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ETHICAL DILEMMAS IN MARRIAGE AND FAMILY THERAPY: IMPLICATIONS FOR TRAINING

The authors provide an overview of the various legal and ethical issues pertaining to mental health counselors engaged in marriage and family counseling and conclude with specific recommendations concerning the training of mental health counselors.

Increasing numbers of mental health professionals are practicing marriage and family counseling (Huber & Baruth, 1987; Margolin, 1982). If those engaging in marriage and family counseling have been educated primarily in programs focusing on individual and group counseling, various legal and ethical issues arising in marriage and family counseling may not have been included in this training (Huber & Baruth, 1987). As a result, traditionally trained mental health counselors may find it necessary to make difficult ethical decisions for which they are poorly prepared. Mental health professionals trained in marriage and family therapy may also encounter difficulty in this area if their training has been limited to the American Association of Marriage and Family Therapists Code of Ethics (American Association of Marriage and Family Therapists [AAMFT], 1986).

Huber and Baruth (1987) posited that individual counseling and marriage and family counseling differ on both conceptual and pragmatic levels. These differences center on the perspective regarding psychological dysfunction. In adopting a systemic (marriage and family) perspective, therapists view causes as circular, not linear (individual) (Aponte, 1985; Nichols, 1984). Individual symptoms are thus seen from the interpersonal context (Huber & Baruth, 1987) that serves as a regulating, stabilizing, and communicating function in that context (O'Shea & Jesse, 1982). This perspective focuses on the interaction between individuals rather than on the characteristics of a given person (Sluzki, 1978). When a person's actions, characteristics, or both are the focus of a therapeutic session, they are explored in terms of how these shape the actions and reactions of other members of the system (Huber & Baruth, 1987). Margolin (1982) suggested that this represents a conceptual change for individually trained mental health counselors in that the couple or the family is considered the active, whole unit.

In addition, ethical guidelines for individual and group counseling may not always be sufficient or even directly applicable to family therapy (Margolin, 1982). Miller, Scott, and Searight (1990) suggested that most ethical codes follow linear causality, and when mental health counselors encounter issues that are nonlinear in nature and involve the rights of more than one person, they may be unprepared to meet the ethical challenge. Even normally simplistic issues such as who the client is and the notion of client welfare can be

confusing in counseling families (Okun & Rappaport, 1980). Furthermore, ethical codes developed specifically for marriage and family counselors (i.e., AAMFT Code of Ethics [AAMFT, 1988]) are themselves often insufficient in dealing with the complex ethical issues encountered in family counseling (Green & Hansen, 1989).

The focus of this article is on reviewing the literature on the complex ethical issues that may arise in counseling families. These issues include defining the client, the welfare and rights of individuals versus those of the family system, issues of informed consent and manipulative therapeutic interventions, issues related to family members who decline to participate in treatment, confidentiality (including dealing with family secrets and differing therapist), and family values. The implications for training in mental health counseling are explored.

**ETHICAL ISSUES**

**Defining the Client**

The protection of client welfare is one of the primary obligations of the mental health counselor (Boszormenyi-Nagy, 1985; Margolin, 1982). A frequent ethical dilemma encountered in family therapy stems from the ambiguity regarding the identification of the client. In individual counseling the counselor is responsible for one person, identified as the client. In marriage and family counseling, this issue becomes more complex (Fenell & Weinhold, 1989). Deciding whose best interest is to be served can become confusing (Hines & Hare-Mustin, 1978; Margolin, 1982; Morrison, Layton, & Newman, 1982; Sider & Clements, 1982), especially when each family member, the relationship between members, and the system itself all need to be considered (Corey, Corey, & Callanan, 1984).

