ETHICS EDUCATION IN MARRIAGE AND FAMILY THERAPY GRADUATE PROGRAMS

by

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(ABSTRACT)

Mental health professionals place value on education in the hopeful expectation that ethics instruction will provide the knowledge and awareness required to empower therapists to make ethical clinical decisions. This study examined the current status of ethics education in accredited and non accredited marriage and family therapy graduate programs in the United States and Canada. Surveys were sent to ethics instructors in 123 graduate programs, 72 of which have full or provisional accreditation by the AAMFT Commission on Accreditation for Marriage and Family Therapy Education. A total of 65 surveys were returned, resulting in an overall response rate of 53%.

Information was gathered using a modified version of a survey designed by Vanek (1990) that examined eight areas of ethics training: 1) professional and educational characteristics of the instructor, 2) structure of ethics education, 3) instructional methods, 4) goals for ethics education, 5) specific content areas, 6) evaluation indices, 7) instructional materials, and 8) rationale for ethics education. Particular attention was placed on ethical content areas that are unique to a systemic approach to therapy.

The future direction of ethics instruction was examined to determine whether instructors would significantly alter ethics education in the future. A series of paired t tests for within-group comparisons was used to determine if significant differences existed between the current and desired emphasis placed on 16 educational goals and 34 content areas. With the exception of four goals, there were statistically significant differences ($p<.05$) between the current and future emphasis placed on all other goals by ethics instructors. There were also statistically significant differences ($p<.05$) between the current and future emphasis placed on 22 of the 34 content areas by ethics instructors.

These results indicated that the majority of ethics instructors place emphasis on these goals and content areas, but acknowledge a desire to place greater emphasis on them in the future. A series of t tests for independent groups determined that there were no significant differences ($p<.05$) between accredited and non accredited programs in the degree of emphasis currently placed on any of the specified goals or content areas.

DEDICATION

To the people who have honored me by courageously sharing
the sorrows and triumphs of their lives-
you are truly the inspiration for this work

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CHAPTER I

Introduction

Unethical behavior on the part of therapists represents an area of growing concern among mental health professionals as reflected in the increasing numbers of complaints filed with ethics boards (AAMFT, 1994; APA, 1988). Preister, Vesper, and Humphrey (1994) reported that the Ethics Committee for the American Association for Marriage and Family Therapy (AAMFT) maintained an active caseload of over 100 allegations per quarterly review of ethical violations in 1991. This represented a seven-fold increase in ethics cases from 1986. Brock and Coufal (1994) conducted a national survey of randomly selected Clinical Members of AAMFT to ascertain therapists' self-reported adherence with the *AAMFT Ethics Code* and their attitudes toward its principles. The findings demonstrated that marriage and family therapists have the capacity to act in an ethical manner as well as the capacity to do harm. While most of the therapists surveyed reported compliance with the code, the results also indicated a degree of non-compliance on each identified behavior. As any amount of exploitation or negligence of ethical principles in a therapeutic relationship is too much, many marriage and family therapists look to ethical codes and training in ethics to provide guidance regarding these problems.

The purpose of professional codes of ethics for the mental health professions is to define basic principles dictating appropriate therapeutic practice, describe therapists' responsibilities to clients, and provide a degree of assurance that therapists will abide the rules and expectations of society (Huber, 1994). Ethical codes can only provide a general framework for professional responsibility

as it is impossible to address all potential ethical dilemmas. Although their influence is limited, therapists and educators rely on ethical codes to represent the foundation of what constitutes acceptable therapeutic practice.

The *AAMFT Code of Ethics* (1991) is comprised of eight general principles with an additional 56 subprinciples that delineate particular areas of appropriate or problematic behavior (Preister, Vesper, & Humphrey, 1994). The eight general areas of ethical principles are: Responsibility to clients; Confidentiality; Professional competence and integrity; Responsibility to students, employees, and supervisees; Responsibility to research participants; Responsibility to the profession; Financial arrangements; and Advertising.

A number of studies have suggested that there is a lack of knowledge among professionals regarding ethical guidelines and confusion pertaining to the definition of ethical behaviors (Conte, Plutchik, Picard, & Karasu, 1989; Green & Hansen, 1986, 1989; Pope, Tabachnick, & Spiegel, 1987). Brock and Coufal (1994) found that 25% of their sample of Clinical Members of AAMFT had not read the *AAMFT Ethics Code*. Green and Hansen (1989) investigated the self-reported behaviors of marriage and family therapists in relation to 16 ethical dilemmas, 8 which were addressed in the *AAMFT Code of Ethics* (1984) and 8 which were not. All of the ethical dilemmas were encountered by some of the participants and 13 of the 16 dilemmas were encountered by more than 50% of the respondents. There was a lack of consensus among those sampled as to appropriate ways to deal with the ethical dilemmas presented, even when the issue was addressed in the *AAMFT Code of Ethics.* It was concluded that the *AAMFT Code of Ethics* provides guidance for many areas of professional conduct, but fails

to specifically address a number of the ethical issues associated with a systemic clinical approach.

While all of the helping professions share a common heritage, there are fundamental theoretical and methodological differences that require ethical codes of conduct that address issues specific to marriage and family therapy. The systemic theoretical orientation that predominates in the field of marriage and family therapy poses unique challenges because the clinical focus is on transactions between individuals rather than the individual characteristics of a single person (Huber, 1994). In individual counseling there is one identified client as opposed to family therapy where individual family members, the relationship between them, and the system itself are all considered (Beamish, Navin, & Davidson, 1992; Corey, Corey, & Callanan, 1988.). A review of the literature identified the following ethical issues specific to marriage and family therapy: defining the treatment unit; treating the entire family or withholding treatment; client welfare; informed consent; confidentiality issues related to family secrets; changing treatment modalities; use of the *Diagnostic and Statistical Manual of Mental Disorders -IV (DSM-IV)*; marital status decisions; and the use of covert strategies.

Vasquez (1992) stated that many professionals concerned with the issues of unethical behavior believe that education of trainees may be the most powerful weapon against professional misconduct. As marriage and family practitioners strive to address the ethical concerns inherent in the practice of therapy, attention is increasingly being placed on ethics education and training. The majority of literature reviewed for this study emphasized the need for a more stringent focus on the content and implementation of ethics training. This need is exemplified in

the work of Brock and Coufal (1994) who reported that of the Clinical Members of AAMFT surveyed, 13.5% rated their graduate coursework in ethics as terrible or poor, 24.8% rated it as adequate, and 59.8% rated it as good or excellent.

Although the literature has grown increasingly supportive of the formal process of ethics training, questions remain as to the efficacy of ethics education in improving the ethical behavior and judgment of graduate students. Research suggests a discrepancy between knowledge and understanding of ethical principles and their implementation (Gartrell, 1987). Results of a study by Wilkins, McGuire, Abbott, and Blau (1990) supported the conclusion that clinicians who are capable of recognizing unethical behavior are less willing to follow through with required action. Bernard and Jara (1986) found no significant correlation between ethics education and willingness to take ethical action.

Recent literature indicates that training in the areas of ethical decision-making models and ethical development may address many of the limitations of current ethics education. Kitchener's (1986) model of ethical decision-making is gaining attention in the literature in regard to its potential positive impact on ethics training (Zygmong & Boorhem, 1989). Gawthorpe and Uhlemann (1992) conducted an experiment to determine the effects of training in ethical decision-making on decision-making quality. Results indicated a significant positive difference for those who received training. Zygmond and Boorhem (1989) discussed the perceived benefits of incorporating a decision-making model into the marriage and family therapy curriculum. They stated that teaching students to evaluate their clinical decisions using an ethical decision-making model enables them to examine their clinical decisions from an ethical perspective. Many authors suggested that ethics education be made a formal endeavor where specific

attention is given to the content and process of teaching ethical decision-making processes (Doherty & Boss, 1991; Gawthrop & Uhlemann, 1992; Welfel, 1992; Woody, 1990; Zygmond & Boorhem, 1989).

Mental health professionals place value on education in the hopeful expectation that ethics instruction will provide the knowledge and awareness required to empower therapists to make ethical clinical decisions. Although the Commission on the Accreditation for Marriage and Family Therapy Education (COAMFTE) has validated the importance of ethics education by mandating that accredited graduate programs offer a separate course in ethical, legal, and professional issues (AAMFT, 1991), very little is known about the specific content and process of instruction. It is currently unknown to what extent ethics training is provided in non accredited marriage and family therapy graduate programs.

There is an assumption in the literature that marriage and family therapy training programs utilize a systemic theoretical framework. Beamish and Navin (1992) focused attention on therapists who have primarily been trained in traditional, individually-oriented counseling programs and noted that they may encounter difficulties in rendering ethical decisions which involve a systemic/relational framework (Beamish & Navin, 1992; Huber, 1994; Lakin, 1994). There is no current information in the literature regarding the degree to which individually-oriented programs in marriage and family therapy address the ethical issues unique to working with multiple clients and relationships.

Purpose

The primary purpose of this study was to examine the current status of ethics education in marriage and family therapy graduate programs. Information was gathered, using a survey originally designed by Vanek (1990), that describes

the components of current courses in ethics and the congruence of the findings between marriage and family therapy graduate programs. The specific areas of ethics training that were studied are: 1) professional and educational characteristics of the instructor; 2) structure of ethics instruction; 3) instructional methods used; 4) goals for ethics education; 5) specific content areas addressed, 6) evaluation indices; 7) instructional materials used; and 8) rationale for ethics education. Particular attention was focused on examining specific content areas that are unique to marriage and family therapy and the degree to which ethical decision making models are addressed in the curriculum.

The second purpose of this study was to examine the future direction of ethics instruction by determining whether or not instructors would significantly alter the nature of ethics instruction in the future. A comparison of the current emphasis and the desired emphasis on particular instructional components was made in order to test for significant differences. The final purpose of this study was to examine possible differences in ethical instruction between accredited and non-accredited marriage and family therapy graduate programs.

Research Questions

This survey will address three research questions:

1. What is the current status of ethics education in marriage and family therapy graduate programs?

2. What is the perceived future direction of ethics education by instructors in marriage and family therapy graduate programs?

3. Is there a relationship between accreditation status in marriage and family therapy graduate programs and ethics instruction?

CHAPTER II

Review of the Literature

The purposes of the following literature review are 1) to discuss ethical issues specific to the field of marriage and family therapy; 2) to provide a brief overview of the role of ethical codes of conduct in the marriage and family therapy profession; 3) to discuss the emergence of a model of ethical decision-making as an adjunct to ethical codes; and 4) to discuss the existing research on ethics education in marriage and family therapy graduate training programs and related mental health professions.

Marriage and Family Therapy as a Distinct Profession

During the past 40 years, the discipline of marriage and family therapy has emerged as a vital and distinct branch of the mental health profession. Prior to this time, marriage and family therapists identified themselves as psychologists, social workers, psychiatrists, or counselors who specialized in working with families (Vesper & Brock, 1991). Marriage and family therapy is more than just a novel technique or unique treatment approach - it involves a comprehensive understanding of human behavior and the conceptualization of problems (Huber, 1994).

While all of the helping professions share a common heritage, there are fundamental theoretical and methodological differences that require ethical codes of conduct and subsequent training that address issues specific to marriage and family therapy. Many of these issues stem from the systemic theoretical framework that predominates in the marriage and family therapy profession. Huber (1994) described a systemic epistemology as one that focuses on the interdependence between and among persons, information exchange, and circular

feedback mechanisms. As opposed to an individually-oriented view of psychological functioning that focuses upon individual cognitive, emotional, and physiological states, a systemic/family therapy framework views causes as circular with individual symptoms being considered in an interpersonal context (Beamish, Navin, & Davidson, 1992; Huber, 1994; Searight & Merkel, 1991). If the therapeutic focus is on an individual's behaviors, it is viewed in the context of how the behaviors impact others in the family system and how the family system reciprocally impacts the individual (Huber, 1994).

Ethical Issues Specific to Marriage and Family Therapy

Operating within a systemic framework poses unique ethical challenges to the therapist who conceptualizes and implements the therapeutic process by involving multiple persons, multiple relationships. Even such a fundamental question as "Who is the client?" becomes more complicated. Is it the one 'identified client', each individual, or the relationship system as a whole? The following ethical issues specific to marriage and family therapy will be presented: defining the treatment unit; treating the entire family or withholding treatment; client welfare; informed consent; confidentiality issues related to family secrets; changing treatment modalities; use of the *Diagnostic and Statistical Manual of Mental Disorders -IV (DSM-IV)*; marital status decisions; and the use of covert strategies.

Client Definition

One of the most pervasive problems encountered in family therapy stems from the ambiguity regarding the identification of the client (Beamish, Navin, & Davidson, 1992). In individual counseling there is one identified client as opposed to family therapy where individual family members, the relationship between

them, and the system itself are all considered (Beamish, Navin, & Davidson, 1992; Corey, Corey, & Callanan, 1988.)

As there is a general consensus that the primary client is the family system in marriage and family therapy (Beamish, Navin, & Davidson, 1992; Huber, 1994), one must consider the ethical implications in regard to the imposition of therapist values, client welfare, and the use of conventional diagnostic categories. Fieldsteel (1982) asserted that marriage and family therapists impose a different set of values and assumptions on their clients when they redefine a presenting concern as a systemic problem. Defining the treatment unit as the system also raises questions regarding client welfare in that treatment may benefit individuals in the system differentially (Hare-Mustin, 1980; Margolin, 1982). Ethical difficulties may also arise for those operating within a systemic paradigm who utilize diagnostic categories based on a linear, individual framework (e.g. DSM-IV) for financial reimbursement (Denton, 1989).

Client Welfare

Doherty and Boss (1991) stated that while all therapy is aimed at promoting the welfare of clients, family therapy has the additional burden of treating multiple individuals in a relational context. The *American Association for Marriage and Family Therapy Code of Ethics* (AAMFT, 1991) clearly states, "Marriage and family therapists advance the welfare of families and individuals". Despite this specific policy, Green and Hansen's (1989) survey of AAMFT clinical members found that the ethical dilemma of "family vs. individual needs" ranked as the second (out of 16) most important in ethical significance and 11th in frequency of occurrence. Many therapists believe that the solution to the dilemma of family vs. individual needs is to consider the entire family system as the treatment unit,

thereby negating the necessity of being an advocate for any single family member (Margolin, 1982).

In Hare-Mustin's (1980) seminal article on client welfare in family therapy, she claimed that ethical dilemmas arise when trying to determine whose welfare to protect because treatment that benefits the family entity may not equally promote the welfare of each individual member. She also challenged that individual members may sacrifice confidentiality and the acquisition of personal goals by participating in family therapy where the family system is the client.

Margolin (1982) stated that it is the responsibility of the family therapist to determine that one family member does not improve at the expense of another family member. She cautioned that viewing the family system as the sole treatment unit and advocating for changes in the interactional patterns of relationships may not always be in the best interest of clients. Clinical situations that involve one spouse desiring to leave the relationship or that involve the behavioral change of only one individual are examples of a relational therapeutic focus thar could infringe upon individual welfare. Legal situations, such as the reporting of child abuse, also help to define when individual welfare takes precedence over systemic welfare. She concluded,"a family therapists responsibility includes being an advocate of individual family members who cannot accurately represent their own needs or recognize when these are infringed upon by another family member" (p. 790).

Although the concerns related to client welfare in marriage and family therapy were initially raised over 15 years ago, there continues to be confusion and a lack of consensus among marriage and family therapists. This is reflected in the results of a survey of Clinical Members of AAMFT that revealed that only 66.3%

of the randomly selected sample always or often reported child abuse (Brock & Coufal, 1994).

Informed Consent

There is an assumption in a systems-oriented clinical practice that treatment will have an impact not only on participating members, but will influence the larger family system as well. The term "informed consent" refers to the responsibility of therapists to provide clients with information regarding the risks and benefits of therapy, the risks of foregoing therapy, and therapeutic alternatives to the specified treatment (Bray, Shepherd, and Hays, 1985). A central tenant of marriage and family therapy is that procedures for informed consent be conducted prior to the onset of treatment with all potential family members, including those who join at a later time, (Bray et al., 1985; Margolin, 1982). Although it is usually the parent who takes responsibility for providing the consent to treatment, Margolin (1982) also recommended that informed consent procedures be followed with children. Describing the therapeutic process to children in simplified language and questioning them as to their understanding, reveals to both therapists and parents the extent to which children understand what to expect in therapy.

Treating Entire Family or Withholding Treatment

Because the conceptual and empirical literature has lended support for systemic family therapy, engaging nonattenders becomes an essential goal for many therapists (Patten, Barnett, & Hulihan, 1991; Wilcoxin & Gladding, 1985). The relatively widespread practice of refusing to see a family unless all members are present is a controversial tactic which represents possible coercion and directly violates the ethical principles of many helping professions (Margolin, 1982; Patten et al.,1991; Searight et al.,1991). Tiesmann (1980, cited in Wilcoxin et al.,1985)

noted that this position reflects a possible ethical problem because it withholds services from motivated family members and can create an implicit alliance between the nonpartipating member and the therapist (Huber, 1994). The potential ethical difficulties associated with this tactic are reflected in the survey by Green and Hansen (1989) that found the issue of providing treatment if one member refuses to participate to be the most frequently occurring ethical dilemma for the AAMFT Clinical Members sampled.

The acceptance of this practice is founded in part upon the conceptual perspective of Napier and Whitaker (1978) that therapists' ability to engage all significant family members prior to the onset of therapy is a prerequisite to successful treatment outcomes (Huber, 1994; Wilcoxin et al., 1985). O'Shea and Jessee (1982) claimed that withholding treatment is not a refusal to provide therapy, but is a professional responsibility in order to provide relationship-appropriate services. Patten, Barnett, and Houlihan (1991) cited the review of empirical literature by Gurman and Kniskern (1981) that claimed that family therapy is at least as effective as individual therapy and that the failure to use systemic therapy for relational problems may promote negative therapeutic effects.

Searight and Merkel (1991) challenged that there is little empirical support to substantiate the position of refusing treatment and that recent empirical studies have shown individual therapy to be equally, not negatively, effective with relational problems. Margolin (1982) suggested that marriage and family therapists who insist on treating the entire family should inform their clients that there are other therapists who do not require this and should offer appropriate referral sources.

Confidentiality

The basic premise behind confidentiality in therapy is that clients have the right to be protected from the disclosure of information revealed in therapy, except when they specifically authorize otherwise (Doherty & Boss, 1991). Maintaining client confidentiality can be particularly problematic in marriage and family therapy involving multiple clients, especially when dealing with family secrets (Beamish, Navin, & Davidson, 1992; Miller, Scott, and Searight, 1990). This is reflected in the fact that violations of client confidentiality are cited as the primary cause of professional liability claims against marriage and family therapists (Engelberg & Symansky, 1989 cited in Lakin, 1994).

