Ethical Decision Making in Family Therapy

MARY JO ZYGMOND, Ph.D.a
HARRIET BOORHEM, M.S.b

aDepartment of Counseling and Special Education, The University of Akron, Akron OH 44325.
bDepartment of Counseling and Guidance, East Texas State University, Commerce TX 75428.

In family therapy, effective clinical decisions promote the welfare and interests of the family and its individual members. However, the needs of the family and its individual members are often in conflict. Resolving this conflict is an ethical as well as a therapeutic dilemma. Kitchener has developed a model of ethical decision making that we have found useful in teaching students and supervisees how to resolve conflicts between the family’s needs and the needs of its members. The purpose of this article is to discuss this model and show how it can be applied to clinical decision making.

The AAMFT code of ethical principles (1) states that marriage and family therapists “are dedicated to advancing the welfare of families and individuals” (p. 1). However, clinical interventions often promote the welfare of the family unit while producing harmful consequences for some family members. The opposite pattern may also occur. Therefore, it is imperative that therapists, when formulating clinical interventions, consider the possible benefits and costs for the family unit and its members as the result of the clinical intervention. Choosing clinical interventions that promote the welfare of the family and its members, while minimizing the harmful consequences that may occur, is both an ethical and a therapeutic decision.

Many articles have been written in recent years about the role of ethics in marriage and family therapy (2, 6, 8, 10, 16, 18, 20, 22). These articles have examined such issues as confidentiality, privileged communication, family secrets, use of paradoxical techniques, and the role of therapists’ values within the treatment context. Although these articles have offered valuable discussion about the role of ethics in marriage and family therapy, none has offered family therapists useful guidelines that enable them to evaluate their clinical decisions.

Kitchener (see 11, 12, 13) has developed a model of ethical decision making that we have found useful in teaching students and supervisees how to evaluate their clinical decisions. Using this model, students and supervisees can evaluate the possible consequences of their clinical decisions, that is, the effects they may have on the family and its members.

Using a model of ethical decision making when formulating and evaluating clinical decisions is not commonplace. In the family therapy field, the accepted practice is to rely on acknowledged schools of family therapy. This practice has promoted conflict between family therapists about the most effective treatment approach. For instance, when strategic family therapists work with a couple that has established a complementary relationship, they often prescribe the symptom (that is, the dysfunctional, one-down behavior). The purpose of prescribing the symptom is to activate the recid factors within the given set of relationships such that the system renews itself (9, p. 309). In other words, the couple will respond to the absurd intervention by changing their complementary relationship to a more symmetrical one.

Feminist therapists question this approach (5, 15). They argue that describing families as patterns of interactions and relationships indicates that husbands and wives are equal partners. According to Goldner (5), this assumption “obscures the difference in power between men and women, implicitly reducing a political and social problem to a technical operation” (p. 20). Consequently, marital interaction patterns may change, but the problem of gender inequality remains.

The focus of feminist therapy is to equalize the power differential between husbands and wives such that spouses can relate as individuals who are truly equal. When working with couples in which the wife is in a one-down position, feminist therapists “facilitate the growth of a strong, competent woman who has enhanced control over resources” (15, p. 8). Furthermore, women and husbands examine the effect gender socialization has had on their perceptions and behaviors.

Through this self-examination, spouses are better able to relate to each other as equals.

We believe that various family therapy approaches, if used appropriately, can promote the welfare of families and individuals. However, it is important to teach students and supervisees that relying solely on a therapeutic approach may result in unethical decisions. We are all aware of situations in which our actions or our colleagues’ actions were based on an accepted therapeutic approach, yet they produced harmful consequences for the family or some of its members. By teaching students and supervisees to evaluate their clinical decisions, using Kitchener’s model of ethical justification, they can examine their clinical decisions from an ethical perspective:

ETHICS and VALUES

In order to evaluate their clinical decisions from an ethical perspective, students and supervisees need to differentiate
between values and ethics. The importance of differentiating between values and ethics lies in the following: Values are not always ethical. Values are "enduring beliefs that specific modes of conduct or end-states of existence are personally or socially preferable to opposite modes of conduct or end-states of existence" (19, p. 5). For example, prior to the Civil War, southern slave owners followed personal and group values, which stated that owning slaves was socially and economically preferable to not owning slaves. Even Biblical teachings were used to substantiate their beliefs and actions.