Part of the dilemma results from the fact that what promotes the welfare of one family member may not promote the welfare of another (Fenell & Weinhold, 1989; Jensen, Josephson, & Frey, 1989). In addition, clinical interventions that often promote the welfare of the family itself may not be beneficial to all family members (Hines & Hare-Mustin, 1978; Zygmond & Boorhem, 1989). Thus, the immediate ethical dilemma centers on identifying whose welfare the counselor is ethically bound to protect (Jensen et al., 1989; Patten, Barnett, & Houlihan, 1991).

This is not an easily resolvable issue. AAMFT (1988) stated that marriage and family therapists are committed not only to the advancement of the welfare of families but also of individuals. The family includes at least two major systems: the entire family and the individual members that make-up that family (Boszormenyi-Nagy, 1986). Systems theory, according to Sider and Clements (1982), suggests that every family problem is a problem for the individual family member.

Viewing the system or the relationship as the client is usually productive (Margolin, 1982). Some system purists would advocate that the client is the family and its needs always take precedence over those of individual family members (Watkins, 1989). Others have suggested that individuals may have to subordinate their own needs while the family needs are being met (Patten et al., 1991). Nonetheless, there is widespread disagreement regarding when the needs of the individual family members take precedence over the family’s needs. For example, for a fundamental change to occur in the family system, individuals may, as a by-product, experience distress. Hoffman (1981) suggested that this distress needs to be raised to a crisis level for change to occur. O’Shea and Jessue (1982) were concerned about how much distress any one member of the family should be required to tolerate so that the relationship system can experience long-term benefits. Huber and Baruth (1987) acknowledged that when seeking relational change the needs of the family system are usually primary for the marriage and family counselor. Individual needs are possibly equal but usually secondary. When the welfare of an individual is in jeopardy, however, Margolin (1982) and Huber and Baruth (1987) strongly recommended that individual needs take priority. In safeguarding an individual, however, the mental health counselor may be reinforcing that individual’s continued scapegoating and the dysfunction of the family system (Langsley & Kaplan, 1968).

All other things being equal, not harming others is generally a stronger ethical mandate than benefiting others (Kitchner, 1985). In Kitchner’s discussion on ethical decision making, she suggested that when the ethical decision is between potential risk and potential harm, the stronger obligation would be to avoid harm. Zygmond and Boorhem (1989) suggested that choosing interventions that benefit the family and, at the same time, minimize any harmful outcomes is an appropriate ethical and therapeutic decision.
Informed Consent

The mental health counseling profession's commitment to informed consent stems from concerns regarding the respect of client autonomy (Kitchner, 1986). Informed consent has been defined as gaining the client's consent to being involved in the counseling process (Stricker, 1982) and being informed of the procedures to be used and the possible risks and benefits of such approaches (Corey et al., 1984).

Because so much discussion surrounds defining the identity of the client in marriage and family counseling, informed consent of all members of the family becomes an important issue (Fenell & Weinhold, 1989; Margolin, 1982). If children participate in family counseling, it is recommended that they too be included in the informed consent process (Basel, 1989). This is particularly salient when the child is opposed to counseling (Morrison et al., 1982). Kitchner (1985) recognized that infants are not competent to participate in this process and that younger children may have limited abilities to give informed consent. Yet, including children in the process even if they are not competent to give formal consent is preferable to leaving them out (Margolin, 1982).

Huber and Baruth (1987) noted that frequently simple descriptions of procedures, possible experiences, and effects are sufficient to reduce most anxiety experienced by clients. More detail is particularly necessary when there are risks involved and possible negative as well as positive benefits (Jensen et al., 1989). Because of the differences in risks and benefits between marriage and family counseling and individual counseling, discussing the negative effects in family counseling is especially important (Huber & Baruth, 1987). Huber and Baruth (1987) also suggested that clients need to be warned of the possibility of negative outcomes for different family members to reduce the associated risks. Hare-Mustin (1980) recommended that counselors be explicit about the primacy of the relationship goals and the extent to which individual goals may be incompatible with the system goals.

