

Virtue, Ethics, and Legality in Family Practice

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Introduction

As you read this chapter, we are going to consider three aspects of professional work that should be related, but often are not even complimentary to each other: **virtue** or goodness, professional ethical codes, and legal conduct.

First, we want you to think about what constitutes personal and relational virtue—a good life—and the morality that supports these two. In recent years, virtue has become almost exclusively the domain of religion, but it once was a matter of public discourse (Aristotle, 350 B.C./1985; Cicero, 44 B.C./1991; Plato, 380 B.C./1992; and more recently, Bellah, Madsen, Sullivan, Swidler, & Tipton, 1985/1996, 1991)—and it needs to be again. We also will look at what the masters of family counseling and therapy might contribute to this discussion.

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Second, although professional ethics can serve as guidelines for appropriate conduct with clients, as well as provide opportunities for the personal learning and growth for the professional helper (Corey, Corey, & Callanan, 2007; Sperry, 2007), it too often has been addressed simply as a way to avoid malpractice lawsuits (Austin, Moline, & Williams, 1990). Real ethical questions in family practice are almost never easy to answer, and even the principles that underlie our professional codes often need adjusting for application across cultures, locations, and with each gender (Wilcoxon, Remley, Gladding, & Huber, 2007).

Third, there are the legal requirements of each state that define our responsibilities in relation to professional practice. This is especially true in the areas of confidentiality; child and elder abuse; harm to self, others, and sometimes property; informed consent; dual relationships; professional identity and competence; and education and training. In addition, there are federal requirements to consider, such as HIPAA¹ and *Jaffee vs. Redmond* (Supreme Court of the United States, No. 95-266), which deal with federal validation and limitations on confidentiality in psychotherapy. Although personal virtue and professional ethics ought to be foremost in our relationships with clients, it is the laws of each state and the federal government that ultimately dictates these standards in our work.

A Consideration of Virtue

Within western cultures, most discussions of virtue have yielded relatively common themes. Although Aristotle (350 B.C.-1985) chose happiness as the highest good, it was never to be achieved in isolation. Indeed, happiness was the result of virtuous actions that were conducted with moderation; bravery (or courage); temperance; generosity; mildness and friendliness; truthfulness; wit; justice and fairness; consideration and considerateness; and rational thought, intelligence, and even wisdom. To this list, Cicero (44 B.C.-1991) added orderliness, goodwill, honor, faithfulness, and service. We find many of these same themes in the thoughts of Plato (380 B.C.-1992) and most subsequent philosophers in western societies. These western traits were formulated for and assigned to individuals who sought to live a good life in relation to others of similar status and condition.

As Aristotle (350 B.C.-1985) noted, there are certain preconditions to such virtuous action and, again, each of these preconditions must be held by the individual or they invalidate virtue. Included in the preconditions are free will and voluntary action, the capacity for rational decision-making, the intention of achieving rational ends, and choice (or the power to enact either good or evil). These individual conditions have, for the most part, been enshrined in each of the codes of ethics that address professional practice in the helping professions. But what does this mean for cultures and societies in which the individual is not the most important character in the determination of moral action—as is true for many Asian countries? And what does it mean for the systemic therapies that choose to work *relationally* rather than *individually*? Do systemic therapy masters have anything to add to a conversation about individual virtue or goodness and a good society (or system)?

Systemic perspectives. Perhaps the most fully developed individual and systemic positions on virtue comes from Adler (1927/1946, 1933/1938). Adler posited that the nature of human beings was to be connected to and in relationship with others. He called the capacity for such connectedness a **community feeling**. The enactment of a community feeling was characterized by the taking of an active **social interest** in the well-being of others. Not only was this the basis for virtue but, by extension, it was also the basis for individual and family mental health.

Heinz Ansbacher (1992) addressed and clarified *community feeling* and *social interest*, noting that having a community feeling is related to the feeling of being in harmony with the universe and with the development of life throughout time. He called social interest “the action-line of the community feeling” (p. 405): the practical implementation of an interest in the well-being of others. What are people and families with a community feeling and social interest like?

They are more relaxed, having a sense of humor about the whole situation and about themselves. They will make a contribution when in a group, will be the better followers and the better leaders. They will be interested in the interests of others. They will be more mature and more reliable. They will be the better cooperators. (Bitter & West, 1979, pp. 96–97)

To Ansbacher's description of people with social interest above, we would add that the following traits can be found in the writings of many Adlerians: cooperation, contribution, caring, connectedness, **courage**, confidence, and competence (what might be called the 7 Cs).

Although Adler may have had the most developed perspective on what constituted a good life, he was not the only systemic thinker to contribute to this discussion. Other family therapists have developed models that directly or indirectly suggest a diversity of values, virtues, and qualities of a good life.

Kerr and Bowen (1988) highly valued rational thought and placed it in opposition to emotional reactivity, but the true test of a differentiated self was the ability to stay calm and observant in the midst of often emotionally charged personal family systems. It was in elevating one's rational responsiveness that whole systems had a chance to change.

Satir (1983) wrestled with the same concerns for the individual in relation to the system. For her, however, the answer was not in rational thought, but in emotional honesty communicated congruently in the present moment. The mark of maturity could be seen in "one, who having attained his (sic) majority, is able to make choices and decisions based on accurate perceptions about self, others, and the context . . . ; who acknowledges these choices and decisions . . . ; and who accepts responsibility for their outcomes" (p. 118).

One of the virtues that emanates from the work of both Bowen and Satir is the value of clarity in both mind and heart. Both masters knew that such clarity came from reflection and from a refusal to act based on automatic reactions. Although Whitaker (1976) appeared to value spontaneity of experience over all else, including reflection, in practice his interventions were designed to do many of the same things that Bowen and Satir valued: (a) release the family from self-imposed constrictions; (b) augment freedom of movement and expression; and (c) help family members find a balance between individuation and connectedness, dependence and independence, and personal needs and family requirements.

Similar dialectical themes are reflected in the structural work of Salvador Minuchin (1974, 2004) and most of the strategic therapists. In these models, a diversity of resources and cultures is valued over limited perspectives and options; order and boundaries facilitate openness and freedom, including the right of an individual or system to close down periodically; the individual and the system are structurally and developmentally interdependent; flexibility and adaptability are valued over rigidity; and leadership is better when it is balanced and seeks harmony. To these values, Adlerians, Satir, **solution-focused therapists**, social constructionists, and **feminist therapists** would add the value of **social equality**, and the importance of **collaboration**. Feminists would further note that the valuing of the right, just, or principled action may be the valuing of an illusion: That relational morality calls on all of us to care for others as well as ourselves (Gilligan, 1982). Feminist research echoes Adler's call for community feeling and social interest.

Both the global village and systems orientations reframe individual virtue within communal contexts. Quality connections with others are increasingly valued over individual, even heroic, action—although the goal is always for both the individual and the system to grow and develop. In this sense, words like caring, clarity, cooperation, courage, confidence, and competence take on a relational focus. Freedom for the individual is balanced with the survival needs and development of the whole. Individual capacities are contextualized as one set of resources among many that may be available to the group, the family, or the relationship. Difference and diversity are valued over sameness and routine. This valuing and appreciation of multiple perspectives (Breunlin, Schwartz, & MacKune-Karrer, 1997; Lum, 2003) is key to re-shaping what constitutes virtue in an increasingly intimate world with diverse and interdependent cultures.