Ethics, however, is a system of ethical values and ethical theories, which are used to determine what is right in general, not what promotes the welfare of a specific individual or group while harming other individuals or groups. Like values, ethical values are enduring beliefs about specific modes of conduct or end-states of existence, which are preferable to opposite modes of conduct or end-states of existence. However, they are different from values. When ethical values are acted upon, they can protect the interests and welfare of all people involved (19).

When the ownership of slaves was examined from an ethical perspective, as opposed to an economic or social perspective, the abolitionists argued that the slaves' human rights were being violated. Although the owning of slaves protected the welfare and interests of the slave owners, their actions were harming an entire population. Consequently, an issue in the Civil War was to free the slaves.

Students and supervisees must learn that adhering to their personal and group values may not always result in clinical decisions that protect the welfare and interests of their clients. Becoming aware of their personal and group values and learning how they differ from ethical values are important components of their training.

**MODEL OF ETHICAL DECISION MAKING**

Clinical decisions emerge from the interweaving of a complex set of circumstances consisting of the therapist's theoretical orientation, the idiosyncratic circumstances of the family, the personal values of the therapist that are often beyond awareness, the relationship between the therapist and the family, and the element of timing. These various factors cannot be reduced to a simple process of "If A, then B." Teaching students and supervisees to evaluate their clinical decisions by using a model of ethical justification is not an attempt to provide them with correct answers. Kitchener's model provides useful guidelines that students and supervisees can use to examine their own personal and group values, to evaluate their clinical decisions, and to consider the complex set of circumstances that influence a clinical decision. It cannot provide answers that are unequivocally correct.

Kitchener's model of ethical justification is based on the assumption that ethical decisions are dependent upon the situation. In other words, a decision that is considered ethical under one set of circumstances may not be considered ethical under a different set of circumstances. The model distinguishes between two levels of ethical reasoning: the intuitive level and the critical-evaluative level. The critical-evaluative level is further divided into three distinct levels: ethical rules, ethical principles, and ethical theory. The levels are distinct and mutually exclusive, with the lower levels being derived from the higher levels (see Figure 1).
The process of ethical reasoning is hierarchically tiered. When an individual is unable to resolve a situation at a lower level of reasoning, such as the intuitive level, he or she can move to a higher tier. As an individual moves to higher tiers, he or she is required to engage in increasingly more general and abstract levels of ethical reasoning. Knowledge gained from reasoning at the critical-evaluative level can be used to clarify, modify, or change personal beliefs, perceptions, attitudes, and behaviors.

**Intuitive Level**

The intuitive level consists of a firm set of ethical beliefs concerning what is right or wrong, good or bad. Kitchener (11) has labeled this intuitive set of ethical beliefs, ordinary moral sense. Ordinary moral sense is not intrinsic within the individual; it is developed. Furthermore, its development is dependent upon individual experience, ethical knowledge, and level of ethical development (7). Ordinary moral sense is not a static set of beliefs concerning what is right or wrong, good or bad. It can be changed to accommodate new experiences and new ethical knowledge.

When individuals operate on the intuitive level, their responses are influenced by the facts of the situation and ordinary moral sense. Ordinary moral sense is crucial when making everyday decisions because it allows individuals to take immediate, prerereflective action (12). For instance, ordinary moral sense is used by experienced therapists when confronted with a physically abused child. On the basis of prior experiences and available ethical knowledge, experienced family therapists can act immediately to protect the child. Beginning therapists may lack the experience or ethical knowledge necessary to take immediate, prerereflective action. Thus, they would consult with a supervisor or their professional code of ethics before taking action.