Communicating a commitment as a systems advocate becomes an important component in informed choice procedures in marriage and family counseling (Huber & Baruth, 1987; Margolin, 1982). Therefore, if the position is incompatible with the values of the family or individual family members the degree of incompatibility and goals should be discussed (Hare-Mustin, 1980), and clients can make an informed decision about becoming involved in the counseling process (Leigh, Loewen, & Lester, 1986).

It is recommended that the following types of information be provided to marriage and family clients to help them make informed choices: (a) the procedures and goals of the mental health counselor, (b) any reasonable harmful effects or risks, (c) reasonable potential benefits, (d) qualifications, policies, practices, and theoretical orientation of the mental health counselor, (e) assurance that family members can withdraw their informed consent and discontinue counseling at any point, and (f) alternative referral sources for treatment (Hare-Mustin, 1980; Huber & Baruth, 1987; Margolin, 1982). Therefore, if risks are involved, informed consent guarantees that individuals will only be exposed to them voluntarily (Leigh et al., 1986).

Margolin (1982) was not convinced that even with an accurate portrayal of counseling procedures and practices that the counselors would be able to be truly objective. Huber and Baruth (1987) noted the need for counselors to carefully examine how their therapeutic orientations influence their informed consent practices. Some counselors believe that providing a great deal of information is detrimental to the therapeutic process (Haley, 1976). The degree of information specificity may be determined by theoretical orientation.

Nevertheless, informed consent can provide families with a cognitive readiness for some of the discomfort and anxiety they may experience (Jensen et al, 1989). Informed consent for Jensen et al. (1989) involved more than just enabling families to make informed decisions—they also believed that it gave clients the opportunity to become involved in the decision-making process and facilitated the establishment of the therapeutic alliance.

The Treatment Unit

Controversial ethical issues arise around who should be included in the therapeutic process in marriage and family counseling. The most debated ethical issue revolves around the refusal to treat a family without all family members being present (Green & Hansen, 1986; Huber & Baruth, 1987; Patten et al., 1991). Although supporters of this practice acknowledge that its use is controversial (O'Shea & Jesshee, 1982), it is considered to be of therapeutic value (Napier & Whitaker, 1978; Wilcoxon, 1985). Gurman and Kniskern
(1981) suggested that when a systemic format is not used in counseling families it may well produce negative therapeutic outcomes rather than problem resolution. They also noted, however, that the effectiveness of particular treatments for particular clients has not been sufficiently tested empirically.

Ethical problems with this practice may involve the issue of voluntary participation (Margolin, 1982). Teismann (1980) questioned whether this constituted an ethical problem based on refusing to serve motivated family members. For mental health counselors employed in public agencies funded by tax dollars, such withholding of services would create not only ethical problems but legal and political ones as well (Huber & Baruth, 1987).

Several alternatives have been proposed in attempts to address issues related to the treatment unit. Huber and Baruth (1987) suggested that the reluctant family member be encouraged to participate in the initial assessment. Wilcoxon and Fenell (1983) recommended that a letter containing the research findings of marital counseling, particularly on one-spouse intervention be sent home with the attending spouse, along with an invitation to the other spouse to participate in treatment. Teismann (1980) made several alternative suggestions that include (a) brief sessions with the attending members that only focus on a plan for engaging the nonparticipant, (b) an agreement between the non-attenders and the counselor for a single, private session in return for a conjoint session, (c) audio or videotaping segments of sessions for nonattenders, and (d) an agreement for short-term counseling for the attending members. For mental health counselors who are unwilling to see the family without full family participation in counseling, it is suggested that a referral be made to another counselor rather than to deny services to motivated family members (Margolin, 1982). Marsolin also recommended that the family be informed that not all counselors insist on seeing the entire family.