Ethical Codes and Standards of Professional Practice

As everyone who has ever read their profession's ethical codes soon learns, ethical codes primarily provide guidance, rather than absolute directives, for professional activity. Almost every family counselor has wished, at one time or another, to find a clear and concise answer to an ethical dilemma carefully defined in our profession's codes of ethics. Having such a definition would make clinical life so much easier. Ethical dilemmas would surface and answers would be found in some section of a code of ethics; further, a concrete requirement for action would be immediately clear. And, once in a while, we actually can find clear directives in our standards of practice: Don't have sex with your clients; do not let clients harm self or others; and provide informed consent are a few examples. Most ethical dilemmas, however, are much more difficult to understand and resolve.

Those who have chosen to work in the helping professions, particularly with families, find themselves working with what Donald Schön (1983) refers to as ill-defined problems. Ill-defined problems occur when human beings frame a given experience as a problem. Conducting a family counseling or therapy session with a family that has a member who serves as your mechanic is simply an experience that has to be addressed. Most, if not all, helping professions would frame this experience as a potential problem because of the dual or multiple relationships involved. Jensen (2005) defines a dual relationship as "a separate and distinct relationship that occurs between the therapist and a patient, or a patient's spouse, partner, or family member, either simultaneously with the therapeutic relationship, or during a reasonable period of time following the termination of the therapeutic relationship" (p. 17). In the example above, there is the "customer–mechanic" relationship, the "family counselor–client" relationship, the "family counselor–other family member" relationship, and the "family member–family member" relationship.

Let's see what help various codes of ethics may provide. The *ACA Code of Ethics* [American Counseling Association (ACA), 2005] encourages counselors to avoid nonprofessional relationships, except when "the interaction is potentially beneficial to the client" (p. 5). Similarly, the *IAMFC Code of Ethics* [International Association of Marriage and Family Counselors (IAMFC), 2005] encourages family counselors to "avoid whenever possible multiple relationships, such as business, social, or sexual contacts with any current clients or family members" (p. 5). The AAMFT Code of Ethics [American Association for Marriage and Family Therapists (AAMFT), 2001a] also requires that therapists:

... make every effort to avoid conditions and multiple relationships with clients that could impair professional judgment or increase the risk of exploitation. Such relationships include, but are not limited to, business or close personal relationships with a client or the client's immediate family. When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists take appropriate precautions. (principle 1.3)

We find similar language in the *NASW Code of Ethics* [National Association for Social Workers (NASW), 1996]:

Social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable, social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries. (principle 1.06c)

So now what? Let's say you are a family counselor, and you are a member of both IAMFC and ACA. IAMFC suggests avoiding business relationships, whereas ACA's code would allow such a relationship *if* it is beneficial to the client. To which code are you bound: the one for a division of ACA that represents your counseling specialty or the one for the entire counseling

profession? Another difficult question is how would you determine what might be a beneficial relationship? That's apparently not so easy to answer, because the ACA goes on to suggest that potentially beneficial interactions "may include purchasing a service or product provided by a client" (ACA, 2005, p. 5).

AAMFT (2001a) lists two highly problematic concerns with dual relationships that could result: impaired professional judgment and client exploitation. Okay, so that's easy. If I think that a dual relationship with my mechanic could impair my professional judgment or result in exploitation, I just don't take that person or family on as a client: That's nice and clear. But what if I don't live in a big city? What if I live in a small town in a rural state or up in the northern territories of Canada? What if I am the only therapist for miles around? How can I avoid dual relationships then? Well, if I can't, I am directed to take appropriate precautions. I wonder what those are.

If it all comes down to my professional judgment, what will motivate my actions: a duty to respectfully follow perhaps multiple codes of ethics; a desire to avoid legal problems; or a desire to do what I think is best, based on my personal virtue, morality, and character? Welcome to the world of ethics in family practice.

We began this chapter by noting that professional ethics provide not only guidance but also opportunity for personal learning and growth. Ethical decision making—especially when dealing with conflicting professional ethical codes—moves you into the realm of ambiguity and uncertainty. It becomes the practitioner's responsibility, hopefully with consultation from experience profession, to make clinical choices that promote the well-being of clients. So, what do "beneficial" or "promote" or "well-being" really mean in action? *How* are these terms defined? *Who* has a role in defining these terms? Even though these are difficult questions to address, some of your most meaningful moments as a family practitioner may occur in the uncertain struggles with professional ethics.

Any consideration of professional ethics is fuzzy, and the phrase, "it depends" will emerge more often than a definitive answer. A dilemma is a dilemma because it is not easily solved, and wrestling with it often raises more questions than it answers.

Perspectives on Ethics

There are multiple ways to address ethics, moral action, and professional practice. In this section, we will discuss two of the most salient and familiar perspectives on ethics as applied to our work with families: **principle ethics** and **virtue ethics**. We then will discuss an emergent perspective on ethics, firmly grounded in postmodern thought, called **participatory ethics** (McCarthy, 2001).

Principle ethics. Principle ethics can be seen as pre-existing obligations a family practitioner embraces prior to any interaction with clients (Meara, Schmidt, & Day, 1996). The most commonly mentioned principles in the fields of counseling, psychology, and social work reflect the western values and themes first articulated by Plato, Aristotle, and Cicero: **autonomy, beneficence, nonmaleficence, fidelity, justice, and veracity** (Remley & Herlihy, 2005).

Autonomy is the principle underlying the individual's freedom of choice. There are many ways the principle of autonomy can play out in family practice. At the outset of family consultation, you will describe to your client your preferred approach or model as part of what is called **informed consent**. Families have the right to say "no" to the services you offer if those services do not fit them. The principle of autonomy also favors the individual over the family or the group. In many Asian cultures, however, what is best for the individual is never considered above what is best for the family. It is important to keep in mind that autonomy is a decidedly western value. Even in western cultures, the principle of autonomy forces family practitioners to articulate who they see as their client(s): Is it each individual in

the family or is it the family as a whole? Will the practitioner support the needs and development of individuals, of the family, or attempt to do both? And how will conflicts in these areas be resolved?

Beneficence means to promote the client's welfare and well-being. Family practitioners take steps to consciously and consistently work toward the betterment of the families with whom they work. Sounds simple, doesn't it?

Let's imagine a family who has come to you for support and guidance. We will use this family throughout the rest of this chapter to consider other ethical questions and concerns. The family has recently been charged with child neglect. The specific charge of neglect involves the family's 14-year-old child, who is suffering from leukemia. The parents hold religious beliefs that do not allow medical intervention to be given for any illness, even cancer. The parents want to gain your support for their freedom to choose the health care interventions they deem appropriate within their religious system. Prayer is their preferred form of intervention.

Supporting their freedom sounds like the right thing to do, but there in front of you is their 14-year-old child, suffering—and most likely dying—from cancer. So what actions do you take that would be seen as promoting the client's welfare? And who, exactly, is your client: the parents, the child, the family as a whole? The answer to this question will be central to every move you make.

Let's say that promoting the 14-year-old child's welfare seems clear to you, but then you are viewing the child's problem from the perspective of what's possible using western medical procedures, a perspective clearly outside of the religious values that are informing the parents' actions. As it turns out, even the child espouses the same religious convictions. So if you support the family's perspective, are you prepared to watch this young person die when everything within your own value system tells you the child has a chance with what you might deem "proper medical care"?