Karpel (1980) defined family secrets as "information that is either withheld or differentially shared between or among people" (p. 295). He defined three major types of secrets: 1) individual secrets-those that involve one person keeping a secret from all family members, 2) internal family secrets-those that involve at least two people withholding information from at least one other, and 3) shared family secrets-those that involve all family members knowing the secret but withholding this information from outsiders. Family secrets can have a deleterious impact on therapy in that they result in deception and distortion of understanding, generate anxiety, and can cause emotional harm to family members.

How do marriage and family therapists handle the difficulties associated with family secrets? Margolin (1982) identified two divergent positions. The first involves the therapist treating every family member's confidences as though they were individual clients by not divulging any information to other family members. Some therapists deliberately arrange individual sessions for the purpose of discovering secrets that will in turn facilitate a better understanding of the family.

The second position involves the therapist refusing to maintain any secrets and actively discouraging differentially shared information.

Margolin (1982) suggested an intermediary position whereby the therapist informs the family that confidentiality conditions generally do not apply, but that the therapist will comply with requests to keep specific information confidential. Wendorf and Wendorf (1985) suggested that therapists inform family members that information shared with the therapist will be used in the best interest of the entire family system. This approach entails greater responsibility on the therapist because maintaining or divulging secrets in an untimely or inappropriate manner could result in harm to family members or premature termination (Huber, 1994). Regardless of the particular position taken, it is strongly recommended that therapists clearly identify their position to all family members prior to the onset of therapy (Doherty & Boss; Margolin, 1982).

Changing Treatment Modalities

Gottlieb (1995) operationally defined a change of format as, "a circumstance in which the formal definition of the client changes after the initiation of treatment such that the responsibility of the therapist is altered" (p.562). Margolin (1982) was the first to raise questions about the ethics involved in changing the format of therapy, specifically from individual to family therapy. Her concerns centered around the impact of the change in format on the issues of confidentiality and informed consent. How can therapists deal with information received in individual therapy? Although they can obtain the client's permission to utilize the information in family sessions, ethical problems related to informed consent arise because permission is granted after the onset of therapy. If a client refuses the release of information, the therapist is in a position to maintain

confidences that may be viewed as detrimental to the therapeutic process. Gottlieb (1995) examined these same concerns 13 years later and provided no additional information to facilitate their resolution.

Use of DSM-IV

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (1994) is a manual for the diagnosis of mental disorders as defined by the American Psychiatric Association (APA). The classification system utilized in the *DSM-IV* prevails as the common standard of language for the majority of mental health professionals (Huber, 1994). The *DSM-IV* embodies a theoretical approach that has been described as objective-descriptive, biological, or medical (Denton, 1989) and that conceptualizes mental disorders as being clinically significant behavioral or psychological syndromes or patterns that reside within individuals (APA, 1994).

The individually-oriented, internal view of psychopathology represents a stark contradiction to general systems theory which promotes the belief that mental distress is due to dysfunction within the entire family system (Huber, 1994). Because the diagnostic classification system of the *DSM-IV* is usually required by third-party payers, many marriage and family therapists must use the *DSM-IV* in order to receive reimbursement for services (Denton, 1989). Denton (1989) stated that the differences between the systems and DSM-IV paradigms can pose two ethical dilemmas for marriage and family therapists. For therapists who believe that the two paradigms are irreconcilable, they would be in the position of conceptualizing the problem from one approach and utilizing another when they file insurance claims. Some could say that this is a violation of professional integrity for financial rewards. The second dilemma could occur if therapists take

the position with families that their problem is relational but provide a *DSM-IV* diagnosis that identifies one person as being the client.

Denton (1989) raised additional ethical concerns related to the use of the *DSM-IV* by marriage and family therapists: the possible stigma associated with diagnosis; misrepresenting diagnoses to third-party payers; and the competency of marriage and family therapists to render a *DSM-IV* diagnosis. While acknowledging that *DSM-IV* diagnoses can be therapeutically beneficial, Denton cautioned that they can also provide an excuse from responsibility, can diminish individuals by labeling their being in a single term, and can cause clients to despair about their ability to improve and change. Particularly noted was the possibility that an individual diagnosis may reinforce and shape a family's interactions around the identified client. Another concern related to the possible stigma of diagnosis involved the fact that therapists have no control over the maintenance of confidential information once it has been released to third parties. The information may subsequently be used in unintended ways by other parties (i. e. to determine future insurance coverage or to determine employment).

Denton (1989) discussed the issue of misrepresentation of diagnosis as another possible ethical dilemma for marriage and family therapists. Pressure from both therapists and clients to obtain an insurance reimbursement increases the potential for a DSM-IV diagnosis to be given when none of the family members truthfully meet all of the requirements (Denton, 1989; Huber, 1994). While some therapists do not see misrepresentation as cause for concern (Huber, 1994), Packer (1988, cited in Denton, 1989) termed this practice "insurance diagnosis" and emphatically stressed that it constitutes fraud.

The *AAMFT Code of Ethics* specifies that, "Marriage and family therapists do not diagnose, treat, or advise on problems outside the recognized boundaries of their competence" (AAMFT, 1991). Denton (1989) stated that graduate students trained solely in marriage and family therapy could conceivably receive their degrees and AAMFT clinical membership without having a sufficient understanding of the *DSM-IV*. Huber (1994) and Denton (1989) urged family therapists to increase their level of competence in the use of the *DSM-IV* because it is their ethical responsibility to be able to recognize and address serious individual symptoms.

Marital Status Decisions

The *AAMFT Code of Ethics* states, "Marriage and family therapists respect the right of clients to make decisions and help them to understand the consequences of the decisions. Therapists clearly advise a client that a decision on marital status is the responsibility of the client" (AAMFT, 1991). While this edict appears to be clear, there exists some ambiguity among professional family therapists as reflected in the results of a national survey of AAMFT Clinical Members. Brock and Coufal (1994) reported that 49% of those sampled indicated that they encouraged clients to stay married at least sometimes, and 57% believed that doing so represented ethical practice at least sometimes. In contrast, only 17.6% encouraged spouses to divorce at least sometimes, and 34% thought it was ethical to do so at least sometimes. These results indicated that Clinical Members often recommend what couples are to do, even if doing so represents a violation of an ethical principle intended to prevent the profession from taking on a value system that prohibits divorce or restricts its scope to maintaining marriages (Brock & Coufal, 1994).

Use of Covert Strategies

The most controversial ethical issue in marriage and family therapy revolves around the use of covert strategies and deceptive practices by therapists (Doherty & Boss, 1991). Covert strategies include hypnotic language, confusion, one-downmanship, reframing, taking sides, and paradox (Beamish, Navin, & Davidson, 1992). Paradoxical techniques involve the escalation or prescription of symptoms and the explaining of problems in counterintuitive terms (Doherty & Boss, 1991). Henderson (1987) listed the positive attributes of paradoxical psychotherapy as being: short-term treatment, high success rate, validity for more resistant clients, the therapist's responsibility for change, and an emphasis on the positive.

Ethical concerns raised about paradoxical techniques challenge that covertly manipulating and deceiving the client can cause harm by intensifying problem behavior and undermining the trust of the therapeutic relationship. Some charge that paradox is too manipulative; that it tricks a family into taking a course of action designed by the therapist and undermines the value of client self-determination (Doherty & Boss, 1991).

Doherty and Boss (1991) stated, "If paradoxical methods are used in a way that invades the autonomy of clients, deceives the client, or undermines the therapist's trustworthiness, then they are unethical. But these are also criteria for evaluating all therapeutic interventions"(p. 616). Haley (1976) argued that manipulation is inherent to all forms of therapy and that concealment is inevitable because therapists cannot possibly reveal all their thoughts to clients. Doherty and Boss (1991) concluded that paradoxical interventions are not necessarily

manipulative and that they require no more or no less ethical justification than conventional interventions in the absence of harmful clinical impact.

Ethical Codes

Websters New World Dictionary of the American Language defined ethics as "standards of conduct and moral judgment of a particular philosophy, religion, or group". As such, ethical codes represent a consensus of many members of a profession as to standards of moral conduct (Huber, 1994). Codes of ethics for the mental health care professions define basic principles dictating appropriate therapeutic practice, describe professionals' responsibility to clients, and provide a degree of assurance that professionals will demonstrate respect for the mores and expectations of society (Huber, 1994).

Huber (1994) stated that codes of ethics are limited to offering general philosophical guidance for conceptualizing and responding to ethical dilemmas. As it is impossible to address all potential ethical conflicts, ethical codes provide a framework for professional responsibility. Ethical codes and principles utilize general terminology as attempts to specify every ethical situation would make them voluminous and inhibit ethical decision making of the professional individual (Vesper & Brock, 1991).

The AAMFT Ethical Code

The *AAMFT Ethics Code* is a distinct professional document that provides three preventive services for both clinical members of the Association and for the field of marriage and family therapy (Brock, 1994). Foremost of these is that the principles of the *Code* and the procedures established to enforce it, provide practice guidelines that allow for disciplinary action to be taken against offending members. These guidelines authorize punitive action to be taken against those

members who harm clients, supervisees, or the profession. The *Code* also presents guidelines that describe the characteristics of safe and effective clinical practice which are based on the collective experiences of the Association. Lastly, the *Code* establishes the perception among members, clients, and those interacting with AAMFT that marriage and family therapists practice safely and promote client welfare.

The *AAMFT Code of Ethics* (1991) is comprised of eight general principles with additional subprinciples that delineate particular areas of appropriate or problematic behavior (Preister, Vesper, & Humphrey, 1994). Each category of principle is listed below with a brief description of specific examples of the subprinciples:

1. Responsibility to Clients. Marriage and family therapists will not: refuse professional services to anyone on the basis of race, gender, religion, national origin, or sexual orientation; enter into a dual relationships; be sexually intimate with clients; make recommendations regarding marital status; abandon or neglect clients.

2. Confidentiality. Marriage and family therapists guard the confidences of each individual client and may not disclose information except a) as mandated by law, b) to prevent harm to self or others, c) when the therapist is a defendant in legal proceedings, and d) when there is a written waiver.

3. Professional Competence and Integrity. Marriage and family therapists: abide federal, state, and professional rules; seek help for problems that impact their work; diagnose and treat problems within the realm of their competence; keep abreast of developments in the field; and refrain from all forms of harassment.

4. Responsibility to Students, Employees, and Supervisees. Marriage and family therapists: avoid dual relationships; refrain from sexual intimacy with students and supervisees; and maintain confidentiality of supervisees.

5. Responsibility to Research Participants. Marriage and family therapists: obtain informed consent of participants; respect participants right to withdraw from research; and maintain confidentiality of participants.

6. Responsibility to the Profession. Marriage and family therapists: are accountable the standards of the profession; assign appropriate publication credit; participate in activities that benefit society; are concerned about developing laws that promote the public interest.

7. Financial Arrangements. Marriage and family therapists: disclose fees at the onset of treatment; refuse payment for referrals; refrain from charging excessive fees; represent facts accurately to clients and third party payers.

8. Advertising Marriage and family therapists: accurately represent their education, ability, and clinical experience.

While the *AAMFT Code of Ethics* provides guidance for many areas of professional conduct, it fails to specifically address many of the aforementioned ethical concerns. Lakin (1994) called for the establishment of ethical codes and principles that better reflect the relational issues associated with marriage and family therapy.

Compliance with the AAMFT Ethical Code

Vesper and Brock (1991) stated that the responsibility of adhering to ethical codes is contingent upon the therapist's sense of ethical integrity and the burden is on the public to inform the professional organization of violations. The Ethics

Committee for the American Association for Marriage and Family Therapy has seen a remarkable increase in the number of cases brought forth to the Committee alleging ethical violations of the code of conduct. Preister, Vesper, and Humphrey (1994) explained that the Committee's caseload had grown from an average of 50 complaints resulting in formal cases for each quarterly review in 1989 to over 100 formal cases per quarter in 1991. They attributed this substantial increase to: the Committee's pro-active stance; increased consumer awareness of what constitutes unethical behavior; state regulations; and an increase in the ethical knowledge of therapists in conjunction with their duty to report violations.

Brock and Coufal (1994) conducted a national survey of randomly selected Clinical Members of AAMFT to ascertain therapists' self-reported adherence with the *AAMFT Ethics Code* and their attitudes toward its principles. Subjects were requested to rate 104 items, each of which was a discrete behavior derived from the marriage and family literature and the *AAMFT Code of Ethics (1988)* . The findings demonstrated that marriage and family therapists have the capacity to act in an ethical manner as well as the capacity to do harm. While most of the therapists surveyed reported compliance with the code, the results also indicated a degree of non-compliance on each identified behavior. Any amount of exploitation or negligence of ethical principles in a therapeutic relationship is too much.

The authors identified 12 specific practices that need particular attention in continuing education efforts and in the ethics training provided to students (p.47): 1) Advising clients on marital status; 2) Failing to obtain consent to tape or observe sessions; 3) Failing to report child abuse; 4) Treating homosexuality as

pathological; 5) Failing to warn potential victims of lethal threats; 6) Failing to participate in continuing education activities; 7) Giving medical advice; 8) Practicing when too tired or distressed; 9) Providing therapy to students and supervisees; 10) Tailoring diagnoses to meet insurance criteria; 11) Failing to verify employee credentials; and 12) Failing to have research reviewed to protect participants.

Green and Hansen (1989) investigated the self-reported behaviors of marriage and family therapists in relation to 16 ethical dilemmas, 8 which were addressed in the *AAMFT Code of Ethics* (1984) and 8 which were not. The sample population was 202 randomly selected from Clinical Members of AAMFT. The ethical dilemmas, in rank order of frequency of occurrence, were: 1) Treating the entire family unit; 2) Differing therapist and family values; 3) Treating the entire family after one member leaves; 4) Professional development activities; 5) Imposing therapist values-feminist; 6) Manipulating family for therapeutic benefit; 7) Payment for services; 8) Decision on marital status; 9) Reporting child abuse; 10) Supervision of trainees, 11) Family vs. individual needs, 12) Professional consultation; 13) Informed consent; 14) Testifying; 15) Unethical organization; and 16) Sharing research results. All of the ethical dilemmas were encountered by some of the participants and 13 of the 16 dilemmas were encountered by more than 50% of the respondents. It was concluded that the *AAMFT Code of Ethics* is helpful but incomplete in providing guidance for many ethical situations.

Ethical Decision Making Models as an Adjunct to Professional Codes

Maddock (1992) stated that “therapeutic ethics refers to more that legal requirements or codes of professional conduct.... ethics involves reasoning and

decision making about good or right actions based upon one's personal values and moral character" (p. 116). Because professional ethical codes are limited by their inability to address all situations, Beamish and Navin (1992) recommended that therapists and therapist educators go beyond the learning and teaching of ethical codes and develop an understanding of the process of ethical decision making. Incorporating knowledge of ethical decision making models allows therapists to interpret their professional codes of ethics and evaluate the impact and potential consequences of their clinical decisions. Zygmond and Boorhem (1989) noted that utilizing models of ethical decision making when formulating clinical decisions is not widespread in marriage and family therapy because the accepted practice has been to rely on acknowledged schools of family therapy in determining what constitutes effective and ethical treatment approaches. An approved philosophy or technique in one model may be considered a breach of ethics by another. Zygmond and Boorhem urged educators to teach students that strict adherence to a therapeutic approach may result in unethical decisions and suggest the incorporation of an ethical decision making model into the curriculum in order to facilitate ethical evaluation. Kitchener's (1986) model of ethical decision making is garnering increased attention in the mental health literature as a possible model to be incorporated into the graduate curriculum.

Kitchener's Model

Kitchener's (1986) model of ethical decision making identifies four major processes underlying applied ethics in therapy. The model is based on the assumption that ethical decisions are situation-dependent and utilize a tiered approach which moves to increasingly more abstract levels of ethical reasoning and justification (Zygmond & Boorhem, 1989).

Process 1: Interpreting a Situation as Requiring an Ethical Decision

The first stage involves the ability of the therapist to perceive the impact of one's behaviors on the welfare of the client. Huber (1994) stated that this process depends on therapists' developing ethical sensitivity and an awareness that their therapeutic interventions may be potentially harmful as well as beneficial.

Process 2: Formulating an Ethical Course of Action

The second stage of ethical decision making recognizes the necessity of fundamental ethical guidelines because one must not only be aware that an ethical situation exists, one must be able to formulate an appropriate course of action (Huber, 1994). Kitchener (1986) made a distinction between two types of ethical justification: an intuitive level and a critical-evaluative level. The intuitive level depends on the use of what she terms 'ordinary moral sense', a set of ethical beliefs and feelings about appropriate and inappropriate behavior. Ordinary moral sense is essential when encountering frequently-occurring ethical dilemmas because it enables the therapist to take immediate action (Zygmond & Boorhem, 1989).

The critical-evaluative level of ethical justification consists of three tiers: ethical rules, ethical principles, and ethical theory (Kitchener, 1986). At the first tier, an appropriate ethical action can be determined by consulting formal ethical rules, such as professional codes of conduct or state laws. One moves to the second tier, that of general ethical principles, if the professional codes are deemed insufficient. Kitchener (1992) has identified five ethical principles intrinsic to the helping professions: autonomy, nonmaleficence, beneficence, fidelity, and justice.

The principle of **autonomy** purports that individuals have the freedom of thought , choice, and action as long as their behaviors do not interfere with these

same freedoms of others. Therapists do not have the right to impinge upon their client's lives just because they disagree with their beliefs and choices; therapists are obligated to accept these beliefs and choices as long as these decisions do not interfere with the rights of others (Zygmond & Boorhem. 1989). the second principle, **nonmaleficience**, fundamentally asserts that above all else, therapists should do no harm. The third principle, **beneficence**, involves one of the key concepts underlying the helping professions: promoting the health and welfare of others. **Fidelity**, the fourth principle, addresses the characteristics of trustworthiness and loyalty which are essential to the privileged nature of the therapeutic relationship. The last principle, **justice**, refers to the fair treatment of individuals and is based on the assumption that people should be treated as equals (Vasquez, 1992; Zygmond & Boorhem, 1989).

The third level of critical-evaluative decision making involves the use of ethical theory in order to ascertain which principles are relevant to a specific situation (Beamish & Navin, 1992). Kitchener (1986) has identified two ethical theories, universalizability and the balancing principle, that may be used when general ethical principles are in conflict. The universalizability theory states that a decision may be considered ethical only if it can be unambiguously generalized to all similar cases. According to the balancing principle, potential harm to a client must be balanced against possible benefits in order to make an ethical decision that will produce the least amount of avoidable harm.

Process 3: Integrating Personal and Professional Values

Process 3 addresses the incongruence between having knowledge of ethically appropriate behaviors and acting accordingly. Research conducted by Wilkins, McGuire, Abbott, and Blau (1990) concluded that while most

professional clinicians are capable of recognizing behavior deemed ethical by professional standards, they are less than willing to follow through with appropriate actions. This third process involves the degree to which individuals incorporate knowledge of ethical principle into their lives (Huber, 1994).

