential sexual transmission of HIV.

LIMITATIONS AND IMPLICATIONS

Results of this study must be viewed with caution. The scenarios in this study were constructed from the point of view of the person causing harm or potential harm, alone in a session with the therapist, revealing information that provoked a duty-to-warn implication. Although this achieved its purpose in this study, the scenarios are probably not typical. Family therapists see families, and sometimes the victim of child abuse reveals the information that provokes duty to warn. Hence, the research scenarios and the results of the study must be viewed as limited in scope. However, the process of discerning the components of the ethical decision can be variously applied to whatever and however scenarios are presented to therapists. Although the idiosyncratic responses were forced by the construction of the scenarios in this study, the actual process of picking apart ethical decisions can be enhanced by using this model, no matter the dilemma.

The response rate of 41% may reflect bias. Missouri, located in the midsection of the United States, is traditionally viewed as more conservative than other states. It may also seem obvious that those most interested in the survey subject matter may have responded in greater numbers. In addition, this sample included only one professional group in the State of Missouri, the Missouri members of the AAMFT, which limits the ability to generalize results to other counseling professionals. Future research should diversify the sampling method to achieve a more representative sample of practicing family therapists.

Further research using this principle ethics model should be done. This format clearly identifies the cogent and hierarchical understandings of the clinical situation concerning duty to warn, in this case, for the marriage and family counseling professionals as well as preferences between different clinical situations. Additional research using different scenarios could be helpful in further fleshing out the hierarchical preferences in the principle-ethics decision-making process.

This model is based on Western philosophical thought. It may, therefore, be seen as incongruent to other cultural philosophical understandings. Conversely, the "breaking out" or operationalization of the components of ethical decisions could be a helpful exercise in ethical decision making. This process emphasizes a personalized view of priorities in ethical decision making (Mattison, 2000) that can be of value to students, teachers, and practitioners.

The principle ethics components as operationalized in the Ethical Decision Making Survey could be applied to almost any ethical dilemma to help identify the preferred ethical decision-making processes of family therapists. The format of breaking out the discrete elements of ethical decision making could be used in teaching, in supervision, in self-examination in practice decisions, and in practicum/internship conversations. Further, these research results imply that the lower-level decision base of professional ethics and knowledge of the law are important in ethical decision making. This should certainly help solidify the importance of professional ethics courses infused with legal understanding.

Family therapists make ethical decisions. The outcome of an ethical decision, the "what!", is apparent to both the client and the therapist. The method described in this study of carefully analyzing the process, the "how" of ethical decisions, provides family therapists with a very studied method with which to examine every element of the principle ethics decision making process.

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210 JOURNAL OF MARITAL AND FAMILY THERAPY April 2002

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211

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