The third ethical principle is nonmaleficence. This is the classic credo of doctors since the days of Hippocrates: Do no harm. This directive seems so simple, but the meaning of "harm" can be individual, contextual, cultural, or even historical. What the family practitioner means by harm can be quite different from the family's definition and, even within the family, differences may exist as to what constitutes harm for each family member.

In the early days of family therapy, Jay Haley (1963) used **paradoxical interventions** when certain client symptoms were thought to be maintaining a family's problems: Haley would sometimes prescribe and augment the symptom as opposed to working directly to relieve it. For example, a father might exhibit great anxiety and worry about his family's welfare, checking on his kids at school 3, 4, or 5 times a day. Haley might tell the father that he is not worrying enough. What about all the hours of the night when other family members are asleep? Haley might even instruct the father to set his alarm clock to wake him on the hour, every hour. Upon awakening, he is to get out of bed and wake each of his children and ask if they are okay. For 5 nights in a row, the father is directed to carry out this task.

We already have noted that the definition of *harm* can differ across different periods in history. During the 1960s and 1970s, paradoxical interventions might have caught the scorn of some, but they would have been allowed to continue. Such interventions certainly brought about sudden, beneficial changes at times, even though their use raised the issue of whether the end justified the means. Today, standing up in your agency's case meeting and describing this intervention might very well lead to charges of an ethical violation.

Fidelity refers to the responsibility to maintain trust in the therapeutic relationship. Family practitioners must remain faithful to the promises they make to clients, especially when maintaining the client's right to privacy. What does this principle mean in relation to family secrets? Building and maintaining trust is the cornerstone to an effective therapeutic alliance with clients. The codes of ethics for all of the helping professions recognize the importance of keeping individual family members' private conversations with their counselor or

therapist confidential unless that individual has given consent to share the content of the conversation. This right to privacy also is codified in law through the current HIPAA regulations and requirements.

Let's say the 16-year-old daughter of a family speaks to you one-on-one prior to a family session about her recent experimentation with marijuana and her fear of her parents' potential response. You listen intently and affirm the confidentiality of the conversation. During the family session, the father and the mother both indicate that they are worried about their daughter. Her grades in school are getting worse ("She has always been a good student."); she is hanging out with a different set of friends, and she sneaks out to see them at night, but she won't introduce any of her friends to them; and she is dressing differently. The parents ask her: "Are you doing drugs?" The girl denies that she is. The parents look to the counselor: "Do you think she is doing drugs?" How do you reconcile the principles of beneficence, nonmaleficence, and fidelity in this case? What affect would disclosing this **family secret** have on the 16-year-old daughter? How might she view the counseling process and you as a family counselor? If you think this dilemma is hard, what will you do when you know that one of the parents is having an extramarital affair that is directly harming other members of the family? With each additional ethical principle, the professional waters muddy even more.

Justice refers to fairness, including equitable service for all clients. As of 2004–2005, Counselors for Social Justice (CSJ), a new division of the ACA, has a website that specifically targets issues of equity, oppression, discrimination, and injustice (see <http://www.counselorsforsocialjustice.org>). Such a development highlights how valued this principle is within the counseling profession:

Counselors for Social Justice is a community of counselors, counselor educators, graduate students, and school and community leaders who seek equity and an end to oppression and injustice affecting clients, students, counselors, families, communities, schools, workplaces, governments, and other social and institutional systems.
(CSJ mission statement)

In the teaching of ethics, the principle of justice has been the most misunderstood and debated principle. For many, equality and fairness mean equal treatment or the same treatment. For us, equality means that all people have an equal right to be valued and respected even when they are different from one another. Both philosophy (Aristotle, 350 B.C. 1985) and systems theory (Bateson, 1979) have noted that *differences* cannot be ignored: justice means treating similar people similarly and different people differently.

For example: Is working with a family with an only child and an income of more than \$100,000 the same as working with a family of eight whose income is less than \$25,000? Is the difference in incomes different enough to warrant a different way of providing family counseling or therapy? Do you think poverty has real effects on family life? If you are in private practice and you have set a rate for your services at \$100 per hour, will you even see the poorer family? How will you bill them? Will you see them for free or on a sliding scale—and how many poor families will you be able to accept in your practice and still make a living yourself? Justice requires that you wrestle with these issues before you even see your first family. It also has a place in your consideration of whether you work with oppressed families as if they have control over their own lives or work with the macro-systems to change society, as feminist family therapists (Silverstein & Goodrich, 2003), among others, would recommend.

Veracity is the implementation of truthfulness: It is intimately related to personal and professional integrity. It is only recently that veracity has been included in major ethical texts (Corey, Corey, & Callanan, 2007). One reason for the inclusion of veracity on the list of ethical principles is the increasing requirements of **managed care**. Managed care not only dictates the treatment people receive from medical doctors, but also the services delivered to individuals and families for mental health problems. In the name of controlling health care

costs, managed care companies limit the type and duration of services offered to clients. For family practitioners to remain on a preferred provider list, they must agree to abide by the parameters set by such companies. Managed care means that family practitioners within that system must wrestle with split loyalties. Being truthful, an essential part of informed consent, is essential for resolving professional conflict in the managed worlds of hospitals and community agencies.

These six common ethical principles do not exist independent of one another. Hill (2004) has suggested that these ethical principles are present in any ethical dilemma; the family practitioner, however, needs to assess which principles are most relevant to any given situation and how other principles might also be addressed. Deciding which ethical principle is most pertinent in any given situation can be a difficult task. The decision often depends on your in-the-moment interpretation of the ethical principles, consultation with other professionals, and guidance from your profession's code(s) of ethics. What would be an action that you would define as promoting the clients' welfare in the case of the 14-year-child with leukemia?

In reviewing your profession's codes of ethics, you find no statement that begins with "when counseling a family whose child has leukemia and whose religious beliefs do not support medical intervention, you must . . ." What you will find in the codes of ethics are statements such as, "The primary responsibility of counselors is to respect the dignity (of clients) and to promote the welfare of clients" (ACA, 2005, p. 4); "Marriage and family counselors do not engage in activities that violate the legal standards of their community" (IAMFC, 2005, p. 11); or "Marriage and family therapists participate in activities that contribute to a better community and society" (AAMFT, 2001a, Section 6.6); and "Social workers may limit clients' right to self-determination when, in the social workers' professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others" (NASW, 1996, 1.02).

So what can we glean from these statements that might help? The ACA's Code of Ethics makes beneficence the primary ethical responsibility. Okay, what action(s) serve(s) to promote the family's welfare? Respecting their welfare may mean respecting their autonomy to make decisions on their own. Yet respecting autonomy may contribute to the parents ending up in court either facing jail time or the removal of their child from their custody. Whose welfare is served then?

IAMFC's Code of Ethics asks you to ponder the legal standards of the community within which you practice. At issue here is the community's definition of "child neglect" (probably a state statute). For example, the state of Wisconsin defines child neglect as:

Any person who is responsible for a child's welfare who, through his or her actions or failure to take action, intentionally contributes to the neglect of the child is guilty of a Class A misdemeanor or, if death is a consequence, a Class D felony. (State of Wisconsin, 2005)

So, if you are practicing in Wisconsin, respecting the parents' autonomy may contribute to the death of their child, a Class D felony. A similar statute exists in the state of Idaho. It appears that in both states the most relevant principle is beneficence, particularly the beneficence of a child.