Process 4: Implementing an Action Plan

The fourth process involved in ethical decision making recognizes therapists' need to develop and maintain a sense of ethical responsibility. Huber (1994) claimed that it is not sufficient for therapists to be concerned about and knowledgeable of ethical issues; the professional practice of therapy demands that they take responsibility for their behaviors and the consequences of those choices.

To determine the extent to which ethical decision-making is being addressed in marriage and family therapy graduate training programs, ethics educators in this survey will be asked to rate the current and future emphasis placed on decision-making. This subject will be addressed in the sections on the goals and on the content of ethics training.

Ethics Education and Training

As marriage and family practitioners strive to address the ethical concerns inherent in the practice of therapy, attention is increasingly being placed on ethics education and training. The majority of literature reviewed for this study emphasized the need for a more stringent focus on the content and implementation of ethics training. Brock and Coufal (1994) reported that of the Clinical Members of AAMFT surveyed, 13.5% rated their graduate coursework in ethics as terrible or poor, 24.8% rated it as adequate, and 59.8% rated it as good or excellent. Many professionals rely on codes of ethics as their primary source of information on appropriate ethical behavior. While professional codes provide a useful

framework for guiding ethical therapeutic behavior, they are insufficient without the larger context of ethics training. There is a growing consensus in the literature in support of the incorporation of ethical decision making models into the curriculum of graduate training programs in order to teach therapists the **process** of ethical decision making (Beamish & Navin, 1992; Doherty & Boss, 1991; Gawthorp & Uhlemann, 1992; Zygmond & Boorhem, 1989).

The American Psychological Association began to require ethics training in its accreditation standards in 1979 (Welfel, 1992). Welfel stated that the percentage of psychology training programs offering a separate, required ethics course has grown from 6% in 1956 to 69% in 1990. Coverdale, Bayer, Isbell, and Moffic (1992) reported in their national study of ethics education in psychiatry programs that 60% offered a formal course or seminar in ethics. Counselor education programs that are accredited by the Council for the Accreditation of Counseling and Related Educational Programs (CACREP) are required to provide ethics instruction in the curriculum (Beamish & Navin, 1992). The Commission on the Accreditation for Marriage and Family Therapy Education has joined these other schools of therapy in mandating that graduate programs in marriage and family therapy offer coursework in ethical, legal, and professional issues (AAMFT, 1991).

Mental health professionals place value on education in the hopeful expectation that ethics instruction will provide the knowledge and awareness required to empower therapists to make ethical clinical decisions. A number of specialized areas of the helping professions, including psychiatry, psychology, nursing, and sociology, have recently begun to examine the nature of their ethics training. Studies have examined a variety of ethical training issues: professional

and educational experience of the ethics instructors, instructional format and materials, program goals, specific content areas, theoretical models used, and perceived effectiveness.

Ryder and Puckett (1991) described the components of Multi-Course Sequential Learning, a model for integrating ethics education into the undergraduate programs of nursing. The model incorporated ethics training into existing coursework and trained faculty to enhance their ethics instruction by using the rich examples inherent in students' clinical experiences. Folse (1991) urged the sociology profession to infuse ethics training into all areas of the curriculum and to move beyond the prevalent mentor/apprenticeship model and adopt an ethical decision making model. A study of medical faculty involved in formal ethics training indicated the types of difficulties encountered by educators; the most prevalent being logistical problems, lack of reinforcement for teaching ethics, and deficiencies in faculty background and training (Strong, 1992). Vanek (1990) conducted a comprehensive survey of accredited clinical and counseling psychology programs to examine characteristics of ethics instructors, specific content areas, goals of ethics instruction, and instructional practices. She found that lecture, discussion, and case studies were the predominant instructional methods and that course outcomes were assessed using term papers, tests, and class discussions. The educational goals that faculty most strongly endorsed were: 1) to become sensitive to ethical issues, 2) to execute ethical behavior, 3) to facilitate ethical decision making, and 4) to gain knowledge of the ethical code (Welfel, 1992; Vanek, 1990).

While the profession of marriage and family therapy has joined with other mental health disciplines in mandating formal ethics education for accredited

training programs, little is known about the specific nature of the content and process of instruction. Harris (1995) conducted a qualitative study that involved a content analysis of the syllabi from a sample of ethics courses in 45 accredited graduate programs in marriage and family therapy. He found common categories of syllabi content to be: course content; course objectives; required papers; grading and participation; and a wide variety of specific course content areas. Due to a great deal of diversity in the ethical subject matter presented, he suggested the possibility that the self of the therapist/professor influences what is being taught in ethics courses more than the Commission on Accreditation.

Piercy and Sprenkle (1983) described a model course entitled "Ethical, Legal, and Professional Issues in Family Therapy". Topics covered in each of these three areas are detailed, along with suggested teaching strategies and course materials. The ethical component included the following subjects: feminism and hedonism; ethics of an ecosystemic epistemology; ethical use of paradox; confidentiality and privileged communication; and ethical codes. The authors recognized that many important issues, such as the requirement of some therapists that all family members be present, were not covered due to time constraints.

Norcross, Alford, and DeMichele (1992, cited in Huber, 1994) conducted a survey that requested psychotherapists to predict the most popular theoretical orientations in the future. Systems/family therapy was ranked as the most popular theoretical orientation and the preferred treatment modality of the future, ahead of group and individual orientations. This trend is reflected in the fact that the number of COAMFTE accredited graduate programs in marriage and family therapy has grown from 29 in August 1985 (Huber, 1994) to 72 in 1995 (AAMFT, 1995) .

As the number of practitioners in the profession of marriage and family therapy grows, there is an increasing obligation to ascertain ways to facilitate the education of ethically responsible therapists. This becomes especially urgent considering that 51 out of the 123 identified training programs are not accredited by COAMFTE. While COAMFTE accredited programs in marriage and family therapy are required to offer a separate course in ethics, it is unknown to what extent ethics training is provided in non accredited programs. A specific course on ethical issues in marriage and family therapy is not required by the CACREP guidelines for specialization in marriage and family therapy (Beamish & Navin, 1992). Therapists who have primarily been trained in traditional, individually-oriented counseling programs may encounter difficulty rendering ethical decisions which involve a systemic/relational framework (Beamish & Navin, 1992; Huber, 1994; Lakin, 1994). Additional concerns arise from the implications of being trained to abide other codes of ethics that do not address and prepare therapists to deal with relational issues (Lakin, 1994).

Educating and training therapists to be knowledgeable of ethical principles and capable of executing ethical clinical decisions is an enormous challenge. The literature substantiates the importance of examining the prevalence of ethics training, the specific curricular components that attend to ethical knowledge and conduct, and the extent to which graduate students are being trained to address ethical dilemmas unique to marriage and family therapy. It is my hope that this inaugural study will further the commitment of the profession of marriage and family therapy to ethics training by providing a foundation of information that will stimulate professional discussion and research on ways to improve its quality and effectiveness.

CHAPTER III

Methodology

Sample

All graduate programs offering masters and doctoral degrees in marriage and family therapy in the United States and Canada were the focus of this study. The current list of training programs was derived from the 1995 edition of *Peterson's Guide to Graduate Programs in the Humanities, Arts, and Social Sciences.* and the *List of Accredited and Candidacy Status Programs* (COAMFTE, 1995). There were 123 graduate programs identified, with 72 having full or provisional accreditation by the Commission on Accreditation for Marriage and Family Therapy Education (see Appendix A).

The target person of the survey was the person mainly responsible for ethics education within each graduate training program. A list of the program directors/department chairs was garnered from the *Peterson's Guide to Graduate Programs in the Humanities, Arts, and Social Sciences* (1995) the *List of Accredited and Candidacy Status Programs* (COAMFTE, 1995) so that they could forward survey materials to the appropriate parties. The program director was asked to complete the sections of the survey that focus on the future direction of ethics education if the program did not offer formal ethics instruction.

Procedure

A cover letter, survey, and a return envelope were mailed to all program directors in the designated programs. The cover letter detailed the purpose of the study, the major areas of ethics education to be investigated, and an explanation of how the information would be used (see Appendix B). The program director was requested to forward the survey materials to the person responsible for ethics

instruction or to personally respond to the appropriate sections of the survey if there was no formal ethics instruction.

Participants were assured that any information provided would be used collectively, with individual responses remaining confidential. Surveys were coded for the purposes of following up on those not returning survey materials and determining a list of those programs that wished to have a copy of the results sent to them at the completion of the study. The coding protocol was kept in a locked filing cabinet accessible only to the principle investigator and was destroyed after the closing date for final return of survey materials. In an attempt to maximize the response rate, an additional mailing was conducted two weeks after the initial mailing to those sites not returning the survey. Those individuals who had not returned a survey after four weeks were contacted by telephone to determine if they needed an additional set of materials and to request the return of the materials at their earliest convenience. Because 22 surveys were returned with the "Desired" portion of the survey incomplete in two sections, an adjustment was made to the original methodology. Telephone contact was attempted in order to gather the missing information. Thirteen programs were able to supply the missing data.

Instrumentation

Vanek (1990) stated that the concept of ethics education involves the instructional features of education in conjunction with the theoretical aspects of ethics. The concept of ethics education applied to the realm of therapy entails the integration of ethical theory and language with therapeutic conceptualizations and practice within a didactic structure.

Vanek (1990) developed the Survey on the Current and Future Direction of Ethics Education for Clinical and Counseling Psychologists as a means of investigating ethics as applied to the field of psychology within an educational design. This survey emerged from an extensive review of: position papers on ethical foundations; fundamental literature on ethical analysis; research studies on ethical decision-making and educational practices; and previous surveys on ethics education in psychology. The survey was subjected to critical review by a Survey Research Laboratory specialist and faculty members from a variety of theoretical backgrounds and professional orientations.

Vanek identified eight dimensions from the literature that she used to construct the survey:

1. Characteristics of the ethics instructor
2. Structure of ethics education
3. Instructional practices
4. Instructional materials
5. Goals of ethics education
6. Content of ethics education
7. Evaluation indices
8. Reasons for ethics education

In order to increase the validity and reliability of the survey, the items were structured to encourage an increased response rate with less missing data and fewer random responses. In addition to multiple choice items, Likert scales were used to examine dimensional aspects in an efficient and fluid manner.

All additional survey material was extrapolated from the marriage and family therapy literature, the *AAMFT Code of Ethics*, and the empirical literature

on ethical decision-making. Modifications have been made in the language, format, and content of Vanek's survey instrument in order to adapt it to the survey population of marriage and family therapy . These changes included the substitution of the terms 'marriage and family therapy' for 'psychology' and 'American Association for Marriage and Family Therapy' for 'American Psychological Association'. Five questions were deleted because they were deemed inappropriate for the purposes of this study.

Section A was expanded to include questions pertaining to accreditation status and departmental affiliation of the graduate program. Participants were also asked to describe the theoretical framework that best describes their program (individual vs. systemic), to list the theoretical orientations that are represented by the faculty, and to specify the theoretical orientation that best describes their own practice.

Section F included the addition of 10 content areas derived from an extensive review of the literature that pertain specifically to ethical issues in marriage and family therapy. Respondents were asked to rate the current and future emphasis on the following issues: 1) Defining treatment unit; 2) Client welfare; 3) Treating entire family or withholding treatment; 4) Informed consent of all family members; 5) Switching treatment modalities; 6) Confidentiality issues related to family secrets; 7) Use of DSM-IV; 8) Differing therapist and family values; 9) Decisions on marital status; and 10) Use of covert strategies.

Data Analysis

The information was coded into a computer database and then computer analyzed by the StatView statistical package. Descriptive statistics (i.e. mean and standard deviation, percent, frequency) covering all sections of the survey were

utilized to delineate the present and future status of ethics education in marriage and family therapy graduate programs. A series of paired t tests for within-group comparisons was used to determine if significant differences existed between what graduate programs are currently doing versus what they hope to do in the future regarding ethics education. The last test statistic employed was a series of Student t tests for independent groups that addressed whether there were significant differences between accredited versus non-accredited marriage and family therapy programs in how they conduct ethics education (Vanek,1990).

CHAPTER IV

Results and Discussion

Surveys were mailed to 72 accredited and 51 non-accredited marriage and family therapy graduate programs in the United States and Canada. A total of 65 surveys were returned, resulting in an overall response rate of 53%. Of the 65 surveys returned, 62 were usable; two were discarded because of incomplete data and one was unusable due to discontinuation of the graduate program. Sixty-four percent (N=40) of the returned surveys were from accredited programs, with the remaining 36% (N=22) representing non-accredited graduate programs. The sample appears to be representative of the overall graduate marriage and family therapy program population where 59% of the programs are accredited and 41% are not accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE).

General Information

Description of Graduate Programs

In addition to the 64.5% of the marriage and family therapy programs that were accredited by COAMFTE, 1.6% were accredited by the American Psychological Association (APA), 3.2% were accredited by the Council for the Accreditation of Counseling and Related Educational Programs (CACREP), and 8.1% were accredited by other professional organizations. It is interesting to note that nearly one quarter (22.6%) of the sample was not accredited by any sanctioning professional organization.

Table 1 describes the type of graduate degrees offered by marriage and family therapy programs. The master of science degree was offered by 46.8% of

Table 1
Type of Degree(s) Offered

Degree Type	Accredited (n=40) %	Not Accredited (n=22) %	Total Sample (n=62) %
MA	17.5	59.1	32.3
MS	52.5	36.4	46.8
Ph.D.	30.0	4.5	21.0
Post-degree certificate	15.0	4.5	11.3
Other	5.0	4.5	4.8

Note. % = percentage of respondents

Note. Totals are greater than 100% due to multiple degrees offered

all graduate programs, followed by the master of arts degree (32.3%), doctor of philosophy (21.0%), and post-degree certificate (11.3%). There appear to be differences in the proportion of degrees offered by accredited and non-accredited programs. A higher percentage of non-accredited programs (59.1%) offered the master of arts degree than accredited programs (17.5%). Conversely, more accredited programs (30.0%) offered the doctor of philosophy degree than do non-accredited programs (4.5%).

Because it is often assumed that marriage and family therapy training utilizes a systemic theoretical framework, participants were questioned regarding the overall theoretical orientation of their department in an attempt to assess any diversity among programs. Respondents indicated the theoretical framework , individual or systemic, that best described the theoretical orientation of their graduate program. While the overwhelming majority (91.9%) of participants reported a systemic theoretical framework, 6.4% reported an individual orientation, and 1.6% stated that their program incorporated both orientations. None of the programs that reported an individual theoretical orientation was accredited by COAMFTE.

Professional Characteristics of Ethics Educators

Table 2 describes the academic rank of those persons responsible for ethics education. In the total sample of ethics educators, 35.6% held the rank of professor, 27.1% held the rank of assistant or associate professor, and 10.2% held the rank of instructor/lecturer. The percentages of educators who held the academic ranks of associate and assistant professor were quite similar in both accredited and non-accredited graduate programs. A larger percentage of ethics educators in non-accredited programs held the rank of professor (41.0%) than

Table 2
Academic Rank of Ethics Instructors

Rank	Accredited (n=37) %	Not Accredited (n=22) %	Total Sample (n=59) %
Professor	32.4	41.0	35.6
Associate professor	27.0	27.3	27.1
Assistant professor	27.0	27.3	27.1
Instructor/lecturer	13.5	4.5	10.2

Note. % = percentage of respondents

educators in accredited graduate programs (32.4%). Ethics educators in accredited programs had a higher percentage of individuals holding the rank of instructor/lecturer (13.5%) than educators in non-accredited programs (4.5%).

The academic positions of ethics instructors are described in Table 3. The majority of ethics educators held the position of faculty member (40.3%) or program director (41.9%), with a smaller percentage holding all other positions (17.7%). Table 4 describes the primary departmental affiliation of ethics instructors within their university/college. In accredited marriage and family therapy programs, the largest percentage of instructors were affiliated with a department of family studies (40.0%); this contrasts starkly to 4.5% of the instructors in non-accredited programs. In non-accredited graduate programs, 31.8% of the ethics instructors were affiliated with a department of psychology as compared to 2.5% of the accredited programs. Fifty percent of the instructors in non-accredited programs cited their primary affiliations as the departments of psychology and education while 55% of the instructors in accredited programs cited the departments of marriage and family therapy and family studies. Diversity among graduate programs in this area of departmental affiliation was exemplified by the substantial percentage of instructors that chose the category "Other" (15.0% accredited; 22.7% non-accredited). The following departments were cited by at least one respondent: sociology, psychiatry, counseling, social work, counseling psychology, behavioral science, and professional psychology.

The doctor of philosophy was the highest academic degree earned by the largest percentage of ethics instructors in both accredited (76.9%) and non-accredited (68.2%) programs (see Table 5). Instructors in non-accredited graduate programs reported a higher percentage of doctor of education degrees (18.2%)

Table 3
Academic Position of Ethics Instructors

Position	Accredited (n=40) %	Not Accredited (n=22) %	Total Sample (n=62) %
Faculty member	37.5	45.5	40.3
Adjunct/affiliate faculty	5.0	4.5	4.8
Department chair	7.5	13.6	9.7
Program director	45.0	36.4	41.9
Other	5.0	0.0	3.2

Note. % = percentage of respondents

Table 4
Primary Affiliation in University/College

Primary Affiliation	Accredited (n=40) %	Not Accredited (n=22) %	Total Sample (n=62) %
Department of psychology	2.5	31.8	12.9
Department of theology	5.0	4.5	4.8
Department of family studies	40.0	4.5	27.4
Department of education	2.5	18.2	8.1
Department of marriage and family therapy	15.0	4.5	11.3
Post-degree program	7.5	9.1	8,1
Interdivisional	12.5	4.5	9.7
Other	15.0	22.7	17.7

Note. % = percentage of respondents

Table 5
Highest Academic Degree Earned by Ethics Instructor

Degree	Accredited (n=39) %	Not Accredited (n=22) %	Total Sample (n=61) %
MA	2.6	4.5	3.3
MS	2.6	0.0	1.6
Ed.D.	5.1	18.2	9.8
Ph.D.	76.9	68.2	73.8
Other	12.8	9.1	11.5

Note. % = percentage of respondents

than accredited programs (5.1%). The other degree options were fairly proportionate between accredited and non-accredited programs. Examples of other degree types cited were: doctor of ministry; juris doctorate; and masters in social work, theology, and education.

Table 6 describes the professional field of the highest academic degree earned by ethics instructors. The largest percentage of instructors in accredited programs earned their degrees in marriage and family therapy (47.5%) while the largest percentage of instructors in non-accredited programs earned their degrees in psychology (50.0%). Conversely, only 15.0% of the instructors in accredited programs earned their degree in psychology and 22.7% of the non-accredited instructors received their degrees in marriage and family therapy. The percentages of the remaining field options for accredited programs were proportionate, ranging from 10.0% to 15.0%. There was a slightly larger range of percentages (4.5% to 13.6%) in the remaining field options for non-accredited programs.