Individuals are more likely to act unethically by ignoring their moral sense than by following it (11). However, to rely exclusively on the intuitive level can be dangerous. First, situations occur in which an individual's ordinary moral sense does not result in ethical decisions (that is, decisions protecting the welfare and interests of all people involved). Such a situation existed prior to the court's ruling that children's welfare took precedence over adults' right to privacy. Having been taught the importance of maintaining confidentiality, most therapists believed they were acting ethically when they did not report alleged incidents of child abuse. Using ordinary moral sense, they chose to protect the adult client's right to confidentiality. The problem inherent within this decision was that, if treatment was unsuccessful, the child abuse continued. The parent's right to privacy was protected, but at great cost to the child's welfare.
A second reason for not relying exclusively on the intuitive level is that some situations are so unique that ordinary moral sense provides no direction (11). In unique situations, an individual's sense of right and wrong, good and bad, is called into question. Furthermore, the prereflective actions normally used do not seem appropriate. In the 1950s, such situations confronted therapists who recognized the effect of the family on schizophrenic children. The accepted therapeutic stance was to treat the individual; the common ethical practice was to protect the confidential nature of a patient-therapist relationship (3, 21). Yet some therapists chose not to rely on their ordinary moral sense to treat the schizophrenic individually. Instead, they chose to treat the entire family because they had observed the tremendous impact that families had on their schizophrenic member (17).

The final and most important reason for not relying solely on the intuitive level is that it does not allow individuals to critically evaluate their decisions (11). Use of the critical-evaluative level enables individuals to evaluate the possible consequences of their decisions, thus improving their ability to make decisions that protect the welfare and interests of the individuals involved while minimizing the costs. The critical-evaluative level also provides a means by which individuals can examine their beliefs concerning what is good or bad, right or wrong.

Critical-Evaluative Level

As depicted in Figure 1, the critical-evaluative level consists of three hierarchically tiered levels of ethical reasoning. These levels include the following: ethical rules, ethical principles, and ethical theory. The rationale for this ordering is that ethical rules are derived from ethical principles, which in turn are derived from ethical theory. When a clinical decision cannot be reached at a lower, more specific level, individuals need to use a higher, more abstract level of ethical reasoning.

Ethical Rules

The first level of ethical justification is ethical rules. Ethical rules prescribe standards of behavior that individuals and groups use to guide and judge their behavior as well as other peoples' behavior. Ethical rules consist of professional codes of ethics and other sets of rules or laws that protect the welfare and interests of particular individuals and groups (for example, the AAMFT Code of Ethical Principles and the Ten Commandments). In situations in which ethical rules fail to address a particular issue, or the ethical rules are in conflict, reference to ethical principles is necessary.

For instance, the AAMFT Code of Ethical Principles (1) states that marriage and family therapists "are dedicated to advancing the welfare of families and individuals" (p. 1). Yet it does not clarify how therapists are to promote the welfare of a family and its individual members when the needs of the family unit are in conflict with the needs of a family member.

Ethical Principles (Ethical Values)

Ethical principles are enduring beliefs about specific modes of conduct or end-states of existence that, when acted upon, protect the interests and welfare of all people involved. The five ethical principles identified as most critical for members of the helping profession (see 11, 12, 13) include the following: autonomy, nonmaleficence, beneficence, fidelity, and justice.

The principle of autonomy states that individuals have the freedom of action, choice, and thought as long as their behavior does not infringe upon the rights of others. This principle implies that even if we disagree with an individual's choice, we are obligated to accept it as long as the choice does not infringe upon the rights of others. "To do otherwise is to acknowledge that others may interfere in our lives when they believe us to be mistaken" (12, p. 20).

Nonmaleficence can best be described by using the maxim "Above all do no harm." Kitchener (11) defines harm as (a) engaging in activities that have a high probability of hurting others; (b) infringing upon the rights of others; and (c) intentionally inflicting physical and psychological pain on others. This definition alone raises several ethical concerns. For example, in therapeutic treatment, how much psychological pain is justifiable? Is it justifiable to use new treatments before their reliability and validity have been confirmed? And, is it justifiable to make a therapeutic decision that in the short run may be considered beneficial, yet in the long run may produce negative consequences?