The AAMFT code of ethics is more utilitarian, asking the marriage and family therapist to consider which course of action brings about the greatest good. In our family example, promoting the welfare of the child, who may not be fully informed about her own best interests, probably meets this ethical standard. This position is also supported by the NASW code of ethics and seems to align with community and state laws.

This family example shows the constructivist nature of ethical decision-making when viewing problems through principle ethics. The words and intent of the codes, together with relevant legislation, all carry variations of meaning. In such cases, the local interpretation of ethical principles significantly influences a family practitioner's actions.

Freeman and Francis (2006) note one significant problem with principle ethics: They have been given relevance and authority separate from and prior to their actual use in ethical decision-making. Autonomy, for example, is important in any given case, because autonomy is valued as a principled guide to action. In theory, it supercedes localized interpretations and applications of ethical standards. To be sure, principle ethics in some cases can remind family practitioners to be sensitive to diverse cultures when local interpretations and laws are not (for example, in supporting the welfare of gay and **lesbian** clients). In some cases, however, the principles themselves may not be culturally sensitive (for example, autonomy in relation to an Asian culture), and the practitioner is left to adapt the principle to fit the needs of the culture, thereby challenging the very foundation on which principle ethics is based (Dubois, 2004).

The family case we have presented highlights the potential impact of religion on the application of the ethical principles. Other cultural influences include race, ethnicity, nationality, age, gender, sexual/affectional orientation, ability and disability, and poverty. Dubois (2004) suggests that ethical principles may have universal relevance, but the focus should be on how the specific principles are enacted within a given culture. That is, the question is not whether autonomy is a relevant principle in Sri Lanka; rather it is how Sri Lankans perform respect for autonomy.

Virtue ethics. Where principle ethics focuses on actions and choices based on predetermined values (Corey, Corey & Callahan, 2007), virtue ethics focuses on the character traits of individuals or the profession (Kleist & White, 1997). Principle ethics asks, “What shall be *done*?” Virtue ethics asks, “What kind of person shall the family practitioner *be*?” What do you think? Is it possible that your ethical behavior as an emergent family counselor or therapist is more about personal moral being than a mere understanding and application of a set of ethical principles?

There are multiple positions on virtue ethics just as there are on principle ethics. Jordan and Meara (1990) define virtue as “nurtured habits grown mature in the context of a formative community and a shared set of purposes and assumptions” (p. 110). Virtue in this sense is not innate: It is learned. Although principle ethics can be taught, it is not as so easy to teach integrity, courage, and humility. And if these are important virtues to have, how does one measure these virtues? Advocates of virtue ethics argue that family practitioners should not merely seek the safety of ethical behavior, as in principle ethics, but should aspire to an ethical ideal. At the beginning of this chapter, we considered some of the virtues that might serve as ethical ideals in family practice. Cohen and Cohen (1999) and Vasquez (1996) have long argued for ethical decision-making based on principle ethics, but grounded in a virtue ethic foundation. For Vasquez, virtue ethics can facilitate multicultural practice in the same way that flexibility is enhanced by boundary setting.

For example, you are seeing a Native American family in counseling at a local agency that offers free counseling for those families with limited means. You have successfully guided the family to a place at which they would like to terminate the counseling relationship. At your final session, the family presents you with a blanket that they have made together. To them, the blanket represents a “thank you” for the services provided. Typically, great caution is suggested in all professional codes when considering the acceptance a gift or bartering for therapeutic services. Vasquez suggests that the virtue of respect may contribute to understanding that the blanket is offered as a cultural means for expressing appreciation. Emphasis on the character of the individual and the profession provided by virtue ethics adds a sense of personal responsibility to the more external guidelines of principle ethics.

That said, virtue ethics has plenty of detractors. Like the challenge to principle ethics, virtue ethics can be challenged for their cultural relevance. Bersoff (1996) acknowledges the social construction and social embeddedness of virtues and community wisdom, the very foundation of a virtue ethics perspective. Think of the virtues that you hold dear. Where did

they come from? Do you have any idea of the history of these virtues in your own cultures? The very nature of multiple cultures means that their will be a diversity of perspectives on what is defined as virtue and virtuous behavior.

The teachability of virtue ethics is an additional dilemma (Bersoff, 1996; Kitchener, 1996). Can the virtues of the helping professions be taught within a two- to three-year program? What about the nurtured habits that you developed within your family-of-origin? Assuming that some values were nurtured in you from the time you were an infant, what if these values do not fit well with the virtues of the helping professions? Would you be willing to give up values you have held all your life and adopt the values supported by your profession? What would that mean for you within your own family life? If professionally congruent virtues cannot be taught and learned during a graduate program, those programs may have to adopt the difficult position of choosing candidates who already possess professionally desirable attributes and values (Bersoff, 1996). What are the problems that accompany this idea? The problems would be even more complex if members of a profession had to agree on a set of professional virtues and then create a means of assessing candidates during the interview process. Impossible, you say! Maybe, but some preparational programs are currently attempting to do exactly that.

Participatory ethics. A third perspective on ethics is grounded in postmodern philosophy, thought, and sensibilities: It is called participatory ethics. Postmodernism believes in a multiplicity of realities and truths; it values people's meaning-making processes as they create narratives of experience; and it examines dominant cultures that impede the self-agency of people whose voices have had only marginal participation in society. Feminism, social constructionism, and **multiculturalism** all have embraced this shift away from the modern to the postmodern. Participatory ethics invites families to be co-contributors to the ethical decision-making processes in family practice (Rave & Larsen, 1995). Postmodernists have critiqued family counseling and therapies based in modernist philosophy as colonizing clients by viewing family practitioners as the keepers of knowledge and the people responsible for any decision related to counseling or therapy (see Hoffman, 1985). Participatory ethics seeks to include and value the knowledges brought to counseling or therapy by families. Client feedback on the processes of family practice is encouraged. That is, client input is valued as "expert" in relation to how individuals and families experience their own lives, and practitioner "expertness" is related to leadership of the therapeutic process.

For our family with the 14-year-old child, how might their stories of lived experience be prized? How, if at all, has the dominant discourse in which this family is situated oppressed their self-agency, their self-determination? A family practitioner adopting participatory ethics might invite and emphasize the family's experience and meaning-making processes in interactions with the dominant culture or the stories told by the court system about child neglect and how such stories influence the preferred view of their family. As participatory ethics attends to the marginalized, the voice of the 14-year-old child might be encouraged and amplified. The family counselor could work with the parents to help them imagine themselves through the eyes of their child, to imagine what the experience of the situation might be like and what the child's preferred choices might be. The postmodern shift to participatory ethics can be quite powerful: In this model, the family practitioner's position of power is counter-balanced by honoring the family's own power in their process of living.

We have introduced three perspectives on ethics: principle, virtue, and participatory. Take a moment to reflect on the essence of each of these perspectives and your emotional reaction to them. With principle ethics, you have externally derived guidelines based on at least six principles to guide your professional actions. Virtue ethics calls on you and the helping professions to examine the character traits essential to family practice and how these characteristics may impact ethical processes. Last, participatory ethics takes you to the space between you and your clients, to the relationship in which clinical decisions are co-constructed and

negotiated with families. What are the potential positives in each that you see? What are the problems? What does your “gut” tell you about your thoughts and feelings about each? Now look at your answers to these questions. What do they say about you and your work with families? If you are not satisfied by one and only one perspective on ethics, then which blend fits for you? How would you integrate that blend? Continue to ponder such questions as we now move through various decision making models.