Ethics instructors were requested to indicate the number of years of professional experience they had in their academic work and clinical practice. The mean scores of the total sample of ethics instructors are reported in Table 7. The mean number of years of academic experience for the sample was 14.5 with a range of 1 to 36 years. The mean number of years of clinical practice was 18.0 with a range of 0.5 to 35 years. While there is a wide range in the number of years of professional experience, the results indicate that ethics educators have strong clinical and academic backgrounds.

Table 8 describes the ethics training experiences of ethics educators in marriage and family therapy graduate programs. All of the respondents in the total sample indicated that they had received formal training in ethics. Discussion with

Table 6
Field of Highest Academic Degree Earned by Ethics Instructors

Degree	Accredited (n=40) %	Not Accredited (n=22) %	Total Sample (n=62) %
Marriage and family therapy	47.5	22.7	38.7
Family studies	10.0	4.5	8.1
Theology	12.5	4.5	9.7
Psychology	15.0	50.0	27.4
Counselor education	12.5	13.6	13.3
Other	12.5	9.1	11.3

Note. % = percentage of respondents

Note. Totals greater than 100% because of multiple degrees earned

Table 7
Years of Professional Experience by Ethics Instructors

Type of Experience	Accredited (n=39)		Not Accredited (n-22)		Total Sample (n=61)	
	M	Range	M	Range	M	Range
Academic work	14.4	1-36	14.6	2-32	14.5	1-36
Professional practice	18.7	.5-35	16.7	5-35	18.0	0.5-35

Table 8
Ethics Training Experiences of Instructors

Type of Training	Accredited (n=40) %	Not Accredited (n=22) %	Total Sample (n=62) %
Graduate course work	80.0	72.7	77.4
Postgraduate course work	32.5	18.2	27.4
Clinical supervision	77.5	63.6	72.6
Discussion with colleagues	82.5	91.0	85.5
Conference	67.5	59.1	64.5
Workshop	70.0	59.1	66.1
Readings	85.0	81.8	83.9
No formal training	0.0	0.0	0.0
Other	17.5	18.2	17.8

Note. % = percentage of respondents

colleagues (85.5%), readings (83.9%), and graduate course work (77.4%) were reported as the top three types of ethics training received by instructors in both accredited and non-accredited programs. The category "Other" was selected by 17.8% of the total sample of ethics instructors. Some examples of other forms of ethics training cited by the instructors were: teaching the ethics course; individual supervision; ethics committee work;undergraduate coursework; legal training; and "spiritual growth as a Christian".

Ethics instructors were requested to state the theoretical orientation that best described their own work. A single theoretical orientation was identified by 59.0% of the respondents while the remaining 41% described their theoretical framework with multiple terms. The following is a list of the theories cited: structural, strategic, oppression-sensitive, psychodynamic, gestalt, social exchange, general systems, developmental, ecological, cognitive-behavioral, feminist, ecostructural, Bowenian, behavioral, solution-focused, postmodern, integrative, existential, Sullivanian, interpersonal, constructivist, social constructionist, experiential, cognitive, narrative, responsible decision making,transgenerational, Eriksonian, Milan, feminist constructivist, collaborative linguistic systems, attachment, symbolic interactional, MRI, and Adlerian. Systems, solution-focused, structural/strategic, and cognitive-behavioral theories were the most frequently cited orientations by ethics instructors.

Structure for Ethics Education

Respondents were requested to describe the manner in which ethics education is currently handled within their graduate marriage and family therapy program as well as the manner in which they believe ethics education should be handled in the future. Results indicated that 100% of the programs sampled

offered ethics education and believed that ethics education should be offered in the future. Ethics education was a required feature in all graduate programs and the entire sample also indicated that they believed it should remain a required feature in the future.

Table 9 describes the actual format and the desired format of ethics training in graduate programs. None of the participants reported that ethics was solely taught as a part of practicum/internship training and only a small percentage reported that ethics training was a part of a course or infused into other courses. The largest percentage (59.6%) of programs in the total sample reported that they currently offered a separate course in ethics, and 53.8% reported that ethics should be taught as a separate course in the future. The percentage of respondents who chose multiple categories to describe their training format increased from 38.5% in the "Actual" category to 42.3% in the "Desired" category. Ninety percent of those who chose multiple categories indicated that their programs currently offered a separate course in ethics and should continue to do so in the future. Therefore, 94.2% of the total sample of graduate programs currently offered a separate ethics course. The apparent decrease in the percentage of programs that indicated that ethics should be taught as a separate course in the future can be explained by the fact that there was an increase in the number of programs that believe that ethics education should consist of a separate course as well as being infused into other courses and practicum/internship training.

Participants were questioned about the total number of clock hours devoted to ethics education (see Table 10). The question focused on clock hours as opposed to semester hours in order to allow for programs that did not offer a separate course, to account for differences among course hour requirements and

Table 9
Format of Ethics Education

Format	Accredited (n=35)		Not Accredited (n=17)		Total Sample (n=52)	
	Actual	Desired	Actual	Desired	Actual	Desired
A separate course in ethics	62.9	60.0	52.9	41.2	59.6	53.8
Part of a course or infused in other courses	0.0	2.9	5.9	5.9	1.9	3.8
As a part of practicum and/or internship training	0.0	0.0	0.0	0.0	0.0	0.0
Multiple responses	37.1	37.1	41.1	52.9	38.5	42.3

Note. Numbers represent percentage of respondents

Table 10
Total Numer of Clock Hours Devoted to Ethics Training

Number of Hours	Accredited (n=33)		Not Accredited (n=19)		Total Sample (n=52)	
	Actual	Desired	Actual	Desired	Actual	Desired
0-5	3.0	3.0	0.0	0.0	1.9	1.9
6-12	3.0	3.0	5.3	0.0	3.8	1.9
11-20	9.1	6.1	10.5	10.5	9.6	7.7
21-30	12.1	12.1	21.1	15.8	15.4	13.5
More than 30	72.7	75.8	63.1	73.7	69.2	75.0

Note. Numbers represent percentage of respondents

semester/quarter systems, and to render more specific data about the exact quantity of time spent educating students about ethics. For the total sample of graduate programs, 69.2% indicated that more than 30 hours were actually devoted to ethics training and 75.0% stated that ethics training should consist of more than 30 hours in the future. A larger percentage of non-accredited programs (36.9%) currently offered less than 30 hours of ethics education than accredited programs (27.2%). Considering that COAMFTE requires that accredited programs offer a three to four hour course in ethics and professional issues, it is surprising that over one-quarter of the accredited programs reported providing ethics training for less than 30 clock hours - fewer hours than are generally associated with a three to four hour course.

Table 11 describes the point at which ethics education takes place in marriage and family therapy graduate programs. Fifty percent of the instructors in non-accredited and 36.4% in accredited programs stated that ethics education takes place in the middle of the training program. For both accredited and non-accredited graduate programs, there was a decline in the percentage of programs that reported training should take place in the middle of the program and a subsequent increase in the percentage of programs that reported ethics education should be integrated throughout the training program. The largest percentage of accredited programs indicated that ethics education should be integrated throughout the training program (42.4%), while the largest percentage of non-accredited programs indicated that ethics training should continue to take place in the middle of the program (38.8%).

More accredited programs reported that ethics education currently (21.2%) and should (24.2%) take place in the beginning of the training program than non-

Table 11
When Ethics Education Takes Place

When	Accredited (n=33)		Not Accredited (n=18)		Total Sample (n=51)	
	Actual	Desired	Actual	Desired	Actual	Desired
Beginning of program	21.2	24.2	5.6	11.1	15.7	19.6
Middle of program	36.4	24.2	50.0	38.9	41.2	29.4
End of program	3.0	3.0	11.1	11.1	5.9	5.9
Integrated throughout program	30.3	42.4	5.6	22.2	21.6	35.3
Multiple responses	9.1	6.1	27.8	16.7	15.7	9.8

Note. Numbers represent percentage of respondents

accredited programs (5.6%,actual; 11.1%, desired). Of the 15.7% in the total sample who used multiple responses to describe when ethics education takes place, only 12.5% cited that training currently takes place at the beginning of the program. Some programs (3.0%, accredited; 11.1%, non-accredited) reported that ethics education currently takes place at the end of the training program, Because graduate students usually begin working with clients prior to the end of their training program, one can question the efficacy of educating students on appropriate clinical practice after they have initiated therapeutic relationships.

The overwhelming majority (84.0%) of respondents in the total sample indicated their belief that the primary locus of responsibility for the teaching of ethics resides with the graduate training program (see Table 12). An additional 12.0% chose multiple categories to describe their current opinion as to primary responsibility. The percentage of non-accredited programs who selected multiple options increased from 11.8% in the "Actual" category to 23.5% in the "Desired" category, with the percentages for accredited programs remaining stable.

Instructional Materials and Practices

Instructional Materials

Participants were requested to list by title three basic educational materials that are currently employed in their ethics education program (e.g. articles, textbooks, literary works). The most frequently cited text was the first and second editions of "Ethical, Legal and Professional Issues in the Practice of Marriage and Family Therapy" (Huber & Baruth, 1987,1990). This book was utilized by 45.3% of the ethics instructors in the total sample. The following is a list of the other frequently used texts by ethics instructors: "AAMFT Code of Ethical Principles", (AAMFT, 1992); "AAMFT Ethics Casebook", (Brock, 1994); "Ethics, Legalities,

Table 12
Primary Locus of Responsibility for Ethics Training

	Accredited (n=33)		Not Accredited (n=17)		Total Sample (n=50)	
	Actual	Desired	Actual	Desired	Actual	Desired
Graduate training program	84.8	84.8	82.4	70.6	84.0	80.0
Practicum supervision	0.0	0.0	0.0	0.0	0.0	0.0
Internship supervision	0.0	0.0	5.9	5.9	2.0	2.0
Other	3.0	3.0	0.0	0.0	2.0	2.0
Multiple responses	12.2	12.2	11.8	23.5	12.0	16.0

Note. Numbers represent percentage of respondents

and Professional Practice Issues in Marriage and Family Therapy", (Vesper & Brock, 1991); and "Issues and Ethics in the Helping Professions", (Corey, Corey, & Callanan, 1988, 1994).

Instructional Methodologies

The majority of the ethics instructors reported that they utilized lectures (90.2%), simulations (65.6%), discussion (96.7%), case studies (95.1%), and small group activities (72.1%) in the teaching of ethics in their graduate marriage and family therapy programs (see Table 13). Over one-quarter (27.9%) of the total sample indicated that they used educational techniques other than those listed in the survey. Some examples of other instructional methodologies cited by the instructors were: videos; worksheets; student presentations; self-analysis of moral development; state law volumes; supervision; position papers; case staffing during practicum; and a field trip to meet ethics committee staff.

Evaluation Measures

Table 14 describes the evaluation indices that were used by ethics instructors to measure student performance in ethics education. The majority of marriage and family therapy programs evaluated students through classroom discussion (82.3%), case studies (82.3%), term papers (74.2%), classroom observations (71.0%), and essay tests (61.3%). While the most frequently utilized evaluation measure in non-accredited programs was term papers (90.9%), only 65.0% of the accredited programs reported using them. The most frequently utilized evaluation measure in accredited programs was case studies (87.%) as compared to 72.7% of the non-accredited training programs. Peer reviews (4.8%) and standardized tests of ethical development (4.8%) were the least cited methods

Table 13
Instructional Methods Utilized

Type of Method	Accredited (n=39) %	Not Accredited (n=22) %	Total Sample (n=61) %
Lectures	84.6	100.0	90.2
Simulations (role-plays, games)	71.8	54.5	65.6
Discussion	97.4	95.5	96.7
Case Studies	94.9	95.5	95.1
Small group activities	66.7	81.8	72.1
Seminars	41.0	27.3	36.1
Other	28.2	27.3	27.9

Note. % = percentage of respondents

Table 14
Evaluation Indices Used To Measure Student Performance

Evaluation	Accredited (n=40) %	Not Accredited (n=22) %	Total Sample (n=62) &
Classroom observations	72.5	68.2	71.0
Term Papers	65.0	90.9	74.2
Observations outside the classroom	32.5	18.2	27.4
Standardized tests of ethical development	7.5	0.0	4.8
Simulations (role play, games)	42.5	50.0	45.2
Tests: Essay	57.5	68.2	61.3
Multiple choice	20.0	45.5	29.0
Classroom discussion	80.0	86.4	82.3
Case studies	87.5	72.7	82.3
Peer reviews	5.0	4.5	4.8
Self-evaluations	40.0	27.3	35.5
Informal evaluations	22.5	22.7	22.6
Formal evaluations	27.5	31.8	29.0
Instructor/student conferences	20.0	13.6	17.7
Other	20.0	13.6	17.7

Note. % = percentage of respondents

of evaluation for all programs. Supervision and student presentations were some of the examples given by instructors who chose the "Other" category.

Each participant was requested to rank order the three most important evaluation methods employed in ethics education. Classroom discussion was selected as the most important evaluation method by the most ethics instructors (19.6%), followed in succession by term papers (14.3%) and tests (14.3%). Case studies was selected by 20.4% of the sampled instructors as the second most important evaluation method, followed in succession by classroom observations (13.0%) and tests (13.0%). Case studies was selected by 24.1% of the sample as the third most important evaluation, followed in succession by tests (14.8%), term papers (11.1%), and self-evaluations (11.1%). An examination of the overall frequency in which each method was ranked in importance revealed that case studies, tests, and classroom discussion were the three evaluation methods most frequently cited.

Best Avenue for Improving Ethical Knowledge

Participants were questioned as to their opinion regarding the best way to improve knowledge of ethical issues and standards in graduate training programs (see Table 15). The majority of instructors in accredited (71.1%) and non-accredited (61.9%) graduate programs indicated that they believed that a formal course in ethics was the superior means to increase their students' knowledge of ethics. Of those participants who were unable to chose a single response (11.9%), all but one included the formal course category among their selections. By including these multiple responses in the overall percentage of respondents citing the formal course category response, the rate increased from 67.8% to 78.0%. None of the respondents stated that exposure to published works is the best way to

Table 15
Best Avenue for Improving Knowledge of Ethical Issues and Standards

Format	Accredited (n=38) %	Not Accredited (n=21) %	Total Sample (n=59) %
Formal course	71.1	61.9	67.8
Workshop/seminar	0.0	4.8	1.7
Exposure in practicum	10.5	0.0	6.8
Exposure to ethical codes	2.6	4.8	3.3
Exposure to published works	0.0	0.0	0.0
Other	7.9	9.5	8.5
Multiple responses	7.9	19.0	11.9

Note. % = percentage of respondents

improve knowledge of ethical issues. Over one-half of the instructors who chose the category "Other" stated that the best means to improve ethical knowledge is to teach students how to utilize ethical decision-making models.

Reasons for Ethics Education

Because there are many reasons for including ethics education in the curriculum of marriage and family therapy graduate programs, ethics instructors were requested to rate the importance of 10 reasons (see Table 16). All of the reasons were measured on 5-point Likert scales ranging from "very important" to "not at all important" ("do not know" was included as the end point of the scale). There appears to be consensus among graduate programs regarding the most important reasons to provide ethics education. The following reasons were rated as "very important" by the majority of respondents: 1) "To improve ethical practice" (93.4%), 2) "To acquaint students with the norms of professional conduct" (86.9%), 3) "To help students see how their values, needs, and behaviors impact therapy" (80.3%), and 4) "To acquaint students with client rights in therapy and research" (72.1%). The majority of respondents (52.5%) rated the reason, "Due to the rise in litigation/formal complaints" as being "somewhat important". Two reasons, "To satisfy the interest of students/faculty" and "Due to rapid advances in therapy/research methods", were rated by the majority of participants as being "not very important" or "not at all important" (58.4% and 55.0%, respectively).

Ethics educators were provided with the opportunity to state their own reasons for the provision of ethics training; 11.3% did so and all rated their reasons as being "very important". The following were some of the reasons cited : "Because ethical practice leads to sound therapeutic practice....ethics knowledge

Table 16
Percentage of Programs Responding to each Answer Option for Reasons for Ethics Education

Reason	Very Important 1	Somewhat Important 2	Not Very Important 3	Not at All Important 4	Do Not Know 5	N
To acquaint students with client rights in therapy and research	72.1	19.7	6.6	0.0	1.6	61
To acquaint students with the norms of professional conduct	86.9	13.1	0.0	0.0	0.0	61
To meet the requirements for accreditation	14.6	49.2	27.9	4.9	3.3	61
Due to rise in litigation/formal complaints	24.6	52.5	19.7	3.3	0.0	61
Current code of ethics is insufficient as a guide to ethical practice	27.3	32.7	32.7	7.3	0.0	55
To improve ethical practice	93.4	4.9	0.0	0.0	1.6	61
To satisfy the interest of students/faculty	10.0	30.0	46.7	11.7	1.7	60
Due to rapid advances in therapy/research methods	8.3	33.3	46.7	8.3	3.3	60
To help students see how their values, needs and behaviors impact therapy	80.3	11.5	6.6	0.0	1.6	61

empowers beginners to engage their limitations, doubts, and values"; " To develop ethical decision-making processes and an awareness of ethical issues-especially in behavioral health issues"; "To fulfill legal responsibilities"; "To maximize moral aspirations"; 'To develop an ethical sense as a basis of practice"; "Religious values require ethical behavior"; and "To protect clients and practitioners".

Goals for Ethics Education

There are many possible goals for ethics education in marriage and family therapy graduate programs. Ethics instructors rated 16 identified educational goals according to the actual emphasis placed on them and the desired emphasis that should be placed on them in the future. All of the goals were measured on 6-point Likert scales ranging from "no emphasis" to "much emphasis".

A series of Student t tests for independent groups was employed to determine if significant differences existed between accredited and non-accredited marriage and family therapy programs in the degree of emphasis currently placed on educational goals. The results of the analysis indicated that there were no significant differences ($p < .05$) between accredited and non-accredited programs on any of the identified educational goals.