Confidentiality

Numerous ethical dilemmas regarding confidentiality may arise while counseling with couples or families. In the AAMFT Code of Ethical Principles for Marriage and Family Therapists (AAMFT, 1988) the overriding principle concerning confidentiality is that respect for the confidences of clients be shown by practitioners. Thus, it is the responsibility of mental health counselors to state openly and clearly their positions on the issue of confidentiality. Respectful consideration of clients' confidentiality when dealing with multiple clients, however, is not always a simple task because family secrets pose unique confidentiality dilemmas for family counselors.

"Secrets" involve information that is differentially shared between family members. Among the types of secrets encountered in counseling families are individual secrets that are withheld from other family members, internal family secrets in which several family members withhold information from other members of the family, and shared secrets or those that are known by all family members but withheld from outsiders (Karpel, 1980).

A recent study conducted by Green and Hansen (1989) on the actual practice of family therapists relative to issues that pose dilemmas emphasized the lack of agreement among counselors on the proper approach for dealing with issues of confidentiality within a marriage and family counseling context. One ethical dilemma involved a therapist who had been working with a family for 3 months. The wife called the therapist and reported that she had been having an affair, that she planned to leave the family and remarry but did not want this information shared. Of the 202 participants in this study, 63.1% indicated that they would accept the woman's confidence, but only under the condition that she share her secret in a reasonable amount of time. A total of 36.9%, however, disagreed with this decision. In addition, 26% indicated that they would announce at the beginning of therapy that they would not tolerate secrets and risk losing the family by sharing this information, and 14.2% stated that they would share this information with the family because to not do so would influence the family process in a negative way.

Similarly, the literature is replete with differing positions on the issue of confidentiality. Some mental health counselors may simply indicate that secrets will not be kept from spouses or other family members (Hines & Hare-Mustin, 1978; Weiner & Boss, 1985) or in the case of absolute confidentiality that information shared with the counselor will not be shared with anyone else (Watkins, 1989). Several professionals, however, suggested that a more productive middle ground would be to state at the beginning of therapy that "any information provided may be used by the therapist in the interest of helping to resolve presenting issues" (Fenell & Weinhold, 1989, p. 290). Issues to be considered in revealing family secrets would include sensitivity to the timing, consequences for the unaware family member, and strategies that would attempt to minimize the risk and potential negative effects that most likely contribute to mutual mistrust (Karpel, 1980).
Margolin (1982) supported an intermediary position and stated that if information is gained from a spouse or family member in an individual session, the counselor should indicate that in general, confidentiality conditions are not applicable. The client, however, has the right to request that certain pieces of information remain confidential, and the mental health counselor should comply. Another preventive approach to secrets involves discussing the dangers that secrets pose in counseling families and exploring techniques for managing family secrets with all involved in the counseling process (Karpel, 1980).

Ethical Issues Related to Therapeutic Strategies

Most mental health counselors would agree that there is some measure of control in all forms of psychotherapy, and as Hailey (1987) stated the process of counseling itself involves the manipulation of people to influence them to change. Power and control strategies are particularly vital components of counseling families. Theoretical conceptualizations about the family, in fact, are based on the use of these strategies (Heatherington, 1990). Minuchin (1974) stated that change in the family system is achieved primarily by the counselor's use of power. Miller et al. (1990) noted that, pragmatically, counselors are in a position of power relative to the family. Although there is consensus regarding the necessity of using power and control among counselors, concern has been raised regarding the manipulative use of these strategies and their potential for misuse (Huber & Baruth, 1987). Several of the strategies used are controversial because of potential ethical dilemmas posed by their use. These include strategies that involve unilateral decision making by the mental health counselor, deceiving the family by use of covert strategies, and the withholding of information from the family.

Unilateral Decision Making

Many of the decisions that family counselors make involve the structure and boundaries of the therapeutic process (Heatherington, 1990). Heatherington noted that these decisions include problem identification, goal setting, rules regarding the sessions themselves, and the amount of information to be shared with the family regarding treatment. There is disagreement in the field of family counseling regarding the degree to which these decisions should be made unilaterally by the family counselor.

