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ABSTRACT

Family therapy presents ethical dilemmas not encountered elsewhere in mental health practice. For example, who is the patient? Is it an individual, a particular dyad or the family system? If there is more than one patient, how is the therapist to maintain a posture of therapeutic neutrality? How is confidentiality to be managed? Little progress has been made in codifying these issues into ethical rules. Some conclude that family therapy practice is simply too complex to be codified by rules and principles which oversimplify therapy and place practitioners at risk for law suits and ethics charges. This is due to three issues inherent in family therapy which create fundamental limitations to further rule making: (1) ethical challenges of multi-person therapy are considerably more complex than those encountered in individual treatment; (2) informed consent among the family group and dynamics associated therein; and (3) ethical decision making and clinical judgment are not independent processes. Practitioners must be thoroughly educated regarding these matters in order to develop ethical policies applicable to their particular practice circumstances. It is recommended that each practitioner develop an ethics policy based upon particular practice situations. Contains 25 references. (JBJ)

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Developing Your Ethical Position in Family Therapy: Special Issues*

Michael C. Gottlieb, Ph.D., F.A.F.P.

Despite the popularity of family therapy, little has been written, and less resolved, regarding the unique ethical dilemmas that this approach presents for practitioners. My intention today is to make the following points. First, family therapy presents unique ethical dilemmas not encountered elsewhere in mental health practice. Second, little progress has been made in codifying these issues into ethical rules. Third, there are some sound reasons to believe that we may not be able to go much further in the process of rule development. As a result, I will argue that practitioners must be thoroughly educated regarding these matters in order to develop ethical policies applicable to their particular practice circumstances. Finally, I will conclude by outlining how one might develop such a policy with examples to illustrate it. (46")

Unique Ethical Dilemmas

Traditionally, psychotherapy was conducted on an individual basis, and ethical principles were written accordingly (Lakin, 1994; Woody, 1990). The principles were relatively unambiguous and the lines of professional responsibility generally clear. A psychologist's primary obligation was to his or her patient, whose autonomy and welfare he or she was expected to promote (APA, 1990).

Marital and family therapy has been practiced since the early 1950's (Hoffman, 1981) and has received much empirical support. Yet, perhaps due to its more complex and what Lakin calls its "exasperating" nature (Lakin, 1994), many years passed before scholarly articles began to appear regarding the ethical issues involved in such work (e.g., Boszormenyi-Nagy & Krasner, 1980; Grosser & Paul, 1964; Hines & Hare-Mustin, 1978; Karpel, M., 1980; Rinella & Goldstein, 1980). It was not until 1982 that two articles defined and organized the field (Margolin, 1982; & O'Shea & Jessee, 1982), and it was another ten years before psychology made its initial effort to address this work in its ethical principles (APA, 1992).

Margolin (1982) focused on four issues unique to treating couples and families. First, who is the patient? Is it an individual, a particular dyad or the family system? Second, if there is more than one patient, how is the therapist to maintain a posture of therapeutic neutrality, and under what circumstances must this position be abandoned in favor of an individual family member? Third, how is confidentiality to be managed? Should the therapist keep some secrets from family members, keep none or decide on a case by case basis? Finally, what is a therapist to do regarding matters of informed consent? For example,

when using what Lakin (1994) refers to as the "tricks" of strategic approaches, how much information should the therapist reveal, and how will disclosure effect the treatment?

Iatrogenic risk, damage caused inadvertently in the course of treatment, is a problem usually associated with physical medicine. O'Shea and Jessee (1982) extended the concept to family therapy as well because in their words, "a previously asymptomatic family member may become symptomatic during or subsequent to therapy" (p. 15). How is a family therapist to manage treatment in the context of this potential problem?

Recently, I have added two issues to the list, change of format, a term originated by Margolin (1982), and various issues surrounding the use of live supervision (Gottlieb, 1995a). In change of format, the formal definition of the patient changes, for example from an individual to a couple in marital therapy. How is the practitioner to deal with matters of confidentiality, professional responsibility and the iatrogenic risks such decisions may incur?

In live supervision, especially when using teams, who is to be professionally responsible for the family, how is informed consent managed, and how do we avoid problems of group dynamics inherent in team functioning?