A series of paired t tests for within-group comparisons was conducted to determine if significant differences existed between the current emphasis on each of the educational goals and the desired emphasis that should be placed on them. Table 17 describes the results of the statistical analysis for each educational goal of ethics training. All of the desired emphasis mean scores were greater than the actual emphasis mean scores. With the exception of four goals, ("To introduce core terms and concepts of ethical discourse", "To strengthen the ability to detect biases", "To fashion coherent ethical arguments", and "To apply the AAMFT

Table 17
T-test Results for Current and Future Goals for Ethics Education

		Actual			Desired				
Goal/Purpose	N	M	SD	Range	M	SD	Range	t	p<
To facilitate the ethical decision-making process	53	5.434	.991	1-6	5.623	.837	1-6	-2.637	.0110
To explore the major philosophical approaches to ethical issues	52	3.712	1.273	1-6	4.096	1.302	1-6	-2.911	.0053
To introduce core terms and concepts of ethical discourse	52	4.846	1.073	2-6	4.865	1.121	2-6	-.330	.7424
To discriminate among complex ethical issues	53	5.150	1.150	1-6	5.358	1.076	1-6	-2.840	.0064
To improve the moral character of students	51	3.078	1.495	1-6	3.373	1.673	1-6	-2.331	.0238
To stimulate moral empathy by noting consequences of thought and behavior	50	4.260	1.306	2-6	4.540	1.249	2-6	-2.527	.0148
To become sensitive to ethical situations in therapy and research	53	5.528	.932	1-6	5.698	.696	3-6	-2.632	.0111
To strengthen the ability to detect biases	52	4.654	1.356	2-6	4.808	1.358	1-6	-1.935	.0586
To develop confidence and responsibility for one's decisions	52	5.019	1.129	2-6	5.231	1.002	2-6	-2.396	.0203
To advance complex problem-solving and thinking skills	53	4.547	1.309	1-6	4.906	1.181	1-6	-2.897	.0055
To apply theoretical knowledge to practical ethical issues	52	5.000	1.155	2-6	5.231	.962	2-6	-2.277	.0270
To fashion coherent ethical arguments	51	4.059	1.448	2-6	4.294	1.553	1-6	-1.949	.0570
To execute ethically appropriate behavior	52	5.481	.960	1-6	5.673	.857	1-6	-2.850	.0063
To apply the AAMFT ethical standards to ethical dilemmas	53	5.057	1.406	1-6	5.189	1.302	1-6	-1.631	.1090
To understand the reasoning of others	53	3.943	1.499	1-6	4.302	1.488	1-6	-3.045	.0036
To reduce the incidence of unethical behavior	53	5.453	1.011	1-6	5.585	.989	1-6	-2.813	.0069

ethical standards to ethical dilemmas"), there were statistically significant differences ($p < .05$) between the actual and desired emphasis placed on all other goals by ethics instructors.

These results indicate that ethics instructors in marriage and family therapy graduate training programs believe that a stronger emphasis should be placed on these educational goals in the future. However, these findings must be interpreted with regard to their substantive meaningfulness (Pedhazur, 1991). While it can be said that more emphasis should be placed on each of these goals, the exact degree of this change cannot be specified - i.e. one cannot know the difference between a level 5 degree of emphasis and a level 6 degree of emphasis. A conservative interpretation of the results can be that the majority of ethics instructors place emphasis on the identified goals, but acknowledge a desire to place a greater emphasis on them in the future.

Because it was anticipated that many of the goals would be rated highly due to the positive nature of this study, ethics instructors were requested to rank order the three most important educational goals in an attempt to differentiate and prioritize them. "To execute ethically appropriate behavior" was selected as the most important educational goal by the most ethics instructors (27.4%), followed in succession by the goals, "To facilitate the ethical decision-making process" (25.8%) and "To reduce the incidence of unethical behavior"(14.5%). "To execute ethically appropriate behavior" was selected by 25.8% of the sampled instructors as the second most important goal, followed in succession by the goals, "To facilitate the ethical decision-making process" (22.4%), "To become sensitive to ethical situations in therapy and research" (10.3%), and "To develop confidence and responsibility for one's decisions" (10.3%). "To execute ethically appropriate

behavior" was selected by 24.6% of the sample as the third most important goal, followed in succession by, "To become sensitive to ethical situations in therapy and research" (14.0%), "To facilitate the ethical decision-making process" (10.5%), and "To strengthen the ability to detect biases" (10.5%). An examination of the overall frequency in which each educational goal was ranked in the top three in importance revealed that "To execute ethically appropriate behavior", "To facilitate the ethical decision-making process", and "To become sensitive to ethical situations in therapy and research" were the three goals most frequently cited.

Table 18 describes the percentage of programs responding to each answer option for the goals of ethics education. This table helps to provide a picture of the distribution of responses, and to illustrate those programs that reported scores on the extreme points of the emphasis scale. As indicated by the percentage of those who selected the value of "6" at the end point of the emphasis scale, respondents expressed a strong current emphasis on the following educational goals: "To become sensitive to ethical situations in therapy and research (69.8%); "To execute ethically appropriate behavior" (67.3%); "To reduce the incidence of unethical behavior (66.0%); and "To facilitate the ethical decision-making process" (62.3%). These results appear to corroborate the conclusion that ethics instructors actually place much emphasis on the same goals that they rated as being the most important.

For 10 of the 16 goals listed, a percentage of the ethics educators indicated that they currently placed no academic emphasis on these educational goals. The educational goal, "To improve the moral character of students" is currently not emphasized by 13.7% of the sampled instructors. This educational goal was one of only three where there was an increase in the percentage (15.7%) of programs

Table 18
Percentage of Programs Responding to each Answer Option for Goals of Ethics Education

	Actual						Desired					
Goal/Purpose	No Emphasis				Much Emphasis		No Emphasis				Much Emphasis	
	1	2	3	4	5	6	1	2	3	4	5	6
To facilitate the decision making process	1.9	1.9	0.0	5.7	28.3	62.3	1.9	0.0	0.0	3.8	20.8	73.6
To explore the major philosophical approaches to ethical issues	3.8	17.3	17.3	32.7	23.1	5.8	1.9	13.5	13.5	28.8	28.8	13.5
To introduce core terms and concepts of ethical discourse	0.0	3.8	5.8	25.0	32.7	32.7	0.0	3.8	7.7	23.1	28.8	36.5
To discriminate among complex ethical issues	1.9	3.8	1.9	11.3	32.1	49.1	1.9	1.9	1.9	9.4	22.6	62.3
To improve the moral character of students	13.7	22.5	29.4	11.8	9.8	9.8	15.7	15.7	29.4	11.8	9.8	17.6
To stimulate moral empathy by noting consequences of thought and behavior	0.0	10.0	20.0	28.0	18.0	24.0	0.0	6.0	16.0	26.0	22.0	30.0
To become sensitive to ethical situations in therapy and research	1.9	0.0	1.9	5.7	20.8	69.8	0.0	0.0	3.8	1.9	15.1	79.2
To strengthen the ability to detect biases	0.0	11.5	7.7	21.2	23.1	36.5	1.9	7.7	5.8	19.2	23.1	42.3
To develop confidence and responsibiliy for one's decisions	0.0	3.8	5.8	21.2	23.1	46.2	0.0	1.9	3.8	17.3	23.1	53.8
To advance complex problem-solving and thinking skills	3.8	3.8	13.2	17.0	37.7	24.5	1.9	3.8	5.7	15.1	37.7	35.8
To apply theoretical knowledge to practical ethical issues	0.0	3.8	9.6	13.5	28.8	44.2	0.0	1.9	3.8	13.5	30.8	50.0
To fashion coherent ethical arguments	0.0	23.5	9.8	23.5	23.5	19.6	3.9	17.6	3.9	21.6	25.5	27.5
To execute ethically appropriate behavior	1.9	0.0	1.9	7.7	21.2	67.3	1.9	0.0	0.0	5.8	11.5	80.8
To apply the AAMFT ethical standards to ethical dilemmas	5.7	1.9	5.7	9.4	22.6	54.7	5.7	0.0	3.8	7.5	26.4	56.6
To understand the reasoning of others	7.5	13.2	13.2	24.5	26.4	15.1	5.7	7.5	13.2	26.4	18.9	28.3
To reduce the incidence of unethical behavior	1.9	1.9	0.0	7.5	22.6	66.0	1.9	1.9	0.0	5.7	13.2	77.4

that would not emphasize it in the future; the other goals being "To strengthen the ability to detect biases" and "To fashion coherent ethical arguments".

Content Areas in Ethics Education

There are many potential content areas on ethics that can be incorporated into the curriculum of marriage and family therapy graduate programs. In an effort to learn about the instructional topics and issues addressed in graduate training programs, ethics instructors rated 34 content areas according to the actual emphasis placed on them and the desired emphasis that should be placed on them in the future. All of the content areas were measured on 6-point Likert scales ranging from "no emphasis" to "much emphasis".

A series of Student t tests for independent groups was employed to determine if significant differences existed between accredited and non-accredited marriage and family therapy programs in the degree of emphasis currently placed on these content areas. Statistical analyses indicated that there were no significant differences ($p < .05$) between accredited and non-accredited programs on any of the identified content areas.

A series of paired t tests for within-group comparisons was conducted to determine if significant differences existed between the current emphasis on the ethics content areas and the desired emphasis that should be placed on them. Table 19 describes the results of the statistical analysis for each specified content area in ethics training. The desired emphasis mean scores for all items were greater than their actual emphasis mean scores. The content area, "Computers in therapy (treatment; record keeping)" was the only instructional topic that had a mean rating below 3.0 ($M = 2.906$)- the lower half of the scale in measuring emphasis. There were statistically significant differences ($p < .05$) between the

Table 19
T-test Results for Current and Future Content Areas in Ethics Education

		Actual			Desired				
Content Area	N	M	SD	Range	M	SD	Range	t	p<
Ethical principles/AAMFT Code of Conduct	53	5.208	1.116	2-6	5.245	1.072	2-6	-.444	.6590
Theory of ethics	52	3.750	1.007	2-6	4.115	1.078	2-6	-3.552	.0008
Ethical reasoning process	52	4.731	1.239	1-6	5.000	1.066	1-6	-3.083	.0033
Ethical codes/practices of other professions	52	3.365	1.560	1-6	3.500	1.462	1-6	-1.264	.2118
Personal values	53	4.491	1.265	1-6	4.698	1.218	1-6	-1.849	.0701
Research standards	52	3.423	1.273	1-6	3.750	1.235	1-6	-4.031	.0002
Confidentiality	53	5.642	.834	1-6	5.679	.827	1-6	-1.428	.1593
Duty to report abuse	53	5.604	.968	1-6	5.623	.925	1-6	-1.000	.3219
Involuntary commitment and treatment	53	4.038	1.224	2-6	4.283	1.262	2-6	-2.893	.0056
Suicide/homicide and duty to warn	53	5.547	.911	1-6	5.585	.908	1-6	-1.428	.1593
Therapist competency	53	4.792	1.215	1-6	5.189	1.039	1-6	-3.435	.0012
Sexual intimacy/exploitation with clients	53	5.566	.888	1-6	5.660	.831	1-6	-1.696	.0959
Publication issues (authorship/fabrication)	53	3.264	1.389	1-6	3.736	1.389	1-6	-4.060	.0002
Inappropriate public statements/advertising	53	3.943	1.099	2-6	4.208	1.063	2-6	-3.078	.0033
Computers in therapy (treatment; record keeping)	53	2.906	1.334	1-6	3.642	1.194	1-6	-4.894	< .0001
Fee assessment/bartering	53	3.736	1.258	1-6	4.113	1.050	2-6	-4.006	.0002
Professional responsibility	51	5.373	1.058	1-6	5.510	.880	1-6	-1.998	.0512

Table 19 continued
T-test Results for Current and Future Content Areas in Ethics Education

		Actual			Desired				
Content Area	N	M	SD	Range	M	SD	Range	t	p<
Political/social advocacy	53	3.472	1.353	1-6	3.906	1.334	1-6	-3.395	.0013
Diverse populations (aged,disabled,homosexual)	53	4.679	1.105	2-6	4.981	1.047	2-6	-2.934	.0050
Current legal issues	52	5.096	1.053	1-6	5.173	1.024	1-6	-1.272	.2090
Decision-making models	51	4.157	1.678	1-6	4.529	1.488	1-6	-3.055	.0036
Dual relationships	53	5.585	.842	1-6	5.623	.837	1-6	-1.428	.1593
Record keeping	53	4.717	1.081	2-6	4.849	1.081	2-6	-2.440	.0181
Gender/ethnicity	53	4.642	1.415	1-6	4.792	1.306	1-6	-1.428	.1593
Defining treatment unit (family vs. individual)	53	4.151	1.321	1-6	4.453	1.136	1-6	-2.470	.0168
Client welfare (family vs. individual needs)	53	4.566	1.294	1-6	4.887	1.155	1-6	-2.678	.0099
Treating entire family or withholding treatment	53	3.340	1.518	1-6	3.755	1.385	1-6	-3.589	.0007
Informed consent of all family members	53	5.075	1.207	2-6	5.170	1.087	2-6	-2.327	.0239
Switching treatment modalities (e.g. couple to individual)	53	4.038	1.285	1-6	4.226	1.154	2-6	-2.327	.0239
Confidentiality issues related to family secrets	53	4.962	1.255	1-6	5.113	1.031	2-6	-1.828	.0733
Use of DSM-IV	53	3.962	1.480	1-6	4.189	1.401	1-6	-1.947	.0570
Differing therapist and family values	53	4.623	1.228	1-6	4.868	1.075	1-6	-2.283	.0265
Decisions on marital status	51	4.000	1.483	1-6	4.157	1.419	1-6	-2.063	.0443
Use of covert strategies (paradox,hypnotic language)	53	3.849	1.562	1-6	4.057	1.473	1-6	-2.665	.0102

current and future emphasis placed on 22 of the 34 content areas by ethics instructors.

These results indicate that ethics instructors in marriage and family therapy graduate training programs believe that a stronger emphasis should be placed on all of these content areas in the future. However, these findings must also be interpreted with regard to their substantive meaningfulness (Pedhazur, 1991). While it can be said that instructors believe that these content areas should be addressed with more emphasis in the future, the exact degree of this change cannot be specified - i.e. one cannot know how to increase from a level 4 degree of emphasis to a level 6 degree of emphasis. One can interpret these results as indicating that the majority of ethics instructors place emphasis on the identified content areas, but acknowledge a desire to place a greater emphasis on them in the future.

In an attempt to differentiate and prioritize the instructional topics and issues, ethics instructors were requested to rank order the three most important content areas. "Ethical principles/AAMFT Code of Conduct" was selected as the most important instructional topic by the most ethics instructors (25%), followed in succession by the content areas, "Ethical reasoning process" (16.1%), "Therapist competency"(12.5%), and "Professional responsibility"(12.5%). The instructional topics, "Confidentiality", "Therapist competency", and "Professional responsibility" were each selected by 12.7% of the ethics instructors as the second most important content area. "Dual relationships" was selected by 15.4% of the sample as the third most important content area, followed in succession by "Confidentiality" (11.5%), and "Duty to report abuse" (11.5%). An examination of the overall frequency in which each ethics content area was ranked in the top

three in importance revealed that "Ethical principles/AAMFT Code of Conduct", "Professional responsibility", and "Confidentiality" were the three most frequently cited instructional topics.

Table 20 describes the percentage of programs responding to each answer option for the content of ethics education. This table helps to provide a picture of the distribution of responses, and to illustrate those programs that reported scores on the extreme points of the emphasis scale. As indicated by the percentage of those who selected the value of "6" at the end point of the emphasis scale, respondents expressed a strong current emphasis on the following content areas: "Duty to report abuse (79.2%); "Confidentiality" (75.5%); "Sexual intimacy/exploitation with clients (71.7%); "Suicide/homicide and duty to warn" (69.8%); and "Dual relationships" (69.8%). It is interesting to note that the two most highly ranked content areas, "Ethical principles/AAMFT Code of Conduct" and "Professional responsibility", are not receiving the greatest degree of instructional emphasis as indicated by the percentage of those who selected the value of "6" at the end point of the emphasis scale. The results appear to corroborate the conclusion that ethics instructors place much emphasis on the highly-ranked content area of "Confidentiality".

In 27 of the 34 educational content areas listed, a percentage of the ethics educators indicated that they currently placed no academic emphasis on these instructional topics. No emphasis was placed on the content area "Computers in therapy (treatment; record keeping)" by 17.0% of the sampled ethics instructors. Only 5.7% of the sample indicated that there should be no emphasis on "Computers in therapy" in the future. No emphasis was placed on the content area "Ethical codes/practices of other professions" by 15.4% of the ethics educators.