Whitaker and Bumberry (1983) asserted that taking control in the decision-making process reassures family members that the counselors are in control although they themselves may be feeling out of control. This, they believed, enables clients to trust the counselors in the therapeutic process. Heatherington (1990) noted that the use of control is important to the therapeutic process. She believed that facilitating family members in altering their troublesome interpersonal relationships requires that the counselor control client behaviors such as interruptions, instructions, and praise. These counseling techniques are aimed to prevent rambling, repetitive arguing, disengaged silence, enmeshed speaking for others, and other troublesome sequences (Metcoff & Whitaker, 1982).

Huber and Baruth (1987), however, suggested that client dependency may be encouraged as family counselors establish their sphere of influence thereby reducing the autonomous functioning of the family. Miller et al. (1990) added that it may also interfere with the family's development of its own coping mechanisms. There is some concern that controlling the decision-making process may be detrimental to women in particular. Weiner and Boss (1985) cautioned the use of control strategies that may reinforce dependency in women due to their prior socialization for dependency and submission. The American Psychological Association (APA; APA, 1975) stated that when power is exerted in therapy that it should not maintain or reinforce stereotypical dependency in women.

The ethical dilemmas that arise in the use of unilateral decision making involve both the welfare and autonomy of individuals and the family system. Heatherington (1990) noted in her analysis of the various family theories that there is a great deal of variability in family counseling regarding the unilateral use of decision making by counselors.

Manipulative Strategies

The use of covert strategies in counseling families is highly controversial. These strategies include reframing, one-downmanship, paradox, confusion, concealing versus facing insight, hypnotic language, and the need to take and change sides (Hailey, 1987; Heatherington, 1990). The use of paradoxical procedures is particularly controversial (Patten et al., 1991).
A major issue involves whether harm may be caused to clients by the use of deceit (Green & Hansen, 1989; O'Shea & Jessee, 1982; Stuart, 1980; Treacher, 1988; Wendoff & Wendoff, 1985). The use of deceit involved in covert strategies may cause families to terminate prematurely, may encourage family members to engage in troublesome sequences more frequently, and may cause families to feel they are not being taken seriously (Patten et al., 1991). Informed consent dilemmas may also arise by the use of deceit (Margolin, 1982; Miller et al., 1990).

Another ethical issue involves providing services that are beneficial to families. Haley (1987) acknowledged that counselors need to be cognizant of the long-term effects of deceit on clients. He suggested that these be weighed against the potential client benefits. He, however, made a strong ethical case that paradoxical interventions have a beneficial effect on families. In fact, he suggested that families will not change through the use of direct intervention methods and that covert strategies provide a systemic, circular perspective of treating families. These interventions are intended to alter troublesome interpersonal sequences by indirect methods (Huber & Baruth, 1987). A number of family counselors believe that the use of covert procedures is in fact not deceitful in that their use recreates the situation experienced by the family (Fisher, Anderson, & Jones, 1981; Minuchin, Rosman, & Baker, 1978; O'Shea & Jessee, 1982; Papp, 1980) by bringing the covert family patterns to the surface (Watcawick, Wackland, & Fisch, 1974). Miller et al. (1990), however, argued that there is no empirical evidence that suggests that long-term changes are obtained using covert strategies in counseling families.

It is recommended that decisions regarding the use of covert strategies be made based on a number of different factors. One is to carefully weigh the risk of harming clients versus the possible benefits. It is suggested that covert strategies be used only when direct ones have been unsuccessful (Miller et al., 1990; Nichols, 1984). Another recommendation is that the characteristics of the client should be considered before using indirect counseling methods (Heatherington, 1990) that may be particularly indicated with families who are highly resistant (Shoham-Salomon, Avner, & Neeman, 1989).