Ethical Decision Making

Understanding principles and virtues alone does not resolve an ethical dilemma. Some process is necessary that utilizes these principles and virtues. What follows are descriptions of three ethical decision-making models related to the three ethics models we have already presented. These three models do not constitute all available ethical decision-making models. They are simply used to demonstrate how different perspectives might be applied.

Models of Ethical Decision Making

The ACA Code of Ethics (2005) states that “when counselors are faced with ethical dilemmas that are difficult to resolve, they are expected to engage in a carefully considered ethical decision-making process” (p. 3). This same code goes on to note that “. . . counselors are expected to be familiar with a credible model of decision making that can bear public scrutiny and its application” (p. 3). None of the other helping profession codes state the importance of understanding and utilizing ethical decision-making models so explicitly. Because no decision-making model has been shown to be better than any other, the responsibility is on the practitioner to demonstrate and justify publicly the value of solving an ethical dilemma in a particular way. What follows are brief descriptions of three ethical decision-making models.

Critical-evaluation model. Kitchener’s (1984) **critical-evaluation model** is based on the ethical principles of autonomy, beneficence, nonmaleficence, and justice. Today, we would include the principles of fidelity and veracity in this list, and use 8 steps in the critical-evaluation model (Corey, Corey, & Callanan, 2007). They are:

1. Identify the problem or dilemma: ethical, moral, and legal dimensions.
2. Identify potential issues, stakeholders, stakeholders’ responsibilities, and the competing principles involved in the situation.
3. Review ethical guidelines of the profession against your own moral perspective on the situation.
4. Know the applicable laws and regulations of the state in which you practice.
5. Consult.
6. Consider possible courses of action, and the actions of all parties involved.
7. Enumerate possible consequences of various decisions for all stakeholders.
8. Decide which option is the best choice. (p. 21–23)

Let’s walk through each step of this model with the family whose child has leukemia that the parents are addressing with prayer, using the critical-evaluation model. We provide only brief examples and not the complete process.

Step 1: Identify the problem: From an ethical standpoint, we have concerns regarding breaching client confidentiality and the welfare of the clients, including the child. Morally, you may be wondering about the safety and welfare of the child and about our tolerance for the parents’ autonomous decision making.

Step 2: Identify potential issues involved: Do the parents know the potential legal consequences of their actions? Equally important, do you know the potential legal consequences of your actions as a family counselor or therapist? What legal responsibility do you have for any harm that befalls the child? Legally, are there any other stakeholders? What about grandparents? The state is a stakeholder because they are acting on behalf of the welfare of the child. What legal duty do you have as a family practitioner to the state?

The principles of autonomy, beneficence, nonmaleficence, justice, fidelity and veracity all seem pertinent here. Obviously autonomy is very pertinent as it relates to the principle of beneficence and the duties imposed by mandatory reporting laws in various states. Nonmaleficence is a primary concern in relation to the child. Justice is also a concern: What is fair and to whom? If fairness implies affirming that both parents have an equal say in the medical decision, does the child have a say? Would that not be fair? What actions might you take that demonstrates fairness in relation to the state's interest? Who is involved in these discussions? In regard to fidelity, you have duties to both the parents and the child. As a licensed family practitioner, you also would have duties to the state. Feeling stretched in multiple directions yet? Veracity would require that you provide informed consent that spells out the relationships among the various constituents whom you must serve, including the family; its individual members, especially the child; and the state.

Step 3: Review ethical guidelines of profession: As we noted much earlier, ethical codes and standards of practice contain often conflicting guidelines and little that might help to resolve such a case easily. Family practitioners must respect the dignity and promote the welfare of the family; maintain cultural sensitivity, confidentiality, and privacy while respecting differing views toward disclosure of information; and uphold the professional laws of the state. In the end, it comes down to a very complex question: How does the family practitioner work with the family, demonstrate sensitivity for the family's perspective, and decide what constitutes the family's welfare?

Step 4: Know the applicable laws: From the *legal* standpoint, which again depends specifically on various state laws, the parents' withholding of medical care for a life-threatening condition can be viewed as child neglect. If the child were to die, child abuse leading to death would most likely lead to a legal indictment. For the purpose of this example, let's make this step easy: The laws of your state define the parents' religious beliefs as harmful to the child and, therefore, require the family practitioner to report the parental position as intended child abuse.

Step 5: Obtain consultation: This step is by far the easiest and most often-used step by students engaged in family practice. It is also the first step to go once a person is working full-time in private practice or in agencies. Failure to seek consultation will almost always have negative results if an ethical decision is ever challenged within a professional association or in a court of law. Obtaining consultation can provide an opportunity to get feedback and recommendations regarding your decision-making process. The more uncomfortable you are in sharing your decision-making process in consultation, the more likely you are to be taking actions that you already know are not the best for your clients. Legal consultation is vital for any family counselor when considering the case above.

Step 6: Consider possible courses of action: At this step, creative thinking is necessary. This is the time for reflective processes. You want to take enough time to complete this step with the confidence that you have explored solutions from many angles. Your solutions also should address the actions of all the people involved in a solution.

You decide to tell the parents that your primary obligation is to their 14-year-old child due to the state's interest in protecting children. You provide them with the options of either taking their child to a doctor or preparing to have the state remove their child from the home because you are required by law to call the child-protection agency to advise them of the parents'

decision to avoid medical intervention. Your actions and words are firm and deliberate, but friendly. What are your reactions to such a course of action? To what principles are you paying primary attention? Whose interests have been protected?

A second option is to remain loyal to your clients' religious beliefs. You understand the legal requirements placed on you and the legal context in which the family is embedded. Autonomy and cultural sensitivity are your main reasons and, although the results of such actions may lead to harm for the child, you believe that promoting the family's welfare is best served by promoting its autonomy. The idea that not all laws are ethical is central to your reasoning. In addition, you believe that the laws of the state are secondary to the larger laws set forth by the family's religious "higher power." Although such actions may not be what the majority of family practitioners would do in a similar situation, you believe that at times civil disobedience truly provides the best ethical action.

What other ethical stances are possible and what principles support these stances?

Step 7: Enumerate possible consequences of the various options. For the first option, the child probably would receive the medical care indicated. The parents might be placed on probation and mandated to a parenting program, after which they might regain custody of their child. The parents themselves might be bitter and even more distrustful of both the government and family counseling or therapy. There is very little chance that the parents will ever consider therapeutic interventions of any kind again. Imagine this case for a moment. Given today's world, the media already will have attended to this story, and your actions now are known to thousands. These thousands will now take in this event and connect it to their attitudes toward the helping professions. Should the awareness of the public nature of your decision factor into your decision-making process?

The second option will invariably lead the parents to respect your ability to honor the family's right to make decisions regarding their child. It is still uncertain as to whether your actions will lead to further involvement with the authorities—either for the parents or for you. Quite likely, the child's condition will worsen and may lead to death. How will you feel about your decision then? This action, too, will catch the attention of the public. How might the public view family practitioners with this option?