Table 20
Percentage of Programs Responding to each Answer Option for Content of Ethics Education

Goal/Purpose	Actual						Desired					
	No Emphasis					Much Emphasis	No Emphasis					Much Emphasis
	1	2	3	4	5	6	1	2	3	4	5	6
Ethical principles/AAMFT Code of Conduct	0.0	3.8	5.7	13.2	20.6	56.6	0.0	3.8	5.7	7.5	28.3	54.7
Theory of ethics	0.0	15.4	17.3	46.2	19.2	1.9	0.0	9.6	11.5	48.1	19.2	11.5
Ethical reasoning process	1.9	3.8	9.6	21.2	30.8	32.7	1.9	1.9	5.8	19.2	32.7	38.5
Ethical codes/practices of other professions	15.4	19.2	13.5	25.0	19.2	7.7	11.5	15.3	19.2	26.9	19.2	7.7
Personal values	3.8	3.8	11.3	22.6	37.7	20.8	1.9	5.7	5.7	22.6	35.8	28.3
Research standards	5.8	21.2	23.1	28.8	17.3	3.8	3.8	13.5	21.2	32.7	23.1	5.8
Confidentiality	1.9	0.0	0.0	3.8	18.9	75.5	1.9	0.0	0.0	3.8	15.1	79.2
Duty to report abuse	1.9	0.0	3.8	3.8	11.3	79.2	1.9	0.0	1.9	5.7	11.3	79.2
Involuntary commitment and treatment	0.0	13.2	20.8	26.4	28.3	11.3	0.0	11.3	15.1	26.4	28.3	18.9
Suicide/homicide and duty to warn	1.9	0.0	1.9	3.8	22.6	69.8	1.9	0.0	1.9	3.8	18.9	73.6
Therapist competency	1.9	1.9	13.2	15.1	34.0	34.0	1.9	0.0	1.9	20.8	24.5	50.9
Sexual intimacy/exploitation with clients	1.9	0.0	0.0	7.5	18.9	71.7	1.9	0.0	0.0	3.8	17.0	77.3
Publication issues (authorship/fabrication)	9.4	22.6	26.4	22.6	11.3	7.5	3.8	17.0	24.5	24.5	17.0	13.2
Inappropriate public statements/advertising	0.0	9.4	24.5	37.7	18.9	9.4	0.0	3.8	22.6	35.8	24.5	13.2
Computers in therapy (treatment; record keeping)	17.0	26.4	18.9	26.4	9.4	1.9	5.7	11.3	24.5	32.1	24.5	1.9
Fee assessment/bartering	5.7	11.3	20.8	34.0	22.6	5.7	0.0	7.5	17.0	41.5	24.5	9.4
Professional responsibility	2.0	0.0	3.9	11.8	17.6	64.7	2.0	0.0	0.0	5.9	27.5	64.7

Table 20 continued
Percentage of Programs Responding to each Answer Option for Content of Ethics Education

	Actual						Desired					
Goal/Purpose	No Emphasis				Much Emphasis		No Emphasis				Much Emphasis	
	1	2	3	4	5	6	1	2	3	4	5	6
Political/social advocacy	7.5	18.9	20.8	32.1	13.2	7.5	3.8	13.2	18.9	28.3	24.5	11.3
Diverse populations (aged, disabled,etc.)	0.0	3.8	11.3	24.5	34.0	26.4	0.0	1.9	9.4	15.1	35.8	37.7
Current legal issues	1.9	1.9	1.9	13.4	40.4	40.4	1.9	1.9	0.0	13.4	38.5	44.2
Decision-making models	9.8	9.8	13.7	17.6	19.6	29.4	5.9	5.9	9.8	19.6	25.5	33.3
Dual relationships	1.9	0.0	0.0	3.8	24.5	69.8	1.9	0.0	0.0	3.8	20.8	73.6
Record keeping	0.0	5.7	3.8	24.5	41.5	24.5	0.0	3.8	7.5	20.6	35.8	32.1
Gender/ethnicity	7.5	0.0	7.5	24.5	26.4	34.0	5.7	0.0	5.7	22.6	30.2	35.8
Defining treatment unit (family vs. individual)	5.7	3.8	20.8	28.3	26.4	15.1	1.9	3.8	11.3	35.8	28.3	18.9
Client welfare (family vs. individual needs)	3.8	0.0	15.1	30.2	18.9	32.1	1.9	0.0	7.5	30.2	18.9	41.5
Treating entire family or withholding treatment	18.9	9.4	18.9	32.1	13.2	7.5	9.4	7.5	20.8	32.1	20.8	9.4
Informed consent of all family members	0.0	5.7	5.7	17.0	18.9	52.8	0.0	3.8	1.9	22.6	17.0	54.7
Switching treatment modalities (e.g. couple to individual)	1.9	11.3	22.6	20.8	32.1	11.3	0.0	9.4	17.0	26.4	35.8	11.3
Confidentiality issues related to family secrets	1.9	5.7	5.7	9.4	35.8	41.5	0.0	3.8	3.8	13.2	35.8	43.4
Use of DSM-IV	5.7	15.1	11.3	32.1	17.0	18.9	5.7	7.5	13.2	28.3	26.4	18.9
Differing therapist and family values	3.8	3.8	3.8	28.3	35.8	24.5	1.9	1.9	3.8	22.6	39.6	30.2
Decisions on marital status	9.8	5.9	15.7	27.5	25.5	15.7	7.8	3.9	15.7	27.5	27.5	17.6
Use of covert strategies (paradox,hypnotic language)	9.4	13.2	15.1	24.5	20.8	17.0	7.5	9.4	13.2	26.4	26.4	17.0

There was very little change in the percentage of instructors responding to each answer option for this category, with 48.1% of the "Actual" responses and 46.0% of the "Desired" responses falling in the bottom 50th percentile of the emphasis scale.

Areas Specific to the Field of Marriage and Family Therapy

AAMFT Code of Conduct

Statistical analysis of the data revealed no significant difference ($p < .05$) between accredited and non-accredited graduate training programs on the amount of emphasis placed on the content area, "Ethical principles/AAMFT Code of Conduct". This finding indicates that this important topic is equitably addressed in all marriage and family therapy programs. In addition, there was no statistically significant difference ($p < .05$) found between the actual and desired emphasis placed on this instructional topic by ethics instructors (see Table 19). This can be interpreted to mean that ethics instructors are satisfied with the current level of emphasis placed on "Ethical principles/AAMFT Code of Conduct" and foresee no need to change it. All of the respondents indicated that they placed some emphasis on ethical principles and 56.6% indicated that they placed much emphasis on this topic (see Table 20). Of those programs that were identified as being primarily individual in their theoretical orientation, 75.0% indicated an actual emphasis on this topic in the upper 50th percentile of the emphasis scale. "Ethical principles/AAMFT Code of Conduct" was also ranked as the most important content area by the largest percentage of respondents (25.0%).

Statistical analysis of the data revealed no significant difference ($p < .05$) between accredited and non-accredited graduate training programs on the amount of emphasis placed on the instructional goal, "To apply the AAMFT Code of

Conduct to ethical dilemmas". This finding indicates that this educational goal is equitably addressed in all marriage and family therapy programs. In addition, there was no statistically significant difference($p < .05$) found between the actual and desired emphasis placed on this educational goal by ethics instructors (see Table 17). This can be interpreted to mean that ethics instructors are satisfied with the current level of emphasis placed on this goal and foresee no need to change it in the future. Table 18 shows that 5.7% of the instructors indicated that they placed no emphasis on "To apply the AAMFT Code of Conduct to ethical dilemmas" and 54.7% reported that they placed a strong emphasis on this goal. Of those programs that were identified as being primarily individual in their theoretical orientation, 75.0% indicated an actual emphasis on this topic in the upper 50th percentile of the emphasis scale. "To apply the AAMFT Code of Conduct to ethical dilemmas" was not ranked as one of the most important educational goals by any of the respondents.

Ethical Decision-Making Models

Statistical analysis of the data revealed no significant difference ($p < .05$) between accredited and non-accredited graduate training programs on the amount of emphasis placed on the content area, "Ethical decision-making models". This finding indicates that this important topic is equitably addressed in all marriage and family therapy programs. There was a statistically significant difference ($p < .0036$) between the actual and desired emphasis placed on this instructional topic by ethics instructors (see Table 19). This can be interpreted to mean that the majority of ethics instructors place emphasis on "Ethical decision-making models", but acknowledge a desire to place a greater emphasis on this content area in the future. Table 20 shows that 9.8% of the instructors indicated that they

placed no emphasis on "Ethical decision-making models" and 29.4% reported that they placed a strong emphasis on this content area. Of those programs that were identified as being primarily individual in their theoretical orientation, 75.0% indicated an actual emphasis on this topic in the upper 50th percentile of the emphasis scale. "Ethical decision-making models" was not ranked as one of the most important ethics content areas by any of the respondents.

Statistical analysis of the data revealed no significant difference ($p < .05$) between accredited and non-accredited graduate training programs on the amount of emphasis placed on the instructional goal "To facilitate the ethical decision-making process". This finding indicates that this educational goal is equitably addressed in all marriage and family therapy programs. There was a statistically significant difference ($p < .0110$) between the actual and desired emphasis placed on this educational goal by ethics instructors (see Table 17). This can be interpreted to mean that the majority of ethics instructors place emphasis on the goal, "To facilitate the ethical decision-making process", but acknowledge a desire to place a greater emphasis on this content area in the future. Table 18 shows that 1.9% of the instructors indicated that they placed no emphasis on "To facilitate the ethical decision-making process" and 62.3% reported that they placed a strong emphasis on this goal. Of those programs that were identified as being primarily individual in their theoretical orientation, 100.0% indicated an actual emphasis in the upper 50th percentile of the emphasis scale on this goal. Because "To facilitate the ethical decision-making process" was ranked as one of the most important educational goals by ethics instructors, it seems incongruous that only 29.4% of the sample indicated that they placed a strong emphasis on teaching models of ethical decision-making.

Ethical Issues Specific To Marriage and Family Therapy

Statistical analysis of the data revealed no significant difference ($p < .05$) between accredited and non-accredited graduate training programs on the amount of emphasis placed on the 10 content areas (items 25-34) that are unique to marriage and family therapy. These results indicate that these important subjects are equitably addressed in all marriage and family therapy programs.

There was no statistically significant difference ($p < .05$) found between the actual and desired emphasis placed on the instructional topics, "Confidentiality issues related to family secrets" and "Use of DSM-IV" by ethics instructors (see Table 19). This can be interpreted to mean that ethics instructors are satisfied with the current level of emphasis placed on these content areas and foresee no need to change it. Table 20 shows that 5.7% of the instructors indicated that they placed no emphasis on "Use of DSM-IV" and only 18.9% reported that they placed a strong emphasis on this goal. This contrasts with 1,9% of the instructors who indicated that they placed no emphasis on "Confidentiality issues related to family secrets" and the 41.5% of the sample that indicated that they placed much emphasis on this subject.

There were statistically significant differences ($p <.05$) between the actual and desired emphasis placed on 8 out of the 10 identified marriage and family therapy content areas by ethics instructors (see Table 19). The results indicate that ethics instructors in graduate training programs place some degree of emphasis on these content areas but acknowledge a desire to place a greater emphasis on them in the future. A percentage of ethics instructors indicated that they placed no emphasis on each of the identified marriage and family therapy content areas, with the exception of "Informed consent of all family members" (see Table 20).

"Treating the entire family or withholding treatment" was the content area with the largest percentage of instructors who indicated that they placed no emphasis on the topic (18.9%). Results indicated that 47.2% of the sample fell in the bottom 50th percentile on the emphasis scale for this subject.

None of the content areas specifically related to marriage and family therapy was ranked as being in the top three in importance by ethics educators. "Defining the treatment unit", "Client welfare (family vs. individual needs)", "Confidentiality issues related to family secrets", and "Differing therapist and family values" were each cited as the most important content area by 1.8% of ethics instructors. The marriage and family therapy content area that was cited by the largest percentage (2.5%) of ethics instructors was "Informed consent of all family members".

CHAPTER V

Conclusions

General Summary

The primary purpose of this study was to examine the current status of ethics education in graduate marriage and family therapy programs. This study has provided some detailed descriptions on the prevalence of ethics training, the specific curricular components that are used to improve the ethical knowledge of students, and the degree to which topics specific to marriage and family therapy are being emphasized. Additional information has been gathered that has clarified the similarities and difference among accredited and non-accredited graduate programs in their approach to ethics training and the degree to which instructors would change the future level of emphasis placed on selected goals and topics.

One of the most important findings was that ethics training is a required feature in all marriage and family therapy programs. Almost the entire sample (94.2%) reported that they offer a separate course in ethics and a substantial number indicated that ethical issues are also addressed in other areas of their training e.g. practicum. This is reassuring when one considers that 36% of marriage and family therapy graduate students are being trained in non-accredited programs where it was previously unknown to what extent ethics training was being provided.

The largest percentage of the respondents (84.0%) indicated that they believe that the primary locus of responsibility for ethics education resides within their own training programs. It is an encouraging sign that marriage and family therapy programs are assuming the responsibility for educating their students on

appropriate ethical practice and are not presuming that this training will be provided during practicum/internship experiences or even post-graduation.

The largest percentage of educators in both accredited and non-accredited programs reported that ethics education currently takes place in the middle of the training program. Instructors in accredited programs appeared to favor a more integrative and longitudinal ethics curriculum in the future, as indicated by the large increase in the percentage of respondents choosing this option. While there was an increase in the percentage of instructors in non-accredited programs favoring an integrative curriculum, the largest percentage indicated that they would continue to implement training in the middle of the program. Albeit a relatively small percentage, it was startling to discover that 3.0% of the accredited and 11.1% of the non-accredited programs offer ethics education at the end of the training program. One can seriously question whether this represents an effective or appropriate educational method because students frequently have client contact prior to the end of their training program.

This study has provided information about the specific amount of time that is devoted to ethics education. The majority of programs (69.2%) currently spend more than 30 hours training their students about ethics. However, 36.9% of the non-accredited programs and 27.2% of the accredited programs indicated that they designate less than 30 hours to ethics education. When one takes into consideration that most of the programs require a separate class in ethics, one can conclude that some of these classes involve one to two semester hours based on the fact that three-hour courses usually involve over 30 clock hours. As COAMFTE requires programs to offer a three to four-hour course in ethics, it is

difficult to understand this self-reported discrepancy in the time devoted to ethics education in accredited graduate programs.

One of the more interesting findings revolves around the issue of departmental theoretical orientation. There is an overriding tone in the marriage and family therapy literature that seems to presume that systems theory is the sole theoretical framework employed in graduate training programs. In an attempt to substantiate this presumption, ethics instructors were asked to state the theoretical orientation, systemic or individual, that best describes the overall theoretical framework of their department. The results showed that 6.4% of the total sample of graduate programs utilize an individual theoretical framework. Although this represents only a small proportion of the sample, this percentage may prove surprising to many marriage and family therapy educators.

Beamish and Navin (1992) expressed concern that therapists who have been primarily trained in individually-oriented counseling programs may encounter difficulties in rendering ethical clinical decisions which involve a systemic framework. None of the programs that reported an individual orientation was accredited by COAMFTE. Among the instructors in non-accredited programs, 31.8% reported that their primary affiliation within the university was in a department of psychology - a field generally associated with an individual theoretical focus. Only 2.5% of the instructors in accredited programs identified a department of psychology as their primary affiliation. The majority of ethics educators in accredited programs (55.0%) were affiliated with departments of family studies or marriage and family therapy. A thorough exploration into the similarities and differences between individually and systemically oriented

programs will be needed in order to ascertain the legitimacy of Beamish and Navin's concerns.

It appears that graduate students are being trained by professionals with strong academic and clinical backgrounds (M= 14.5 years, academic; M=18 years, clinical). It can be surmised that this professional experience lends itself well to enhancing the educational experience of students in the classroom. Discussion with colleagues (85.5%), readings (83.9%), graduate coursework (77.4%), and clinical supervision (72.4%) were the most frequently reported types of ethics training received by instructors in both accredited and non-accredited programs. It is reassuring to know that all of the instructors had received formal training in ethics.

The largest percentage of the total sample holds the rank of professor (35.6%), and the largest proportion of instructors reported their academic positions as being faculty member (40.3%) or program director (41.9%). The overwhelming majority of respondents (83.6%) reported the doctorate as the highest academic degree they had earned. It is interesting that the majority of ethics educators in non-accredited programs (50.0%) reported that the had earned their highest degree in psychology, while the largest percentage of instructors in accredited programs stated their highest degree was in marriage and family therapy. Students are being exposed to diverse theoretical backgrounds in that thirty-five different theoretical orientations were cited by ethics educators as reflective of their own work. General systems, solution-focused, cognitive behavioral, and structural/strategic were the most frequently cited orientations by ethics instructors.

There appears to be a consensus among all graduate marriage and family therapy programs regarding the most important reasons to include ethics education

in the curriculum of graduate marriage and family therapy programs. The following reasons were all rated as "very important" by the majority of respondents: 1) "To improve ethical practice" (93.4%), 2) "To acquaint students with the norms of professional conduct" (86.9%), 3) "To help students see how their values, needs, and behaviors impact therapy" (80.3%), and 4) "To acquaint students with client rights in therapy and research" (72.1%). The majority of the sample (67.8%) expressed the opinion that the best way to improve their students' knowledge of ethical issues and standards is through a formal course in ethics.

"Ethical, Legal, and Professional Issues in the Practice of Marriage and Family Therapy" (Huber & Baruth, 1987,1994), the most frequently cited text in this study, is currently being utilized by 45.3% of the ethics instructors in the sample. When one considers the enormous range of ethical subject matter that could be presented, the predominance of this one text facilitates a level of congruency among marriage and family therapy programs regarding the subject matter to which students are exposed.

The majority of instructors, regardless of accreditation status, utilized lectures (90.2%), simulations (65.6%), discussion (96.7%), case studies (95.1%), and small group activities (72.1%) in the teaching of ethics in their graduate marriage and family therapy programs. There is also a great deal of similarity between accredited and non-accredited programs in the types of evaluation indices that are used by ethics instructors to measure student performance. The majority of marriage and family therapy programs evaluated their students through classroom discussion (82.3%), case studies (82.3%), term papers (74.2%), classroom observations (71.0%), and essay tests (61.3%).

Goals of Ethics Education

The results of this survey have clarified which educational goals ethics educators value and emphasize in their classroom instruction. An examination of the overall frequency in which each of the identified educational goals was ranked in the top three in importance revealed that, "To execute ethically appropriate behavior", "To facilitate the ethical decision-making process", and "To become sensitive to ethical situations in therapy and research" were the three goals most frequently cited. Much instructional emphasis is being placed on these same three goals as indicated by the percentage of those selecting the extreme point of the emphasis scale.

A series of Student t tests for independent groups was employed to determine if significant differences existed between accredited and non-accredited marriage and family therapy programs in the degree of emphasis currently placed on educational goals. The results of the analysis indicated that there were no significant differences ($p < .05$) between accredited and non-accredited programs on any of the identified educational goals. A series of paired t tests for within-group comparisons was conducted to determine if significant differences existed between the current emphasis on each of the 16 educational goals and the desired emphasis that should be placed on them. With the exception of four goals, there were statistically significant differences ($p < .05$) between the actual and desired emphasis placed on all other goals by ethics instructors. These results indicate that ethics instructors in marriage and family therapy graduate training programs believe that a stronger emphasis should be placed on these educational goals in the future.

Content of Ethics Education

The results of this survey have provided important information regarding the specific content areas that are being taught to students in marriage and family therapy graduate programs. While there has been a seemingly universal call for ethics training, very little has been known about which professional topics and issues are actually being emphasized by the instructors in different programs.

An examination of the overall frequency in which each ethics content area was ranked in the top three in importance revealed that, "Ethical principles/AAMFT Code of Conduct", "Professional responsibility", and "Confidentiality" were the three most frequently cited instructional topics. It is interesting to note that these same two highly-ranked content areas, "Ethical principles/AAMFT Code of Conduct" and "Professional responsibility", are not receiving the greatest degree of instructional emphasis by educators. The results do appear to corroborate the conclusion that ethics instructors place much emphasis on the highly-ranked content area of "Confidentiality". This intense focus can be appreciated when one considers that the primary cause of professional liability claims against marriage and family therapists is a breach of confidentiality (Engelberg & Symansky, 1989 cited in Lakin, 1994),

As indicated by the percentage of those who selected the value of "6" at the end point of the emphasis scale, respondents expressed a strong current emphasis on the following content areas: "Duty to report abuse (79.2%); "Confidentiality" (75.5%); "Sexual intimacy/exploitation with clients (71.7%); "Suicide/homicide and duty to warn" (69.8%); and "Dual relationships" (69.8%). As these issues are arguably the ones that render the most deleterious consequences to clients if they are not adhered to ethically, it is understandable and appropriate that they be the

most stringently addressed. Brock and Coufal (1994) and Green and Hansen (1989) particularly identified the failure of therapists to report abuse as one of the most important areas that needed to be addressed in ethics education. This study provides a degree of reassurance that the mandate to report abuse is being strongly emphasized by marriage and family therapy ethics instructors.

A series of Student t tests for independent groups was employed to determine if significant differences existed between accredited and non-accredited marriage and family therapy programs in the degree of emphasis currently placed on the 34 identified content areas. Statistical analyses indicated that there were no significant differences ($p < .05$) between accredited and non-accredited programs on any of the identified content areas. A series of paired t tests for within-group comparisons was conducted to determine if significant differences existed between the current emphasis on the ethics content areas and the desired emphasis that should be placed on them. There were statistically significant differences ($p < .05$) between the current and future emphasis placed on 22 of the 34 content areas by ethics instructors.