Clearly there is strong disagreement regarding the use of covert strategies in counseling families. The research suggests that the use of covert strategies is the most frequently encountered ethical dilemma faced by family counselors and that family counselors are willing to use them in some situations but not in others (Green & Hansen, 1989). It is unclear, however, as to how these decisions are made. The major issue in the use of covert strategies in counseling families, however, seems to revolve around the welfare of the client(s) versus the therapeutic benefits surrounding their use.

**Counselor Values Versus Ethics**

Awareness of one's own values is exceedingly important in counseling families because of the impact that culture, ethnicity, race, sex, and socioeconomic status have on the conduct of therapy (Aponte, 1985). Taking this even a step further, Haley (1987) and Miller et al. (1990) pointed to the need for counselors to be even more succinctly aware of the ramifications of their own ideology and therapeutic approach in interpreting the goals of counseling.

This interest in values and ethics can be attributed to several recent circumstances. The women's movement has had a significant impact on the implications of sex roles and women's equality in therapy (Hare-Mustin, 1980; Hines & Hare-Mustin, 1978) and the emergence of state laws regulating mental health practices has made professionals more aware of values and ethical issues (Doherty, 1985).

Values and ethics, however, are different entities. Rokeach (1973) provided definitions that demonstrate these differences by stating that values are lasting beliefs that certain ways of living are preferred over others and are not always ethical. Ethics, on the other hand, is a system of ethical values and ethical theories that are used to identify, in general, what is right. These can protect the interests of everyone involved in the situation. Mental health counselors need to become aware of their personal and group values and how these differ from ethical values. Personal values may not always result in ethical decisions and as a result clients' interests and welfare may not be protected (Zygmond & Boorhem, 1989).

Clearly, mental health counselors need to be up front on their positions on such family issues as marriage, sex, parenting, and divorce (Okun & Rappaport, 1980). As Hines and Hare-Mustin (1978) suggested, however, mental health counselors are often unaware of the extent to which their own personal and professional values can affect the therapeutic process. Indeed, as Sider and Clements (1982) noted, even the choice of counselors' therapeutic orientations may be a reflection of their values. Mental health counselors must become aware of their own values and make certain that they provide services within an
IMPLICATIONS FOR MENTAL HEALTH COUNSELOR TRAINING

As more counselor education programs offer courses and specializations in marriage and family counseling, it will be necessary to attend more carefully to the ethical issues inherent in dealing with these clients. The differences between the conceptual frameworks for mental health counseling and marriage and family counseling will need to be addressed. In addition, mental health counselors should become aware of the fact that general professional codes of ethics will not prepare them to adequately anticipate ethical dilemmas in counseling couples and families.

Thus, course work in ethical issues in marriage and family counseling will become a necessity. The authors believe that mental health counselors should position themselves on each of the dilemmas discussed in this article: defining the client, providing informed consent, defining the treatment unit, using therapeutic strategies, unilateral decision making, using manipulative providing strategies, providing confidentiality, and considering counselor values versus ethics. Example of positions for each of these issues will be presented herein. Although these suggestions may not be compatible with those of other mental health counselors, the authors believe that it is important for mental health counselors to have a stance against that to position themselves. Mental health counselors’ learning will be enhanced if they are able to react to rather than simply learn about existing controversies.

In teaching mental health counselors about a definition of the client, the authors suggest adopting a definition that generally will benefit the family and protect individual family members from harm. Use of this definition incorporates Hoffman’s (1981) position that often the family needs to be distressed for a systems change to occur and that individual family members may place themselves in positions that contribute to the dysfunctional family system, and yet the definition follows the strongest ethical position in not harming clients (Kitchner, 1985). The individual needs should take priority when the welfare of an individual family member is at risk. In discussing ethical issues in marriage and family counseling it is suggested that instructors and supervisors thoroughly discuss potential harmful situations and assist mental health counselors in identifying situations in which the individual’s needs take precedence over the family’s (i.e., suicide, homicide, and abusive situations).