The answers to these questions, like answers to other clinical questions, depend upon a complex set of factors. For instance, one factor that influences the answer to the question "How much psychological pain is justifiable?" is the function of the pain. Pain in response to a bad situation can be adaptive, not pathological, especially if this pain accompanies the healthy steps needed to resolve the problem (14, p. 19).

The third principle, beneficence, involves contributing to the health and welfare of others. The concept of beneficence and benefitting others is critical to the field of marriage and family therapy because marriage and family therapists are "dedicated to advancing the welfare of families and individuals" (1, p. 1).

The fourth ethical principle, fidelity, involves being faithful, keeping promises, being loyal, and being respectful of the person's rights, including the right to privacy. Fidelity is essential to voluntary relationships, such as therapeutic relationships. Without fidelity, no meaningful relational bonds can be formed (11, 12).

The last principle, justice, implies fairness and is based upon the assumption that people need to be treated as equals.
*Equal persons have the right to be treated equally and nonequal persons have the right to be treated differently if the inequality is relevant to the issue in question. If the inequality is irrelevant to the issue in question, then treatment must be equal* (11, p. 49). In other words, individuals must be treated as equals unless their differences justify different types of treatment.

An example of differences justifying different treatment is the sexual abuse of a child by an adult family member. When this situation has been viewed systemically, the sexually abused child has been perceived as an equal partner in the family system because she or he participated in the sexual abuse (18, 20, 22). Consequently, family therapists who believe that a child "actively fulfills and maintains this role may opt to treat the [entire] family while allowing the abused and abusing member to remain in the home for the sake of more stable, enduring (i.e., systemic) change" (18, p. 13). The principle of justice calls this therapeutic rationale into question because children are unequal partners. They are unequal because of their status as children, their developmental level, and dependence on adult family members. Consequently, an abused child and other children in a sexually abusive family require differential treatment. Regardless of the systemic role a child has played in maintaining the sexual abuse, differential treatment must include protection from the abuser, even if this protection involves removing the abusing family member from the home.

Ethical principles take precedence over personal and group values. When individuals encounter situations in which their personal or group values conflict with ethical principles, their behavior needs to be guided by ethical principles. If they disregard these principles and act only upon personal and group values, their behavior could be considered unethical.

In addition to taking precedence over personal and group values, ethical principles are considered prima facie, a legal term that means that something (for example, a contract) establishes an obligation which must be upheld unless circumstances or other obligations call it into question. Similarly, an ethical principle must be upheld unless it is in conflict with other ethical principles (11). For example, when clients reveal intentions to harm themselves or others, the ethical principle, nonmaleficence, takes precedence over the principle of autonomy and fidelity (that is, the right to privacy). In these situations, therapists must assess the probability that clients will carry out their intentions. If therapists ascertain that clients are dangerous to themselves or others, the clinical decision they make must uphold the principle of nonmaleficence even if it infringes upon a client's right to autonomy or fidelity.

In the case of Tarasoff v. Board of Regents of The University of California, the California Supreme Court ruled that the psychologist and his supervisor acted irresponsibly when they failed to warn Tarasoff and her parents that Poddar, her former boyfriend, was planning to kill her. In making its ruling, the court affirmed that "the public policy favoring protection of the confidential character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others" (4, p. 836).

Looking at the Tarasoff case from an ethical perspective as opposed to a legal perspective, the authors agree that the actions of the psychologist and his supervisor were unethical. Although the psychologist determined that there was a high probability that Poddar would kill Tarasoff, neither he nor his supervisor took actions that adequately protected Tarasoff, her parents, or Poddar from harm. In other words, their clinical decisions did not uphold the principle of nonmaleficence.

**ETHICAL THEORY**

When ethical principles are in conflict, determining which principles are relevant to the particular situation requires the use of ethical theory. The use of ethical theory enables individuals to evaluate their decisions from a metalevel. From this metalevel, individuals can consider all possible consequences of their clinical decisions, not just the consequences they value.