One can interpret these results as indicating that the majority of ethics instructors place emphasis on the identified content areas, but acknowledge a desire to place a greater emphasis on them in the future. When one takes into consideration that all but one of the mean scores for each item fell in the upper 50th percentile of the emphasis scale, it becomes apparent that it is difficult to discern subtle differences in emphasis. A possible area of future research could be to have ethics instructors quantify the actual time that is devoted to each ethical subject.

While acknowledging that all ethical subject matter cannot be equitably addressed in all programs, two content areas need to be examined further due to their lack of emphasis by a disproportionate percentage of instructors. The content area, "Computers in therapy " (17.0%, No Emphasis; 1.9%, Much Emphasis) deserves further consideration as technology rapidly advances to the point where computer-assisted treatment and record keeping become potentially viable alternatives to the prevailing norms. The content area, "Ethical codes/practices of other professions" (15.4%, No Emphasis; 7.7%, Much Emphasis) deserves a closer scrutiny for a number of reasons. Marriage and family therapists do not work in the proverbial professional vacuum; they interact and oftentimes collaborate with helping professionals who abide by different ethical standards and practices. It would seem beneficial to have a working knowledge of the diversity among ethical codes of different professions. It could also be anticipated that helping professionals who work with couples and families, but who do not necessarily identify themselves as marriage and family therapists, would avail themselves of the ethical principles and standards of our profession. Likewise, marriage and family therapists who work in a multitude of traditional settings could potentially benefit from a reciprocity of ethical knowledge.

AAMFT Code of Conduct

Statistical analysis of the data revealed no significant difference ($p < .05$) between accredited and non-accredited graduate training programs on the amount of emphasis placed on the content area, "Ethical principles/AAMFT Code of Conduct". There was also no statistically significant difference ($p < .05$) found between the actual and desired emphasis placed on this instructional topic by ethics instructors. These findings suggest that this important topic is equitably

addressed in all marriage and family therapy programs and that ethics instructors are satisfied with its current level of emphasis. "Ethical principles/AAMFT Code of Conduct" was also ranked as the most important content area by the largest percentage of respondents (25.0%).

Statistical analysis of the data revealed no significant difference ($p < .05$) between accredited and non-accredited graduate training programs on the amount of emphasis placed on the instructional goal, "To apply the AAMFT Code of Conduct to ethical dilemmas". In addition, there was no statistically significant difference($p < .05$) found between the actual and desired emphasis placed on this educational goal by ethics instructors. These findings indicate that this educational goal is equitably addressed in all marriage and family therapy programs and that ethics instructors are satisfied with the current level of emphasis placed on this goal and foresee no need to change it in the future. A notable contrast is presented by the fact that ethics instructors ranked the content area, "Ethical principles/AAMFT Code of Conduct" as the most important ethical topic, but failed to rank the corresponding goal "To apply the AAMFT code to ethical dilemmas", as one of the most important. One wonders to what extent educators are differentiating between the knowledge of ethical principles and their practical application.

Ethical Decision-Making Models as an Adjunct to Ethical Codes

Statistical analysis of the data revealed no significant difference ($p < .05$) between accredited and non-accredited graduate training programs on the amount of emphasis placed on the content area, "Ethical decision-making models". This finding indicates that this important topic is equitably addressed in all marriage and family therapy programs. There was a statistically significant difference

($p < .0036$) between the actual and desired emphasis placed on this instructional topic by ethics instructors. This can be interpreted to mean that the majority of ethics instructors place emphasis on "Ethical decision-making models", but acknowledge a desire to place a greater emphasis on this content area in the future. "Ethical decision-making models" was not ranked as one of the most important ethics content areas by any of the respondents.

Statistical analysis of the data revealed no significant difference ($p < .05$) between accredited and non-accredited graduate training programs on the amount of emphasis placed on the instructional goal "To facilitate the ethical decision-making process". This finding indicates that this educational goal is equitably addressed in all marriage and family therapy programs. There was a statistically significant difference ($p < .0110$) between the actual and desired emphasis placed on this educational goal by ethics instructors. This can be interpreted to mean that the majority of ethics instructors place emphasis on the goal, "To facilitate the ethical decision-making process", but acknowledge a desire to place a greater emphasis on this content area in the future.

Because "To facilitate the ethical decision-making process" was ranked as one of the most important educational goals by ethics instructors, it seems incongruous that only 29.4% of the sample indicated that they placed a strong emphasis on teaching models of ethical decision-making. "Ethical decision-making models" was also not ranked as one of the most important ethics content areas by any of the respondents. It is difficult to understand how one can facilitate the ethical decision-making process without emphasizing the models of ethical decision-making. This finding lends some credence to the assertion by Zygmond and Boorhem (1989) that models of ethical decision-making are not widely

utilized in marriage and family therapy. They conjectured that this underutilization is associated with the practice of relying on acknowledged schools of family therapy to determine what constitutes ethical practice. This study suggests another hypothesis: that some therapists may not be utilizing models of ethical decision -making because of a lack of emphasis on this subject in their graduate training.

Content Areas Specific to Marriage and Family Therapy

Statistical analysis of the data revealed no significant difference ($p < .05$) between accredited and non-accredited graduate training programs on the amount of emphasis placed on the 10 content areas (items 25-34) that are unique to marriage and family therapy. These results indicate that these important subjects are equitably emphasized in all marriage and family therapy programs - a remarkable conclusion when one considers the potential for diversity among people and programs.

There was no statistically significant difference ($p < .05$) found between the actual and desired emphasis placed on two of the instructional topics by ethics instructors: "Confidentiality issues related to family secrets" and "Use of DSM-IV" This can be interpreted to mean that ethics instructors are satisfied with the current level of emphasis placed on these content areas and foresee no need to change it. There were statistically significant differences ($p < .05$) between the actual and desired emphasis placed by ethics instructors on the remaining 8 content areas . The results indicate that ethics instructors in graduate training programs place some degree of emphasis on these content areas but acknowledge a desire to place a greater emphasis on them in the future.

Particular attentions should be focused on the ethical content area, "Treating the entire family or withholding treatment". Green and Hansen (1989) found that the issue of providing treatment if one member refuses to participate was the most frequently occurring ethical dilemma faced by the sample of AAMFT Clinical Members in their study. No emphasis was placed on this content area by 18.9% of the ethics instructors, the largest percentage of respondents who chose this point of the emphasis scale for any instructional topic in this sample. Considering the prevalence of this ethical dilemma among marriage and family therapists, it would appear worthwhile to examine whether or not this issues is being sufficiently addressed by ethics educators.

Limitations of the Study

While it is a strength of this study that the response rate of 53% of the 123 graduate marriage and family therapy programs represents over one-half of the known population, it is necessary to be cautious about the possibility of selection bias. It is not known how the ethics instructors who responded to the survey differed from those who chose not to participate. Another limitation of this study is related to the use of self-reported data whereby the validity of the findings is dependent on the ability of the participants to accurately report their responses. Because ethics instruction could be construed as a topic where respondents may deliberately or inadvertently give socially desirable responses, the results must be carefully examined. One potential example of these concerns is demonstrated through the findings which suggest that most of the identified goals and content areas in this study are addressed by all of the programs. The limitations of time could make one wonder at the feasibility of achieving these objectives.

Suggestions for Future Research

An immediate follow-up to this research could be a similar study of students' perceptions of the content and quality of the ethics training they received in their graduate marriage and family therapy programs. This would provide important information about what students learned as well as providing valuable feedback regarding the validity of the present study. A qualitative study with instructors and students on the current and future status of ethics education could also provide the field of marriage and family therapy with some rich desciptions of the content and process of ethics education.

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Appendix A

List of Marriage and Family Therapy Graduate Programs

Abilene Christian University*

Adler School of Professional Psychology

Antioch New England Graduate School*

Appalachian State University**

Argyle Institute of Human Relations*

Auburn University*

Azusa Pacific University

Barry University

Blanton-Peale Graduate Institute*

Bowie State University

Brigham Young University*

Butler University*

California Family Study Center

California Lutheran University

California State University, Chico

California State University, Dominguez Hills

California State University, Fresno

California State University, Northridge

Central Connecticut State University**

Chapman University

Chicago Theological Seminary

Christian Theological Seminary*

Colorado State University*

Detroit Institute of Family Systems Therapy*

East Carolina University*

Eastern Baptist Theological Seminary

Eastern Nazarene College

EHS-Family Care Network*

Fairfield University

Family Institute-Chicago*

Family Institute-Philadelphia*

Family Service of Milwaukee*

Fitchburg State College

Florida State University, Interdivisional Program in Family Therapy*

Friends University*

Fuller Theological Seminary*

Gainesville Family Institute*

Harding University**

Hardin-Simmons College

Hofstra University

Holy Cross Hospital*

Indiana State University*

Interfaith Marriage and Family Institute*

Interfaith Pastoral Counseling Centre*

Iona College

Iowa State University of Science and Technology*

Kansas State University*

Kutztown University of Pennsylvania

Loma Linda University*

Long Island University, Brooklyn Campus

Long Island University, C.W. Post Campus

Louisville Presbyterian Theological Seminary*

Loyola Marymount University

Medical College of Pennsylvania & Hahnemann University*

Michigan State University

Mississippi College

Northeast Louisiana University*

Northern Illinois University*

Northwest Christian College

Northwestern University

Nova Southeastern University**

Oklahoma Baptist University

Oklahoma State University*

Oral Roberts University

Our Lady of the Lake University*

Pacific Lutheran University*

Pacific Oaks College

PENN Council for Relationships*

Philadelphia Child Guidance Center*

Presbyterian Counseling Service*

Provident Counseling, Inc.*

Purdue University*

Purdue University, Calumet*

Reformed Theological Seminary*

Saint Joseph College*

Saint Mary's College of California

St. Mary's University of San Antonio*

Saint Paul University

St. Thomas University

San Francisco State University

San Jose State University

Santa Clara University

Seattle Pacific University

Seton Hall University

Sir Mortimer B. Davis-Jewish General Hospital*

Sonoma State University

Southern California Counseling Center*

Southern Connecticut State University*

Springfield College

Stetson University

Syracuse University: M.A.*; Ph.D.**

Texas Tech University*

Texas Woman's University

United States International University

University of Akron

University of Alabama at Birmingham

University of Bridgeport

University of Connecticut*

University of Georgia*

University of Guelph*

University of Houston-Clear Lake*

University of Kentucky*

University of Louisville*

University of Maryland*

University of Minnesota*

University of Nebraska-Lincoln*

University of Nevada-Las Vegas

University of New Hampshire*

University of Pittsburgh

University of Rhode Island*

University of Rochester Medical Center*

University of San Diego*

University of San Francisco

University of Southern California

- Department of Counseling and Educational Psychology
- Department of Sociology*

University of Southern Mississippi*

University of Wisconsin-Stout*

Utah State University**

Virginia Polytechnic Institute and State University

- M.A.(Falls Church)*
- Ph.D.(Blacksburg)*

Wayne State University

Western Conservative Baptist Seminary

Westgate Training and Consultation Network*

* Denotes programs that are accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE)

** Denotes programs that have Candidacy Status with COAMFTE

Sources: 1) Peterson's Guide to Graduate Study Programs in the Humanities, Arts, and Social Sciences (1995)

2) List of COAMFTE Accredited and Candidacy Status Programs, (1995)

Appendix B

Correspondence

Date

Dear <<name>>:

The purpose of this study is to examine the current practices and future direction of ethics education in marriage and family therapy graduate training programs. This survey is being sent to 123 directors of marriage and family therapy programs currently listed in Peterson's Guide to Graduate Programs and the COAMFTE List of Accredited and Candidacy Status Programs. The success of this venture depends in large part on your input.

Your responses will help to define the critical instructional elements of ethics education in marriage and family therapy programs by providing some rich descriptions of the current context of ethics training. The major dimensions of ethics education to be investigated are:

1. the current and future structure of ethics training
2. the current and future goals/content of ethics education
3. the major influences on ethics training
4. the reasons that ethics training is/not included in the marriage and family therapy curriculum

The above four dimensions were derived from an extensive review of the literature. Thus, the time invested by you to complete the survey will benefit the profession of marriage and family therapy by providing a comprehensive view of how training programs prepare students to deal with ethical issues.

****

If you have ethics training in your graduate program, we ask that the survey be completed by the person primarily responsible for that training. If your graduate program lacks formal ethics coursework, we ask that you, the program director, complete the survey.

****

The information that you provide will be used in an aggregate form for statistical analysis with individual program responses remaining confidential. Surveys are coded for the purpose of mailing follow-up postcards and determining a list of those programs that wish to have a copy of the results sent to them at the completion of the study. The coding protocol will be kept in a locked filing cabinet accessible only to the principle investigator and will be destroyed after the closing date for final return of survey materials. A postage-paid return envelope is attached. The survey has been designed so that most questions can be answered by marking the appropriate number/space. You are free to chose to not answer any questions on the survey or not to return the survey without penalty. The average time to complete the survey is 25 minutes.

Your voluntary participation in this research will be greatly appreciated. There will be no compensation for participating in this study. Your responses will provide essential information on the present structure of ethics training and assist in future curriculum development in ethics education. If you have any questions regarding this research, please do not hesitate to contact us at the numbers listed below. Completion and return of this survey will signify your consent to voluntarily participate in this project. We would appreciate hearing from you by **date.**

This research project has been approved, as required, by the Institutional Review Board for Research Involving Human Subjects at Virginia Polytechnic Institute and State University and the Department of Family and Child Development.

Sincerely,

Jean Lucas Daniels, M.A.	Howard Protinsky, Ph.D.	E. R. Stout
Investigator	Advisor	Chair, IRB
(919)231-7201	(540)231-7201	(540)231-9359

Date

Dear <Name>

We just wanted to write and remind you about the survey that we sent you two weeks ago regarding the current and future status of ethics training in marriage and family therapy graduate training programs. The time invested to complete the survey will provide the profession of marriage and family therapy with a comprehensive view of how training programs prepare students to deal with ethical issues. If you have already completed the questionnaire, please accept our sincere thanks. If you have not, we ask you to consider doing so at your earliest convenience. If you need another survey sent to you or if you have any questions regarding the research, please do not hesitate to contact us.

Again, we thank you for your participation.

Sincerely,

Jean Lucas Daniels, M.A.
Investigator

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Appendix C

Survey on Ethics Education in Marriage and Family Therapy Graduate Programs

Survey on the Current and Future Direction of Ethics Education In Marriage and Family Therapy Graduate Programs

Section A - General Information

If you do not provide ethics education in your training program, please answer questions 1 through 9 and skip to Section B on page 3.

This section is intended to gain a better perspective of the professional characteristics of the person responsible for ethics education.

1. What is you academic rank?
   ___Professor ___Associate Professor

   ___Assistant Professor ___Instructor/Lecturer

2. What is your academic position?
   ___Faculty member ___Adjunct/Affiliate faculty ___Department Chair

   ___Program Director ___Other: Please specify._____

3. Where is your primary affiliation in this University/College?

   ___Department of psychology ___Department of theology

   ___Department of family studies ___Department of education

   ___Other:Please specify._____

4. What type of graduate degree does your program offer?

   ___MA ___MS ___Ph.D. Other: _____

5. Is your program accredited by the Commission on Accreditation for Marriage and Family Therapy Education of AAMFT?

   ____Yes ____No

   If Yes, please indicate accreditation status.

   ____Full accreditation ____Candidacy status

6. What is the highest academic degree that you have earned?

   ___MA ___MS ___Ed.D. ___Ph.D. Other:_____

7. In what field was your highest degree earned?

   ___Marriage and family therapy ___Family studies ___Theology

   ___Psychology ___Counselor education Other:_____

8. How many years of professional experience have you had in the following areas?

   Academic work: ____years Professional practice: ____years

9. Although it is often assumed that MFT training utilizes a systemic theoretical framework, we recognize that there is diversity among graduate programs. Please indicate the theoretical framework that BEST describes the theoretical orientation of your program.

____Individual ____Systemic

10. Please list the theoretical orientations that are represented in your department.
_____
_____
_____

11. Please state the theoretical orientation that best describes your own work.

_____

12. Please describe the ethics training that you have received by checking all that apply.

____Graduate course work ____Conference

____Postgraduate course work ____Workshop

____Clinical supervision ____Readings

____Discussion with colleagues ____No formal training

____Other: Please specify. _____

Section B - Structure for Ethics Education

This section is concerned with the manner in which ethics education is currently handled within your program (Column A) as well as the manner in which you would desire ethics education to be handled (Column B).

Directions:
A. Under the heading "Actual" indicate with a check the current manner in which ethics education is structured in your program.
B. Under the heading "Desired" indicate with a check the manner in which ethics education should be structured in your program.

	A. Actual	B. Desired
13.	Does your program offer any ethics education?	Do you believe your program should offer ethics education?
	___Yes-Please continue with the questions in Section B	___Yes
	___No-Please answer the questions under "desired" in Section B	___No

	Actual	Desired
14.	In what manner is ethics education taught in your program?	In what manner do you believe ethics education should be taught in your program?
	___A separate course in ethics	___A separate course in ethics
	___Part of a course or infused in other courses	___Part of a course or infused in other courses
	___As a part of practicum/ internship training	___As a part of practicum/ internship training
15.	Is ethics education a <u>required</u> or <u>optional</u> feature of your graduate program?	Should ethics education be a <u>required</u> or <u>optional</u> feature of your graduate program?
	___Required	___Required
	___Optional	___Optional
16.	What is the total number of clock hours devoted to ethics training in your program?	What should be the total number of clock hours devoted to ethics training in your program?
	___ 0 - 5 hours	___ 0 - 5 hours
	___ 6 - 10 hours	___ 6 - 10 hours
	___ 11 - 20 hours	___ 11 - 20 hours
	___ 21 - 30 hours	___ 11 - 20 hours
	___ More than 30 hours	___ More than 30 hours
17.	At what point does ethics education take place within your program?	At what point should ethics education take place within your program?
	___Beginning of program	___Beginning of program
	___Middle of program	___Middle of program
	___End of program	___End of program
	___Integrated throughout program	___Integrated throughout program

	Actual	Desired
18.	In your opinion where does the primary locus of responsibility reside for the teaching of ethics?	In your opinion where should the primary locus of responsibility reside for the teaching of ethics?
	___Graduate training program	___Graduate training programs
	___Practicum supervision	___Practicum supervision
	___Internship supervision	___Internship supervision
	___Other: Please specify.	___Other: Please specify.
	_____	_____

If you have ethics education, continue with SECTION C, (skip #19)
If you do NOT have ethics education, **answer #19** and move to SECTION E.