If all family members are identified as the client then it would follow that informed consent would involve all family members. If the mental health counselor’s theoretical orientation involves a belief that providing details of the therapeutic process hinders that process clients should be informed not only of this belief but of the possible risks and benefits of that theoretical orientation as well. Clients should also be informed that not all mental health counselors use this particular theoretical orientation thus providing clients with other counseling alternatives. Additionally, when counselor educators teach marriage and family counseling courses, they should present how use of the different theoretical approaches affect informed consent practices.

Theoretical orientations also affect defining the treatment unit. The authors acknowledge the superior benefits of having all family members attend counseling sessions. We recommend, however, that every attempt be made to encourage the participation of all family members, but when this is not possible, the family members willing to participate in counseling should be provided services. As Gurman and Kniskern (1981) noted, although negative therapeutic outcomes of seeing a segment of the family are suggested in the literature, this has not been sufficiently tested empirically. It is also suggested that family members be informed of the drawbacks involved when treating only part of the family system. At the same time changes in any part of the family system can often produce necessary changes. Therefore, the possibility of positive outcomes exists even when not all family members participate in counseling. In marriage and family course work different strategies that may increase the likelihood of all members participating may help mental health counselors feel more comfortable in treating a part of the family system.

Use of informed consent can also be beneficial in resolving some of the ethical dilemmas surrounding the use of unilateral decision making and manipulative treatment strategies by the mental health counselor. It is suggested that early in the counseling process while discussing other informed consent issues mental health counselors also inform families that at times it may be necessary for the mental health counselor to make unilateral decisions in helping the family alter sequential behavior that is troublesome. At the same time, clients need to be informed that they are free to question these decisions and engage in therapeutic discussions surrounding particular directives. Mental health counselors need to be particularly sensitive to sex issues in their use of this type of decision making and class discussions that center on situations that
have potential for reinforcing dependency in women are recommended.

When manipulative strategies are used clients should be informed that these may be used although specific information regarding the strategy need not necessarily be given. Currently, there is little empirical evidence that supports the use of covert strategies. It is suggested that the recommendations of Miller et al. (1990) and Nichols (1984) be followed—covert strategies can be used when more direct ones have proved to be unsuccessful. In addition, the authors suggest that the characteristics of the family be considered before engaging in manipulative strategies. Whenever these strategies are employed, it is strongly suggested that they be used with particular consideration to treating each client with respect and dignity. In marriage and family courses, it is important to explore a variety of situations in which the use of these strategies might be harmful or beneficial.

Rather than supporting an extreme position when teaching mental health counselors about the issues revolving around confidentiality, it would seem that supporting a midpoint in the continuum of this controversy would be most effective. The mental health counselor should discuss the difficulties involved in dealing with family secrets and their management with the family members. In addition, as Margolin (1982) suggested it would be wise for the mental health counselor to state that if information is gained from a spouse or family member in an individual session, that in general, confidentiality conditions do not apply. Discussing the issue openly, arriving at a consensus regarding the manner in which confidentiality will be honored, and knowing how the mental health counselor will react should enhance the effectiveness of the counseling process.

It is imperative that mental health counselors become aware of their values and ethical approaches as well as the differences between the two prior to entering a counseling relationship. Awareness, however, is simply not sufficient to effectively provide assistance in the marriage and family counseling process. Rather, mental health counselors should make their therapeutic approach clear in a disclosure statement and inform clients of their position on such critical issues as marriage, divorce, extramarital affairs, sex roles, and parenting. Providing clients with such information and indicating that if the mental health counselor’s position is incompatible with that of the clients then discontinuing the counseling relationship is certainly acceptable seems to be the only ethical position for the counselor to take.

In counseling families, mental health counselors trained primarily in individual counseling may encounter ethical dilemmas for which they are not prepared. Training specifically geared toward better preparation in this area can serve to enhance mental health counselors’ ethical decision making. As Hines and Hare-Mustin (1978) stated, however, the ethical issues involved in marriage and family counseling are extremely complex and total agreement or resolution may never be fully realized.

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