Other papers have raised ethical issues (e.g. Margolin, 1986; Patten, Barnett & Houlihan, 1991), in areas such as; concurrent individual and family therapy sessions (Gottlieb & Cooper, 1990), relational diagnoses (Gottlieb, in press), operating from a systemic perspective in hospitals (Gottlieb & Cooper, 1993), treating families who have a member with a chronic physical illness (Gottlieb, 1995b) and working with gays and lesbians (Scrivner, 1995).

This body of scholarly work has raised important issues. Unfortunately, it has done little to resolve them or to provide clear guidelines for practice. Nevertheless, some progress has been made.

Progress in Ethical Principles

While other organizations, such as AAMFT, have tried to address some of the ethical issues I have described, psychology remained silent until its ethics code was revised in 1992. At that time, some issues of concern were addressed.

The most significant addition was section 1.03 which acknowledged that psychologists may provide services to several persons who have a relationship with one another. It goes on to emphasize the need to establish patient definition as well as the relationship the psychologist is to have with other family members.

Section 5.01 is also a helpful addition. It addresses the need to discuss the limits of confidentiality in marital and family therapy and the foreseeable uses of the information generated by the

process.

Another issue relevant to family practice is addressed in Section 4.08 which emphasizes the need to plan for facilitating care in the event that services are interrupted. This is a common situation for many family practitioners who work with families episodically over the life span.

These three sections comprise the additions directly relevant to our work. As you can tell, the list is very brief, especially in comparison to the number and complexity of the issues I reviewed a moment ago. Therefore, while the scholarly literature has tried to keep pace with developments in family practice, our ethics code has not. Even subsequent commentaries on the principles have given our issues short shrift. For example, a recent issue of Professional Psychology was devoted to the revised code. One half of one article (Lakin, 1994), actually about two pages, was devoted to the issues we are discusing today. After the code was completed a planned commentary was much anticipated (Canter, et al., 1994). This volume devotes 1 1/2 pages to "Couple and Family Relations," and there are no index terms for family, couple, marital, joint or conjoint.

Limitations to Ethical Rule-Making

Many, including myself, have been critical of APA for not going further. While this criticism may be deserved to some degree, I have concluded that our practice is simply too complex to be codified by rules and principles which oversimplify our work and place practitioners at risk for law suits and ethics charges. I believe that this situation is due to three issues inherent in our practice, which create fundamental limitations to further rule-making.

Probably the most important and basic limitation to ethical guideline writing has recently been renewed by Lakin (1994). He argues, correctly in my view, that the ethical challenges of multi-person therapy are considerably more complex than those encountered in individual treatment because the therapist cannot anticipate the future course of therapy to the same extent that one can with individual patients. This is so because s/he cannot know how each family member will respond to interventions or how the interventions will affect interpersonal relationships outside of the consulting room. Writing ethical guidelines regarding such matters is of dubious value at best since they would risk placing the therapist in a position of having responsibility for matters beyond her or his control.

The second issue is informed consent. Unfortunately, much misinformation surrounds this concept. Many practitioners seem to view it as a burdensome but necessary detour from the work of psychotherapy. Patients are given booklets to read,

forms to sign, and that is that. Well, nothing could be further from the truth. Contemporary ethics scholars now understand that informed consent is a recurrent process of interactive dialogue (Packman et al., 1994) involving communication, clarification, and decision-making (Pope and Vasquez, 1991) throughout the therapy process and that providing or withholding information may produce risk (Sonne, 1994). For example, one may choose to inform a family of a no secrets policy regarding confidentiality. This decision could lead a family member to not disclose information which might be vital to another family member and even place them at risk. How is such a consequence to be anticipated, and how on earth could we write guidelines for such eventualities ? Problems such as these place obvious limits on what can be codified since we cannot inform patients about matters that we can neither predict nor control.

Third, I (Gottlieb and Handlesman, in preparation) and others, have come to conclude that ethical decision-making and clinical judgement are not independent processes. Laura Brown (1994) has noted that ethics should be fundamentally integrated into practice, and Lakin (1994) has argued that family practitioners must understand that ethical pitfalls are "inextricably embedded in the methods" (p. 348) we use to bring about therapeutic change.