Step 8: Choose what appears to be the best course of action. Hopefully you see the two options described here as only two of many more options that might be available. The very application of this model based solely on principle ethics demonstrates how often no-win possibilities occur. Let's see if virtue ethics adds anything to our considerations.

A virtue-ethics model. Most professional codes are based on principle ethics. Except for a few aspirational statements in some codes, there is very little in the documents themselves that pertains to virtue ethics. As we have noted before, virtue ethics requires the professional to look inward and make space for a self-reflective process. Attending to oneself in ethical decision-making opens the door for the emotional experiences of empathy and compassion. Cohen and Cohen (1999) view the role of emotion in decision-making as a legitimate component of a "morally good motive . . . (and) that moral action is no mere affair of rules but is instead infused with emotion, human relatedness, and sensitivity to the nuances of individual context" (p. 24). A decision-making process based on virtue ethics would include many of the questions below:

- What is my "gut" telling me about the family's situation?
- If I were in these parents' shoes, what might I feel or want to do? How would I answer the same question for the child(ren), extended family members, family friends, or the community?
- How important is my own spiritual/religious value system to me, and how hard might I fight to have it respected? Does this tell me anything about what the family is experiencing?

- How open am I to accepting that my view of the “right” choice might be different from the view of the “right” choice held by various family members?
- How open am I to accepting that my view might be different from the state’s view? Am I willing to be courageous and stand up for my view or for the clients’ views if they are different from what the law requires?
- Do I agree with what the codes suggest I do in this situation? Do the codes help me to be the preferred family practitioner I want to be?
- Which possible courses of action best fit my preferred view of myself as a family practitioner? Which personal and professional values are activated in me as I face this dilemma: caring, compassion, judgment, courage, humility, connectedness? Other values or virtues?
- Which choice am I willing to live with? How ready am I to make a choice and live with the uncertainty of its outcome?

When infusing your ethical decision-making with virtue ethics, you bring yourself deeply into the ethical decision-making process. How central to the decision-making process are you willing to place yourself as a family practitioner? Is it possible to be too central? What would that look like for you?

Participatory ethics. What might an ethical decision-making model based on participatory ethics look like? The specific process we will propose here is based on the **feminist ethical decision-making model** constructed by Rave and Larsen (1995) and the model for *the vulnerable therapist* described by Coale (1998). Participatory ethics retains much of the structure of a rational-evaluative process and still requires the self-reflection of a feeling-intuitive process. But instead of leaving ethical decisions completely in the hands of the family practitioner, participatory ethics focus on the relational, co-constructed knowledge that comes from active involvement of clients in the decision-making process. The model may be applied as follows:

1. Recognizing a problem: Problem recognition comes from a combination of perspectives. The family practitioner’s personal and professional knowledge, competence, and “gut” feelings are combined with the clients’ local knowledge and “gut” feelings in an effort to understand and clarify the ethical dilemma. The family practitioner’s task is to open space within the counseling or therapy sessions for the clients to inform the ethical process. Space is opened by actively encouraging input, feedback, and the sharing of client perspectives on the counseling process.

2. Defining the problem: Once you and your clients come to an understanding of the ethical dilemma that is present, each party contributes to a conversation about how to define and frame the problem. All the questions posed during the virtue ethics model related to stakeholders and feelings are relevant here. What extends the virtue ethics model is the inclusion of the clients in defining the problem as well as understanding the cultural values that you as family practitioner bring to the process. From a postmodern perspective, the cultural “selves” of family practitioners are not simply acknowledged and managed, but are embraced and brought into the conversations with clients. In this way, the emphasis is on situating our “selves” as cultural beings within the decision-making process, highlighting, not hiding, such influences. The family practitioner trusts the family to handle the very human, ethical struggle in which the practitioner and all other parties are engaged.

3. Developing solutions: This step of the participatory ethics model is very similar to steps 5 and 6 of the virtue ethics model. Again, the defining element for the participatory model is valuing the client’s conceptualizations of solutions and their reaction to each possibility. In developing solutions, consultation is integral to the process and

may involve inviting still other voices into the collaborative conversations held with clients.

Even though we are presenting the participatory ethics model in linear steps, in this model, like most approaches to family systems, the steps are recursive—with each step influencing and being influenced by the others. Further, it is not uncommon for each additional step to require adjustments and reconsiderations in earlier steps. All of this is especially true when integrating consultation into the process. Consultation may require circulating back to previous conversations as well as being integrated throughout the rest of the process. In participatory ethics, no single step can be a one-time occurrence in the process of ethical decision-making.

4. Choosing a solution: Just as the virtue ethics model values self-reflections at both the rational and emotional levels, participatory ethics values conversations with clients about their processes and reactions, rationally and emotionally, to possible solutions. Respect for self-agency is central to the dialogue and the goal is to select a solution that all parties, including the family practitioner, can support.

5. Reviewing the process: This step starts with the family practitioner openly reflecting on all aspects of the ethical decision-making process in which she or he is engaged.

- Would the family practitioner want to be treated this way?
- How are the values and personal characteristics of the family practitioner influencing the choices that have been made?
- What has been the effect of the family practitioner's power in these ethical conversations?
- Have the clients' perspectives been taken into account?

(Rave & Larsen, 1995)

To open oneself to deliberate reflection may serve to “check” the credibility and trustworthiness of the constructed solution. It also models for clients the importance of self-reflection in this participatory process.

6. Implementing and evaluating the decision: Participatory ethics recognizes that ethical dilemmas force everyone into a state of vulnerability and sometimes anxiety (Coale, 1998). It is a model in which all parties participate in both the decision-making and the consequences of the decisions made. The process cannot end with implementation of a decision: Evaluation and regular re-evaluation are essential.

- Does the outcome continue to feel right?
- How has the decision affected the therapeutic process?
- Is the solution we chose the best we can do?

7. Continuing reflection: The last step in the participatory ethics model returns the family practitioner to self-reflection and a consideration of the ethical decision-making process in a removed or disengaged space.

- What did I learn from the process about myself and about the participatory process?
- How might this experience affect me in the future?
- How, if at all, have I changed as a result of my participation in the process?

Not only is examination of the outcome for the client required, but so is reflection on the decision's impact in relation to the family practitioner. Each and every decision made extends into the future, well beyond the current clients' situation. Valuing personal/professional experience of the process through continued reflection facilitates greater awareness and learning for you as a family practitioner and enhances the ethical process with future clients.

We have presented only three ethical decision-making models. What reactions do you have to each of them? What feelings surface? Your thoughts and feelings are speaking to the kind of person you want to be as a family practitioner.

Commonly Discussed Ethical Dilemmas in Family Practice

We will now shift to a discussion of some of the most commonly encountered, or constructed, ethical dilemmas when working with families and family members. Whole texts have been written addressing ethics in family practice (AAMFT, 1998, 2001b; Golden,

2004; Herlihy & Corey, 2006; Vesper & Brock, 1991; Wilcoxon, Remley, Gladding, & Huber, 2007; Woody & Woody, 2001): The most common dilemmas that surface are related to confidentiality, multiple clients, informed consent, and gender and multicultural issues. We now will delineate some of the issues that family practitioners have faced in these four areas. This is not a comprehensive list and there are no easy answers to propose. We note these issues so that you will know that you are not alone when you are confronted with similar ethical problems.