Kitchener has delineated two ethical theories, universalizability and the balancing principle, which can be used when ethical principles are in conflict. *Universalizability* implies that an act is ethical only if "it can be unambiguously generalized to all similar cases" (11, p. 53). When applying this theory to clinical decision making, students and supervisees need to ask themselves three questions: (a) If I were in a similar situation, would I want my therapist to make this decision? (b) If my family were in a similar situation, would I want their therapist to make this decision? (c) If other people were in a similar situation, would I want their therapist to make this decision? If students and supervisees cannot answer an unequivocal yes to these three questions, their clinical decisions may be unethical.

In addition to universalizability, the ethical theory, the balancing principle, can be used. This principle states that when ethical principles are in conflict, an ethical decision is one that produces the least amount of avoidable harm to all individuals involved, even if the decision limits the amount of possible benefits received (13). When students and supervisees use the balancing principle, they weigh all possible benefits that their clinical decisions may produce against all possible costs. Thus, this procedure yields a clinical decision that produces the least amount of avoidable harm to all individuals involved.

**APPLICATION**

Kitchener's model can be used in both a classroom and in a clinical setting. The students and supervisees use the model
when their ordinary moral sense does not provide direction or when they want to evaluate their clinical options. The first step in this process is to examine the AAMFT Code of Ethical Principles. If the code addresses the situation, these rules may be followed if they protect the welfare and interests of all individuals involved. However, students and supervisees have discovered that in many situations the rules are in conflict, or they fail to address the issue adequately. Consequently, students and supervisees use the two highest levels of ethical reasoning to resolve the clinical dilemma.

Classroom Situation

The senior author first introduces her students to Kitchener’s model in a classroom setting. Here, the students apply the model to a variety of clinical dilemmas. Depending upon the nature of the clinical dilemma, students are asked to choose two or three clinical options they could take; they then use Kitchener's model to evaluate each option. Based on their analysis, they are to choose the option that best protects the interest and welfare of all individuals involved. A variation of this assignment is that the students evaluate the clinical decision that they would make if confronted with this dilemma.

Because many students believe that confidentiality is the most important, if not the only, component of a therapeutic relationship, the first ethical dilemma they are asked to resolve deals with the damaging nature of secrets. The students are asked to read the following clinical dilemma, choose two possible clinical options, evaluate these clinical options using Kitchener’s model; based on their analysis, they then choose the option that best protects the welfare and interest of all individuals involved.

A Clinical Dilemma

A 14-year-old boy with an extremely high I.Q. reveals in confidence that he hates his father but loves his mother and will stick by her and protect her. He says he is trying to get his parents separated by playing tricks on his father. He tells how he placed an earring in the car, a blond hair on his father’s coat, and slight traces of lipstick on his father’s shirt. His mother, he says, is getting terribly suspicious and she and his father quarrel over it frequently (21, p. 29).

The following analysis shows how one student, the second author, used Kitchener’s model to resolve this ethical dilemma:

My intuitive moral sense provides no guidelines for how to respond to this situation. Furthermore, the AAMFT Code of Ethical Principles (1984) does not address this issue. Based on my previous readings, I am aware that the information the boy presented is a secret due to “the relevance of the information for the unaware” (10, p. 298). In this situation, the boy’s behavior influences his parents’ perceptions of each other and their behavior toward each other. In order to resolve this situation, I will consider which of the following clinical decisions will best protect the interests and welfare of all individuals involved:

a) I will not disclose the information to the boy’s parents in hope that the boy will eventually share his secret with his parents or terminate his behavior.

b) I will require that the secret be shared with his parents.

The first option, keeping the secret, upholds the principle of fidelity. The advantage of not sharing the secret is that I will remain faithful to the boy and respect the boy’s right to privacy. Since fidelity is essential to a therapeutic relationship, upholding this principle is important. A disadvantage of allowing the boy to keep his secret is that I am supporting behavior that infringes upon the parents’ right to autonomy. Even if the boy stopped his deceptive behavior, his parents’ perceptions about each other and their behavior toward each other still would be influenced by the boy’s secret.