If we are right, that ethical decision-making and clinical judgement exist in dynamic interaction, then it is not reasonable to assume that we can write definitive guidelines adequate for the complex nature of our work. Rather, it is necessary to understand that various ethical choices may produce different clinical outcomes and that clinical decisions will pose different ethical dilemmas. As a result, ethics codes must be seen only as a series of broad decision-making guidelines for thoughtful and competent professionals. We cannot expect ethics codes to do the work for us.

While these matters may present fundamentally unresolvable problems for the writers of ethics codes, there are two alternatives which may be of assistance to individual practitioners; enhanced educational efforts and development of individual ethical policies for practice.

Practitioner Education

I have seen tremendous growth in ethics as an area of scholarship and training from the time when it was learned piecemeal and on the job, when I was a student, until today when formal course work is a requirement for all APA approved doctoral training programs. Nevertheless, few students will be exposed to many of the issues I have reviewed, and if they are, such matters will receive scant attention.

This is a highly undesirable state of affairs since

the vast majority of psychologists do marriage and family work as a part of their practice. As a result many are insufficiently prepared to cope with the ethical challenges they will encounter, and in the course thereof, some patients may be harmed.

Unfortunately, there are few ethics courses available at this specialized level and it is unlikely that they will be incorporated into an already jam packed doctoral training curriculum.

One bright spot on the horizon is the APA initiative to identify specialties and proficiencies. My hope is that as these areas and their training requirements are defined, we will see more focused and intensive training regarding these issues at both the pre and post doctoral levels. Unfortunately, these developments are a way off, and in the meantime, each of us must make significant efforts to educate ourselves regarding these issues.

An Ethical Decision-Making Policy

The ethical issues we face are formidable and will continue to grow almost faster than we can cope with them. The best contemporary example being the ethically vexing controversy surrounding false memory syndrome. They will continue to manifest themselves with different frequencies and in innumerable variations depending upon one's practice environment whether it be as a primary care provider in a small community, a sub-specialist in forensic family psychology, or as a trainer.

As I have noted, it is unrealistic to expect that an ethics code can possibly cover all of these bases. Therefore, I believe that it is necessary for each practitioner to develop an ethics policy based upon his or her own particular practice situation just as one has office policies for business and legal matters. Now it is hard to make concrete recommendations regarding such a policy because we all work in such different settings, but I would like to conclude with a general framework that may be helpful to you.

First, you must decide what type of policy is needed, that is, what particular issues must be confronted? The answer to this question will be based partly on the type of practice you have, your theoretical orientation and your personal values. For example, an orthodox analyst would not consider going to the marriage of a patient, but a family psychologist might. On the other hand, a practitioner who works with borderlines will require a very different policy than one needed when working in organizational consulting.

Second, examine your type of practice. What ethical problems have you run into in the past? What problems have colleagues in the same area run into? Look at the data in terms of critical incidents. How frequently do these occur? Does the frequency warrant a policy? For example, discussing your ethical position

with a couple who you fear may divorce and fight over custody of their children would seem vital to me based on the frequency of such occurrences. Thinking of things in this way may seem obvious, but I wonder how many of you have ever actually done it.

Third, review the ethical principles in light of your type of practice and see if issues present themselves that you can imagine facing. This is a bit more theoretical and abstract a procedure, but it may be very helpful if you think of things which had not previously occurred to you.

Fourth, once you have worked out a policy try it out. That is, show it to a colleague who does the work you do and ask him or her to review it. They may think of things you did not, and it will probably help them as well.

Five, consider sharing it with some patients who you know well and who are more well integrated. Gaining their perspective could be enormously beneficial to the process.

Six, try it with a selected group of new patients and see what happens. My guess is that you will find yourself refining it at each step of the way as new information is added.

Finally, once it is established, review it periodically in terms of changes which have occurred within your practice area.

Now please understand that working through this exercise, or even implementing policy decisions based upon it, will not solve all of your ethical dilemmas. But, it may do two things. First, it may reduce the number of dilemmas you face, but more importantly, by the policy decisions you make, it will help you to better anticipate and therefore cope with ethical dilemmas when and if they should arise.

Conclusion

A philosopher once said that ethics involves an effort to achieve the impossible. Remaining mind l of this reality, I have tried to alert you to what is ahead of us and to give you some ideas about what is possible and how to cope with it.

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