A Learning Challenge

Family practitioners actually have very little time to reflect on their place in ethical decision-making processes. Managed care has not found a way to reimburse self-awareness. Here's a challenge for you: Take a practicing family counselor or therapist to lunch and ask her or him some of the questions we have asked you to consider. When finished, ask your companion what it was like to spend 30 to 60 minutes in conversation with you about such topics? Now, if you succeed in being genuinely curious during your questioning, we are willing to bet that the majority of family practitioners will say something like, "You know, I don't get to do this very often: This was great! I wish I could find more time to do this." Reflective conversations like this engage professionals in self-care, help to prevent burnout, and encourage ethical practices. ●

Confidentiality. Trust in any therapeutic relationship is intimately tied to the guarantee of **confidentiality**. The ability to speak openly and with emotional honesty is supported by a trusting relationship that ensures a respect for privacy. This right to privacy in psychotherapy is recognized in all fifty states and by the federal government in HIPAA standards and Supreme Court decisions. But what degree of privacy can a family counselor or therapist truly uphold? Confidentiality can be an enormous responsibility for a practitioner working with just one person. When working with multiple people in one room, the challenges to confidentiality increase exponentially. It is in the subtexts of confidentiality and family practice that the ethical issues become extremely difficult, especially in conceptualizing the client(s) served; providing informed consent; and handling relational matters in an individual context.

Conceptualizing the client(s). If one's practice consists solely of individual clients, the definition of client is clear: It is the person sitting across from you in a counseling or therapy session. The more systemically oriented therapies, however, embraced the family-as-a-whole as *the* client—with many, like Whitaker, insisting that all members of the family be present before therapy begins. The first practitioners of **Bowen family therapy**, **structural family therapy**, and the various strategic models emphasized family dynamics in which individuals were little more than parts of an interaction or actors in a systemic drama. In the last decade, there has been a concerted effort to re-instate the individual into family systems theories, with the postmodern models tending to conceptualize families and clients as those individuals who are in conversation about any given problem. In these later models, those in conversation about a problem determine who needs to be involved in "family" sessions.² What happens to confidentiality in these shifting conceptualizations of family is at the heart of one whole set of ethical concerns? Even with in systemic orientations, there are those who

choose to approach families not as one client but as multiple clients, a perspective that is assumed in most state laws.

Remley and Herlihy (2005) indicate that laws hold individuals, not the collection of people called a “family,” accountable for actions that may violate the freedom of others. This should not be surprising in a society that values individualism over collectivism. But it also has a similar impact on the more practical standards of practice involved in professional codes.

A clear example relates to the use of case notes in family practice. If the client is *the family*, there is *one* client. Logically, the family practitioner would write *one* set of case notes for the *one* client. This is not necessarily so: IAMFC (2005), for example, suggests that “in situations involving multiple clients, couple and family counselors provide individual clients with parts of records related directly to them, protecting confidential information related to other clients who have not authorized release” (p. 6). In both the law and this professional code, one family of five equals five individuals. To meet HIPAA standards, each individual has to have his or her own records, notes, consent, and other individual data. Having multiple clients in counseling or therapy has a direct impact on informed consent.

Informed consent. AAMFT (2001a, 2001b) notes that confidentiality and informed consent are interrelated. Specific applications of confidentiality and its limitations need to be discussed early and often in treatment. Further, the family practitioner and the clients need to agree not only on those limitations mandated by law, but also those that the therapist may set for effective treatment.

ACA (2005) echoes this position, calling on

... counselors [to] clearly define who is considered “the client” and discuss expectations and limitations of confidentiality. Counselors seek agreement and document in writing such agreements among all involved parties having capacity to give consent concerning each individual’s right to confidentiality and obligations to preserve the confidentiality of information known (p. 8).

IAMFC (2005) supplements the ACA code, suggesting that “marriage and family counselors have an obligation to determine and inform counseling participants who is identified as the primary client . . . (and) make clear when there are obligations to an individual, couple, family, third party or institution” (p. 5).

Even if you are successful in negotiating a contract that identifies the client as the whole family, issues of confidentiality still persist. The limits on confidentiality with a whole family are the same as those that exist in group counseling or therapy: The practitioner cannot guarantee that members of the family won’t disclose essentially private information to others outside of the session. This potential dynamic also weakens, if not removes, the legal benefit of privileged communication (Remley & Herlihy, 2005). In short, communication between a client and yourself as counselor is valued legally, in that a court of law may find the benefits of protecting privacy outweighs the public’s need to know the content of therapeutic conversations. However, once another person is present in the room, as with couple and family work, the legal protection of privileged communication no longer exists. If clients viewed their individual rights and protections from a legal perspective, agreeing to family counseling might not be in their individual best interest.

Handling relational matters in an individual context. Given the propensity of both the law and professional codes to designate the client as each individual, there are a host of relational concerns that must be clarified and addressed before counseling or therapy can begin. Among these issues are: “extramarital affairs, commitment to the relationship, sexual activities/preferences/orientations, criminal activities, substance use, and mental states

suggesting the risk of violence and dangerousness to self or others” (Woody & Woody, 2001, p. 31). Similar issues for children and adolescents must be considered, as well as “behaviors that pose potential risk to the child’s health and welfare, e.g., truancy, substance use, gang affiliations, etc.” (p. 31).

From the IAMFC (2005) Code of Ethics: “Marriage and family counselors inform clients that statements made by a family member to the counselor during an individual counseling, consultation, or collateral contact are to be treated as confidential.” (Section B-7, pp. 8–9). If both your professional approach and your personal values are grounded in the idea that joining with “family secrets” does not promote the welfare of the family, what do you do with this predicament? Again, from IAMFC (2005), Section B-7:

. . . the marriage and family counselor should clearly identify the client in counseling, which may be the couple or family system. Couple and family counselors do not maintain family secrets, collude with some family members against others, or otherwise contribute to dysfunctional family system dynamics. (p. 9)

All of the family practice codes support individual confidentiality, but only if such actions do not contribute to maintaining unhealthy family dynamics. There is not a great deal of direction in these guidelines for handling ethical dilemmas related to the common issues we have discussed. In holding to individual confidentiality within the context of family counseling or therapy, obvious concerns surface with the principle of beneficence and your obligation to promote client welfare.

Gender and cultural issues. Feminists long have noted that the *normal* family, across cultures, has not always been so good for women. A gender perspective in ethics reminds us that patriarchy has real effects on both genders and has to be taken into account when people are engaged in ethical decision-making. Feminists also remind us that patriarchy is just one form of oppression and that discrimination on the basis of race, gender, disability, religion, age, sexual orientation, cultural background, national origin, marital status, and political affiliation still have to be factored deliberately into ethical stances.

Because discrimination, oppression, and marginalization have been such a strong part of the social contexts in which we live, a consideration of gender and cultural perspectives in ethical decision-making is essential. In spite of what may be codified in law, there are, indeed, multiple perspectives on “the family” that emanate from various cultures. Western cultures tend to portray the nuclear family as normal, limiting it to parents and their children. If the law and western culture want to recognize aunts, uncles, cousins, grandparents, and ancestors as part of a family system, these family members are called **extended family**. Such languaging, easily as much as physical separation, distances individuals from their natural support systems. In cultures in Africa, Asia, the Middle East, and South America, as well as in some Native American societies, many different members—and sometimes multiple wives—and multiple generations are included in the conceptualization of family. Such a conceptualization of family often can bridge the physical distance between individuals and create a very different ethical stance in the world.