19. If no ethics training is offered , cite the reason(s) for the lack of it.

___Lack of time in program	___Lack of funds
___Lack of available faculty	___Lack of expertise
___Lack of student/faculty interest	___Lack of need for formal training
___Designing ethics curriculum for future use	___Other: Please Specify.
	_____

Please continue with Section E

Section C - Instructional Practices

This section is focused on the particular instructional methodologies used in the teaching of ethics in your program.

Directions: Please check all that apply.

20. ___Lectures ___Simulations (role-plays, games) ___Discussions

___Case studies ___Small group activities ___Seminars

___Other: Please Specify. _____ _____

Section D - Instructional Materials

21. List three (3) basic materials used in your ethics education program (e.g. articles, textbooks, literary works).

_____

_____

Section E - Goals for Ethics Education

If no ethics education , please answer the statements for the "desired" part of this section and **question 24.**

Directions:

A. Under the heading "Actual" indicate the current emphasis placed on that goal in your program by circling one number.

B. Under the heading "Desired" indicate the emphasis that should be placed on that goal in your program by circling one number.

22. Goal/Purpose	A. Actual: No Emphasis					Much Emphasis	B. Desired: No Emphasis					Much Emphasis
1. To facilitate the ethical decision-making process	1	2	3	4	5	6	1	2	3	4	5	6
2. To explore the major philosophical approaches to ethical issues	1	2	3	4	5	6	1	2	3	4	5	6
3. To introduce core terms and concepts of ethical discourse	1	2	3	4	5	6	1	2	3	4	5	6
4. To discriminate among complex ethical issues	1	2	3	4	5	6	1	2	3	4	5	6
5. To improve the moral character of students	1	2	3	4	5	6	1	2	3	4	5	6
6. To stimulate moral empathy through noting consequences of thought and behavior	1	2	3	4	5	6	1	2	3	4	5	6
7. To become sensitive to ethical situations in therapy and research	1	2	3	4	5	6	1	2	3	4	5	6
8. To strengthen the ability of students to detect biases.	1	2	3	4	5	6	1	2	3	4	5	6
9. To develop confidence and responsibility for one's decisions	1	2	3	4	5	6	1	2	3	4	5	6
10. To advance complex problem-solving and thinking skills	1	2	3	4	5	6	1	2	3	4	5	6
11. To apply theoretical knowledge to practical ethical issues	1	2	3	4	5	6	1	2	3	4	5	6

Goal/Purpose	A. Actual: No Emphasis					Much Emphasis	B. Desired: No Emphasis					Much Emphasis
12. To fashion coherent ethical arguments	1	2	3	4	5	6	1	2	3	4	5	6
13. To execute ethically appropriate behavior	1	2	3	4	5	6	1	2	3	4	5	6
14. To apply the AAMFT ethical standards to ethical dilemmas	1	2	3	4	5	6	1	2	3	4	5	6
15. To understand the reasoning of others	1	2	3	4	5	6	1	2	3	4	5	6
16. To reduce the incidence of unethical behavior	1	2	3	4	5	6	1	2	3	4	5	6
17. Other: Please specify	1	2	3	4	5	6	1	2	3	4	5	6

_____

23. Rank order three (3) of the above goals that you think are important in ethics education. Place the number of the goal in the appropriate place.

	#
1. Which goal do you consider the most important goal?	_____
2. Which goal do you consider the second most important goal?	_____
3. Which goal do you consider the third most important goal?	_____

Section F - Content Areas

The focus of this section is to learn what instructional topics and issues are covered in your program.

If no ethics education is provided, please answer the statements for the "desired" part of this section and **questions 25, 27-29**.

Directions:

A. Under the heading "Actual" indicate the current emphasis placed on the topic in your program by circling one number.

B. Under the heading "Desired" indicate the emphasis that should be placed on the topic in your program by circling one number.

24. Content Area	A. Actual: No Emphasis					Much Emphasis	B. Desired: No Emphasis					Much Emphasis
1. Ethical principles/ AAMFT Code of Ethics	1	2	3	4	5	6	1	2	3	4	5	6

.Content Area	A. Actual No Emphasis	Much Emphasis	B. Desired No Emphasis	Much Emphasis
2. Theory of ethics	1 2 3 4 5 6		1 2 3 4 5 6	
3. Ethical reasoning process	1 2 3 4 5 6		1 2 3 4 5 6	
4. Ethical codes/practices of other professions	1 2 3 4 5 6		1 2 3 4 5 6	
5. Personal values	1 2 3 4 5 6		1 2 3 4 5 6	
6. Research standards	1 2 3 4 5 6		1 2 3 4 5 6	
7. Confidentiality	1 2 3 4 5 6		1 2 3 4 5 6	
8. Duty to report abuse	1 2 3 4 5 6		1 2 3 4 5 6	
9. Involuntary commitment and treatment	1 2 3 4 5 6		1 2 3 4 5 6	
10. Suicide/homicide and duty to warn	1 2 3 4 5 6		1 2 3 4 5 6	
11. Therapist competency	1 2 3 4 5 6		1 2 3 4 5 6	
12. Sexual intimacy/ exploitation with clients	1 2 3 4 5 6		1 2 3 4 5 6	
13. Publication issues	1 2 3 4 5 6		1 2 3 4 5 6	
14. Inappropriate public statements/advertising	1 2 3 4 5 6		1 2 3 4 5 6	
15. Computers in therapy (treatment;record keeping)	1 2 3 4 5 6		1 2 3 4 5 6	
16. Fee assessment/bartering	1 2 3 4 5 6		1 2 3 4 5 6	
17. Professional responsibility	1 2 3 4 5 6		1 2 3 4 5 6	
18. Political/social advocacy	1 2 3 4 5 6		1 2 3 4 5 6	
19. Diverse populations	1 2 3 4 5 6		1 2 3 4 5 6	
20. Current legal issues	1 2 3 4 5 6		1 2 3 4 5 6	
21. Decision-making models	1 2 3 4 5 6		1 2 3 4 5 6	
22. Dual relationships	1 2 3 4 5 6		1 2 3 4 5 6	

Content Area	A. Actual No Emphasis — Much Emphasis	B. Desired No Emphasis — Much Emphasis
23. Record keeping	1 2 3 4 5 6	1 2 3 4 5 6
24. Gender/ethnicity	1 2 3 4 5 6	1 2 3 4 5 6
25. Defining treatment unit (family vs. individual)	1 2 3 4 5 6	1 2 3 4 5 6
26. Client welfare (family vs. individual needs)	1 2 3 4 5 6	1 2 3 4 5 6
27. Treating entire family or withholding treatment	1 2 3 4 5 6	1 2 3 4 5 6
28. Informed consent of all family members	1 2 3 4 5 6	1 2 3 4 5 6
29. Switching treatment modalities (e.g. couple to individual)	1 2 3 4 5 6	1 2 3 4 5 6
30. Confidentiality issues related to family secrets	1 2 3 4 5 6	1 2 3 4 5 6
31. Use of DSM-IV	1 2 3 4 5 6	1 2 3 4 5 6
32. Differing therapist and family values	1 2 3 4 5 6	1 2 3 4 5 6
33. Decisions on marital status	1 2 3 4 5 6	1 2 3 4 5 6
34. Use of covert strategies (paradox, hypnotic language)	1 2 3 4 5 6	1 2 3 4 5 6
35. Other: Please specify.	1 2 3 4 5 6	1 2 3 4 5 6

_____

25. Rank order three (3) of the above content areas that you think are important in ethics education. Place the number of the content area in the appropriate place.

#

1. What do you consider the most important content area? _____
2. What do you consider the second most important content area? _____
3. What do you consider the third most important content area? _____

If no ethics education, answer **questions 27-29.**

Section G - Evaluation Measures

Directions:
Please indicate with a check the evaluation indices below that you use to measure student performance in ethics education.

26. Evaluation Indices

1. ___Classroom observation
2. ___Term papers
3. ___Observations outside the classroom
4. ___Standardized tests of ethical development
5. ___Simulations (role play, games)
6. Tests: ___Essay
   ___Multiple Choice
7. ___Classroom discussions
8. ___Case studies
9. ___Peer reviews
10. ___Self-evaluations
11. ___Informal evaluations
12. ___Formal evaluations
13. ___Instructor/student conferences
14. ___Other: Please specify.

    _____

27. Rank order three (3) of the above evaluation methods that you think are important in ethics education. Place the number of the method in the appropriate place.

	#
1. What do you consider the most important evaluation method?	_____
2. What do you consider the second most important evaluation method?	_____
3. What do you consider the third most important evaluation method?	_____

28. What do you see as the best avenue for improving knowledge of ethical issues ands standards in graduate training programs? Check one answer.

___Formal course
___Workshop/seminar
___Exposure in practicum/ internship
___Exposure to Ethical Codes
___Exposure to published works
___Other: Please specify.

_____

28. There are many reasons for including ethics education in the curriculum of marriage and family therapy graduate programs. Please rate the importance of each of the following reasons.

Ethics training is provided:	Very Important	Somewhat Important	Not Very Important	Not at All Important	Do Not Know
1. To acquaint students with client rights in therapy and research	1	2	3	4	5
2. To acquaint students with the norms of professional conduct	1	2	3	4	5
3. To meet the requirements for accreditation	1	2	3	4	5
4. Due to rise in litigation cases/formal complaints	1	2	3	4	5
5. Current code of ethics is insufficient as a guide to ethical practice	1	2	3	4	5
6.To improve ethical practice	1	2	3	4	5
7. To satisfy the interest of students/faculty	1	2	3	4	5
8. Due to rapid advances in therapy/research methods	1	2	3	4	5
9. To help students see how their values, needs and behaviors impact therapy	1	2	3	4	5
10. Other. Please specify.	1	2	3	4	5

_____

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EDUCATIONAL BACKGROUND

Doctor of Philosophy in Marriage and Family Therapy
Virginia Polytechnic Institute and State University
August 1993 to June 1996
GPA: 3.95

Master of Arts in Counseling
Appalachian State University
August 1987 to May 1990
GPA: 3.50

Bachelor of Science in Psychology
Appalachian State University
August 1982 to May 1987
GPA: 3.29

TEACHING EXPERIENCE

Instructor, Department of Human Development and Psychological Counseling, Appalachian State University, Boone, NC. January 1992 to May 1993.

Department Chair: Lee Baruth, Ph.D.

- The Addictive Process. An examination of the sociological and psychological contributants to alcohol and drug addiction and abuse in our society. The addictive process and its impact on individuals, families, and society was explored, as well as treatment and preventive program efforts. Students also examined their own feelings and attitudes about alcohol and drugs.

- Human Relations and Interactions. An examination of the key elements in effective interpersonal communication. Students were exposed to one or more human relations models that were designed to improve their communication skills.

Teaching Assistant, Dean of Undergraduate Students, College of Human Resources, Virginia Polytechnic Institute and State University, Blacksburg, VA. August 1993 to May 1995.

Supervisor: Rita Purdy, Ph.D.

Acted as graduate teaching assistant to the Dean for Professional Orientation and Perspectives - an undergraduate course designed to inform students of academic and career opportunities in the College of Human Resources. Responsibilities included: advising students; substitute lecturing; and grading coursework.

Teaching Assistant, Director of Behavioral Medicine, Department of Community and Family Medicine, Duke University Medical Center, Durham, NC. July 1995 to present.

Supervisor: William Gunn, Ph.D.

Collaborate with Behavioral Medicine faculty to instruct Family Medicine residents in the areas of: systems theory; office/family counseling; genograms; life cycle; chronic illness; adjustment reactions; and sexual abuse. Responsible for bi-monthly lectures on a family systems approach to primary care for Duke University medical students.

PROFESSIONAL EXPERIENCE

Coordinator, Employee Assistance Service, Hubbard Center for Faculty and Staff Support, Appalachian State University, Boone, NC. July 1, 1992 to June 30, 1993.

- Managed the organization and administration of programs and counseling services which address the developmental, personal, and psychological needs of university employees and their immediate families.

- Developed and implemented unit goals and priorities, established policies and procedures, managed the budget, and supervised office operations.

- Supervised one full-time support staff and three part-time counseling staff.

- Conducted intake interviews and made appropriate referrals.

- Provided individual, couple, and family counseling services for a range of developmental and remedial concerns including substance abuse, relationship problems, domestic violence, depression, sexual abuse, stress, career concerns, suicidal ideation, grief and loss, adjustment reactions, and anxiety.

- Provided crisis intervention for individuals or work groups in the event of a troubling event, such as the sudden death of a fellow worker or the breakdown of a colleague on the job.

- Developed and implemented a training program for supervisors and administrators detailing program purpose, referral procedures, and troubled employee identification.

- Established a comprehensive clinical referral resources system.

- Provided individual consultation to supervisors and administrators concerned about troubled employees.

- Conducted educational workshops on such topics as: stress management; elderly parents; impaired colleagues; and the impact of alcoholism on families.

Counselor, Counseling and Psychological Services Center, Appalachian State University, Boone, NC. July 1, 1990 to December 31, 1992.

Director: Don L. Sanz, Ph.D.
Supervisor: Dan L. Jones, Ph.D.

- Conducted intakes and provided counseling for students, staff, and faculty for a variety of developmental and remedial concerns including rape survival, substance abuse, suicidal ideation, personality disorders, adult children of alcoholics, career concerns, sexual abuse and incest, identity and individuation concerns, depression, and adjustment reactions.

- Facilitated group processes for: sexual abuse survivors, personal growth, addictions recovery, and operation desert storm support.

- Supervised, both individually and in groups, graduate student interns in their therapeutic work. Used videotapes and direct observation to help students process personal experiences, plan interventions, and perform appropriate documentation.

- Supervised masters-level practicum students from the Department of Psychology and the Department of Human Development and Psychological Counseling.

- Conducted substance abuse assessments, developed outpatient treatment plans, and made appropriate inpatient referrals.

- Participated in after-hours crisis intervention service.

- Coordinated the "Uncle Sigmund" outreach program, a computer counseling service that responded to questions related to personal problems, stress management, and substance abuse.

- Established a weekly training seminar for graduate student interns on substance abuse issues in counseling.

PRACTICUM AND INTERNSHIP EXPERIENCE

Internship in Marriage and Family Therapy, Duke University Medical Center, Department of Community and Family Medicine, Durham, NC. June 1995 to present.

Supervisor: William Gunn, Ph.D.

- Collaborate with the Family Medicine faculty in teaching residents in the Behavioral Medicine rotation.

- Provide individual, couple, and family therapy to individuals referred by Family Medicine physicians for a variety of issues including: depression, post traumatic stress, chronic illness, substance abuse, relationship problems, and adjustment reactions.

- Facilitate a multi-family therapy group for the relatives of patients participating in the Duke Alcohol and Addiction Program.

- Participate in the Family Studies Program, a one year clinical training program in family therapy sponsored by the Department of Psychiatry. (500 hours)

Practicum in Marriage And Family Therapy, Center for Family Services, Virginia Polytechnic Institute and State University, Blacksburg, VA. November 1993 to May 1995.

Supervisors: Howard Protinsky, Ph.D., Joe Maxwell, Ph.D.,
James Keller, Ph.D., and Scott Johnson, Ph.D.

Provided therapy for individuals, couples, and families at the university-based Center for Family Services. The Marriage and Family Therapy program, which is accredited by the American Association for Marriage and Family Therapy, required 500 hours of direct client contact prior to internship. Fifty-one percent of these hours must be relational and there must be one hour of supervision for every five client contact hours. (500 hours)

Internship in Agency Counseling, Counseling and Psychological Services Center, Appalachian State University, Boone, NC. August 1989 to May 1990.

Supervisor: Dan L. Jones, Ph.D.

Completed IACS (International Association of Counseling Services)approved internship. Primary responsibilities were: Conducted intakes and provided individual outpatient therapy; facilitated therapy groups for adult children of alcoholics, sexual abuse survivors, and addictions recovery; conducted psychoeducational programs; and provided substance abuse assessments and treatment. (600 hours)

Practicum in Counseling, Counseling and Psychological Services Center, Appalachian State University, Boone, NC. January 1989 to May 1989.

Supervisor: Susan Moss, Ph.D.

Completed CACREP (Council for the Accreditation of Counseling and Related Educational Programs) approved practicum. Conducted intakes and provided short-term individual counseling.
(100 hours)

Practicum in Counseling, Department of Human Development and Psychological Counseling, Appalachian State University, Boone, NC. August 1988 to December 1988.

Supervisor: John P. Mulgrew, Ph.D.

Conducted intakes and provided short-term individual counseling. (100 hours)

RESEARCH EXPERIENCE

Research Assistant, Assistant Dean of College of Human Resources, College of Human Resources, Virginia Polytechnic Institute and State University, Blacksburg, VA. May 1994 to August 1994.

Supervisor: Michael Sporakowski, Ph.D.

Designed computer database, entered data, performed data analysis, and prepared poster material for a national survey of family life education programs that was presented at the national conference for the National Council on Family Relations in November 1994. Acted as research assistant on various research projects.

Research Assistant, Department of Curriculum and Instruction, College of Education, Appalachian State University, Boone, NC. August 1988 to May 1990.

Supervisor: Jeff Fletcher, Ph.D.

Instructed undergraduate education majors in the use, application, and technique of audio-visual equipment. Produced audio-visual materials. Provided university faculty and students with service.

Research Assistant, Library Science and Educational Foundations, College of Education, Appalachian State University, Boone, NC. August 1987 to May 1988.

Supervisor: Barbara Webb

Performed basic research assistance and general clerical duties.

RESEARCH PRESENTATIONS

Blieszner, R., & Daniels, J. L. (1994, August). Attributions about friendship among older adults. Poster session presented at the 102nd annual convention of the American Psychological Association, Los Angeles, CA.

Daniels, J. L. (1995, July). Substance abuse and families: Assessment and treatment in clinical practice. Presented a one day training seminar at the 7th annual Focus on Families Institute, Boone, NC.

Daniels, J. L. (1996, March). Only the shadow knows: Developing skills in collaboration. Research to be presented at the 16th Annual Family in Family Medicine Conference, Amelia Island,FL.

Daniels, J. L., & Sanz, D. L. (1992, May). Walk-In-Clinics: An alternative to waiting lists. Presented at the North Carolina Counseling Center Personnel conference, Chapel Hill, NC.

Sporakowski, M., Conklin, M., & Daniels, J. (1994, November). Family life education: Observations on the state of the states. Presented at the 56th annual conference of the National Council on Family Relations, Minneapolis, MN.

PROFESSIONAL AFFILIATIONS

American Association for Marriage and Family Therapy
American Counseling Association
American Psychological Association
Collaborative Family Health Care Coalition
National Council of Family Relations
Society of Teachers In Family Medicine

HONORS

Jon A. Hagaseth Intern of the Year, 1990
College of Human Resources Tuition Scholarship, 1993-1995
Phi Kappa Phi Honor Society
Kappa Omicron Nu Honor Society