An advantage of the second option, revealing the secret, upholds the parents’ right to autonomy. If the secret were revealed, their perceptions and behavior would no longer be restricted by the son’s behavior. However, by revealing the secret, I would not be respecting the principle of fidelity; thus, my relationship with the boy could be threatened, if not permanently damaged.

In addition to the principles of autonomy and fidelity, the principle of justice is relevant. The parents’ lack of knowledge concerning their son’s behavior places them in an unequal position vis-à-vis their son. Thus, another disadvantage of keeping the secret is that the parents would remain in this unequal position.

Each of these options is based on different ethical principles. Not only are the options in conflict, but the ethical principles on which they are based are also in conflict. In order to resolve this dilemma, I chose to apply the balancing principle. When applying this theory, I asked myself the following question: Of the two clinical decisions, which one, if acted upon, would lead to the least amount of avoidable harm to all individuals involved? In order to answer this question, I weighed the possible benefits and costs of protecting the parents’ autonomy and their right to equal treatment versus the possible benefits and costs of remaining faithful to the boy. The results of my analysis was that if I allowed the boy to keep
his secret, even if he terminated his behavior, it would produce several avoidable consequences. First, his parents' autonomy would continue to be restricted. Second, they would remain in an unequal position vis-a-vis their son. And, last, my action would indicate to the boy that, when meeting personal needs, he does not have to consider the rights of others.

Recognizing these avoidable consequences, I determined that the harm created by allowing the boy to keep his secret was greater than any possible benefit the boy would receive if I remained faithful to him (that is, allowed him to keep his secret). Therefore, I decided that, in this particular situation, the appropriate clinical decision would be to reveal the boy's secret to his parents. In order to implement this decision, I would use "accountability with discretion" (10, p. 302). This stance requires that the boy and I plan the timing and the circumstances of the disclosure. This sensitivity to the boy's position would minimize the possible negative consequences resulting from the disclosure.

**Supervisory Situation**

In a supervisory situation, supervisees are asked to apply the model in certain situations: (a) when they are confronted with a clinical dilemma in which several viable options are available; (b) when they are uncomfortable with the supervisor's recommendations; or (c) when they or the supervisor have concerns about the clinical decision a supervisee wants to make.

The following is an example of how a group of supervisees resolved a clinical dilemma. The supervisees were three master-level students: Jan Eager, Cynthia Krstic, and Karen Hodge.

One of the supervisees had been working with a single-parent family for about 2 months. The family consisted of a 28-year-old mother who had recently divorced her husband after 10 years of marriage, her 10-year-old daughter who was the identified patient, and a 7-year-old son. Both the mother and her daughter had been physically and emotionally abused by her ex-husband. In addition, the mother and her daughter had a history of conflict. According to her mother, the daughter had always been a difficult child, whereas the 7-year-old son was perfect. In addition to family-related problems, the daughter had been involved in incidents involving the police (for example, staying out past curfew, shoplifting). During the daughter's latest court hearing for curfew violation, the mother informed the judge that she could not handle her daughter and wanted her permanently removed from the home. Because the Child Protective Services was involved with the family as the result of alleged child abuse charges, the court ordered a report from the supervisee about her treatment recommendations. The dilemma facing the supervisee was that the case-worker for Child Protective Services wanted the child to be permanently removed from the home, whereas her agency supervisor wanted the child to remain in the home.

When the group examined other facts of the situation, it learned that this was the first time the family had been in counseling; that the daughter had stated she did not want to leave her family; and that when the daughter had been placed in foster care on a temporary basis, she ran home to her mother.

After evaluating the two options, using Kitchener's model, the group decided that the first option, removing the child from her home, did not uphold the principles of nonmaleficence and beneficence. With the child's history of running away from foster placement and breaking the law, the group feared that this behavior would continue, or even escalate, and result in her eventual placement in a juvenile correction center. Furthermore, the family had been in therapy for only 2 months. The group believed that 2 months of therapy was an insufficient test of the family's ability and willingness to change. In summary, removing the child from the home would not help the family members learn more appropriate ways of relating to each other and resolving their problems.