Even in western cultures today, the forms that constitute family vary widely from the nuclear model that has been enshrined as normal. Functional families are led by single mothers, single fathers, grandparents, single gay fathers, single lesbian mothers, gay co-parents, lesbian co-parents, and cohabitating parents who have never married. Any of these families may also include biological children, children in foster care, children from surrogate parents, or adopted children. In the United States, we are experiencing a cultural war in relation to the debate about what constitutes marriage and the family. It is a war that recognizes that the definitions of both have already changed. Because there is no evidence of inherent harm in any of these different couple and family arrangements, family practitioners have an affirmative

moral and ethical responsibility to support and care for families in all of their diverse forms (Dworkin, 1992).

Think about your own family-of-origin. What perspectives on family, culture, and gender were contained in your upbringing? What were the virtues and limitations contained in your family's worldview? How many kinds of families and cultural perspectives have you encountered in your lifetime? What experiences, if any, did your family-of-origin have of discrimination or oppression based on cultural differences or because your family had a different structure than the heterosexual nuclear family that has been declared "normal" in the dominant culture?

Professional Regulations and Legal Requirements

Stukie and Bergen (2001) note that:

Professional regulation has to do with two things. The first is licensure or certification, which involves deciding who is allowed to perform a certain function of, of all those performing it, who can use a particular title. The second involves setting the standards of acceptable practice. (p. 2)

Although we tend to associate professional regulations with the professional boards of each state, there are actually many groups that get involved in the process of safeguarding both the public and the profession. Among these groups are voluntary professional organizations, state regulatory agencies, federal regulatory agencies, the judicial system, third-party payers (that is, insurance companies and managed care companies), national regulatory associations, and sometimes international regulatory entities. Again, each of these groups has a recursive influence on the others: We often find, for example, that there is very little difference between the legal requirements for the practice of marital and family therapy and the certification requirements of various professional organizations. Indeed, it is not uncommon for licensure requirements to include specific professional certifications as a first step toward licensure.

All of the professional regulation agencies attempt to address three questions related to family practice: What is family counseling or therapy? How is competence as a family practitioner assessed and measured? How valid and relevant are those competency measures for the protection of consumers?

Stukie and Bergen (2001) suggest ten principles that should be considered in the development of professional regulations in the field. Among their recommendations are a comprehensive model based on effective professional development and growth, rather than minimal competence; fully funded, staffed, and empowered regulatory boards; integrated regulatory boards that address all aspects of psychotherapy, rather than separate disciplines; ongoing competency assessments that are demonstrable in spite of the costs and logistical problems that may be involved; standards of practice that detail requirements related to advertising, record keeping, informed consent, and other legal expectations for practitioners; disciplinary procedures that are immediately responsive to the needs of clients and practitioners; and the right of consumers to choose the mental health providers of their choice.

The field of psychotherapy in general, and couple and family therapy in particular, is no longer dominated by psychiatrists and doctoral-level psychologists. By far, most of the couple and family practitioners are now trained at the masters level and have completed approximately two years of supervised practice before being evaluated and obtaining a license. This dramatic change has taken place in just the last thirty to forty years. The number of people seeking psychotherapeutic services is also on the rise. To protect consumers and define professional identities and competence, professional regulations and state laws will become increasingly specific in their definitions and requirements for practice. Although

it is impossible to legislate virtue, morality, good judgment, or clinical skills, state laws and professional regulations forge a professional covenant with the public. These regulations always are based on the application of principle ethics—and the principles always reflect the dominant community standards of the state or organization enacting them.

Indeed, state and national laws often take certain moral, ethical, and professional issues out of the hands of the practitioner. Helping professionals in most states, for example, are mandated to break confidentiality and take affirmative, prescribed actions if (a) clients are dangerous to self, to others, and, in some states, to property; (b) clients engage in or suffer child or elder abuse; or (c) the helping professional is otherwise required to do so by courts in the administration and application of specific laws. Such mandates are considered in law to be so serious that the covenant with consumers requires a consistent outcome every time (that is, reporting)—even if the outcome can be demonstrated to create more problems than it solves.

State and federal legal requirements also have created standards of care for psychotherapeutic practice. This is especially true for those professions and professionals who must operate under HIPAA requirements and standards. Failure to meet professional standards of practice is the most common grounds for malpractice and incurred liability. It is what makes professional liability insurance, a necessity these days and increasingly expensive to purchase.

Conclusion

Ethical practice is supported by an understanding of ethical principles, virtues, the law, professional codes of ethics, ethical decision-making models, and you. If you are in the presence of your client(s), you are engaged in an ethical encounter—from the time you prepare for an upcoming session through completion of your weekly case notes. During all aspects of the encounter, you have the potential to harm or promote the well-being of your client(s). An ethical practitioner recognizes the subtle, nuanced ways in which counseling or therapy influences our clients. Ethical encounters highlight the importance of personal awareness and presence in therapeutic relationships.



Where to Go from Here

You can access the main ethical codes related to counseling, psychotherapy, and family practice at the following websites:

American Association for Marriage and Family Therapy:

<http://www.aamft.org/resources/LRMPlan/Ethics/ethicscode2001.asp>

American Association of Pastoral Counselors:

<http://www.aapc.org/ethics.cfm>

American Counseling Association:

<http://www.cacd.org/codeofethics.html>

American Psychological Association:

<http://www.apa.org/ethics/code2002.html>

International Association of Marriage and Family Counselors:

http://www.iamfc.com/ethical_codes.html

National Association of Social Workers:

<http://www.socialworkers.org/pubs/code/code.asp>



Recommended Readings

- American Association for Marriage and Family Therapy. (1998). *A marriage and family therapist's guide to ethical and legal practice: Answers to questions on current ethical topics and legal considerations in MFT practice*. Alexandria, VA: Author. This short booklet, part of AAMFT's legal and risk-management program, uses the AAMFT code of ethics to address many of the current issues in the practice of marriage and family therapy.
- American Association for Marriage and Family Therapy. (2001). *User's guide to the AAMFT code of ethics*. Alexandria, VA: Author. This book provides vignettes and commentary for each part of the AAMFT code. For programs based on an AAMFT model, this is an excellent casebook.
- Coale, H. W. (1998). *The vulnerable therapist: Practicing psychotherapy in an age of anxiety*. New York: Haworth Press. Helen Coale has written a compelling ethical text on the value of virtue and participatory ethics. Her foundation in postmodern, social constructionism places her work on the cutting edge of family practice ethics.
- Cohen, E. D., & Cohen, G. S. (1999). *The virtuous therapist: Ethical practice of counseling and psychotherapy*. Pacific Grove, CA: Brooks/Cole-Wadsworth. This is the single best book available on virtue ethics. For those who want to review the essential virtues for professional helpers as well as consider applications in practice, Cohen and Cohen have covered the waterfront.
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Endnotes

¹HIPAA stands for the *Health Insurance Portability and Accountability Act* of 1996 and, among other things, it sets very strict standards for how patients' medical records may be used. By extension, these requirements

apply to any licensed person or group accepting third-party payments and/or filing reports with third-parties.

²For an example of such a session in action, see Bitter, Robertson, Roig, and Disque (2004).