When the group examined the second option, leaving the child in the home, it wondered if this option recognized the mother's right to autonomy. After all, she acknowledged her inability to deal with her daughter and was asking for assistance. Furthermore, leaving the child in the home could also be harmful if the family did not make the necessary changes. Her acting-out behavior could continue to escalate and result in arrest and incarceration.

In order to resolve this ethical dilemma, the group members decided to use the theory of universalizability. By imagining themselves in the daughter's position, in the mother's position, and in the son's position, they could examine the situation from different perspectives. Some questions they considered were as follows: If I were this child, would I want to be removed from my home? Under what conditions? If I were this mother, would I want the court to remove my child from my home? Under what conditions? If I were the daughter, what would be the most useful approach under these circumstances? If I were this mother, what would be the most useful approach under these circumstances? If I were the brother/sister, what would be the most useful approach under these circumstances? Similar questions were also applied to their own families and all generalizable cases.

By placing themselves, their own families, and other generalizable cases in this particular situation, they decided that the principle of nonmaleficence took precedence over the other principles. They could not guarantee positive results, but they could limit the amount of avoidable harm. The harm they believed that they could avoid was hasty choosing one of the clinical options without examining the family's ability to change. Therefore, they developed a third option, which recognized the mother's need to have temporary respite from her daughter, the daughter's wish to be with her family, and the supervisee's need to examine the family's ability to change.
The option they developed was that the daughter would be placed temporarily in a structured foster-care situation within the community. While she was in foster care, she would be allowed regular visits with her family and the family would continue with family therapy. The long-term treatment goal would be the reunification of the family. However, if this long-term goal was not attained, then other alternatives would be considered at that time. This plan would be discussed with the family, and, if possible, their approval would be obtained before submitting the plan to the court.

Other Applications

As mentioned earlier, we have observed that many beginning therapists have difficulty with the issue of confidentiality. They believe not only that maintaining confidentiality is the key to therapeutic success, but also, if they disclose information about the individual client to other family members or professionals, that the client will be irreparably harmed.

In order to help them recognize that maintaining confidentiality is not always in the client's best interest, we often advise students and supervisees to alter the balancing principle so that it reads: An ethical decision is one that produces the least amount of avoidable harm to all individuals involved, even if the decision limits the amount of possible benefits the individuals receive from the therapist. By looking at their decision from this perspective, beginning therapists can see that they are not the only persons who can help the client and that, in some situations, disclosing information that the client revealed in confidence is in the client's best interest.

For example, the senior author was supervising a student who was seeing a 15-year-old female. During the third session, the adolescent disclosed that she was getting drunk and using other chemicals on a regular basis. Based on her observations and knowledge of the situation, the senior author concluded that the adolescent needed to be evaluated for possible chemical dependence. However, the supervisee did not want to share this information with the parents, fearing that the adolescent would feel betrayed and would not return for treatment. Thus, the adolescent would be harmed by the therapist's decision to inform her parents.

When the student examined the supervisor's recommendation using Kitchener's model of ethical justification, he recognized the conflict between the principles of non-maleficence, beneficence, and fidelity. By applying the modified version of the balancing principle to the situation, he recognized that he was not the best person to deal with the adolescent's problem. He had no background or training in chemical dependency; consequently, he could not evaluate if the adolescent needed chemical dependency treatment. As a result of this analysis, the supervisee agreed that the parents should be informed.

The purpose of these demonstrations was to show how clinical decisions can be evaluated from an ethical perspective. In no way are we saying that the clinical decisions reached would be unequivocally correct in all situations.

SUMMARY

Clinical decision making is not a simple process of "If A, then B." Depending upon the situation, a clinical decision could be considered ethical or unethical. Consequently, clinical decisions require critical examination of therapeutic issues by using different levels of ethical reasoning. As designed, Kitchener's model of ethical justification provides increasingly more general and abstract levels of ethical reasoning. If a lower level does not provide the necessary ethical rationale, a higher, more abstract level can be employed. By systematically engaging in more general and abstract levels, students and supervisees can critically examine their clinical decisions.

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