Walker, S. & Akister, J. (2004) "*Applying Family Therapy - A guide for caring professionals in the community*." Russell House Publishing.

CHAPTER 8

ETHICAL DILEMMAS IN WORKING WITH FAMILIES

> *"Family therapy is at best time-bound. Each generation of family therapists will engage in activities in terms of their own time, place and context. Every generation of psychotherapists will be faced with certain abstract questions of morality, fairness and justice that will only find answers within the actual practice of therapy."*
> *(Rivett & Street, 2003, p.162).*

Social workers have always paid careful attention to the ethical dilemmas in their practice. The power invested by the law in some of the social work tasks make this imperative. The complexities of the rights of each individual within the family are keenly debated in current social work practice. In legal situations who is the client? Does each family member have appropriate representation and so on. While the issues can be clarified it is not always simple to solve an ethical dilemma since the rights and interests of the individuals may be in opposition.

Ethical guidelines for family therapists caution the therapist to: "respect and guard confidences of each individual client." (AAMFT, 1991, p.2). This general guideline does not recognise the potentially conflicting individual rights within a family system. Newfield et al., (2003) report that while studies have since recognised the potential conflicts they fall short of providing therapists with the guidelines needed to apply ethical decision making in practice.

What is an ethical dilemma in family therapy practice?

One definition is proposed by Burkemper. "Family therapists make ethical decisions. An ethical dilemma presents the therapist with two or more good reasons to make two or more reasonable decisions." (Burkemper, 2002, p.203). This captures the core of the dilemma, that is that there is more than one reasonable decision which could be made and therefore, there has to be some ethical basis on which to make a decision. Even within this notion there are many ways of understanding what would or would not be an ethical decision. We will begin by looking at the different types of reasoning which could be used to underpin decisions in practice. The concepts of 'care reasoning' and 'justice reasoning' can be used to see the dilemma in its simplest form. Further concepts, including 'duty to warn', will then be explored as all these ideas need to be considered as part of any ethical decision making process.

The development of ethical practice is an ongoing task. In this chapter, the subject is approached by looking at some of the recent research into ethical decision making. This

will serve to define the components of ethical decision making and give a basis from which to consider the dilemmas faced in practice by family therapists. What is the evidence base for ethical decision making? The papers described give some answers to this and also give an opportunity to consider some specific issues such as participation in research and ethical responsibilities of parents with chronic illnesses such as diabetes.

Care Reasoning and Justice Reasoning

What are care and justice reasoning? Essentially they propose a value base which can underpin ethical decisions. The care perspective considers the actual consequences of a decision for the involved parties, how the decision would affect the relationship, the context, the need to avoid hurt, and the issues of altruism. Justice reasoning highlights issues of fairness, rights and obligation. Clearly a decision based on justice reasoning may also take care reasoning into account. The point of separating these two concepts is to try to understand which type of reasoning is dominant in different situations and whether therapists agree about this. Evidence from a number of studies suggest that real life and hypothetical dilemmas elicit different responses and it has been suggested that the impersonal nature of the hypothetical dilemma might elicit a justice response. If this were the case then research, using hypothetical examples, would tend to overestimate the use of justice reasoning.

Newfield et al., (2000) in a paper entitled: "Ethical Decision Making Among Family Therapists and Individual Therapists" explored the use of these two types of reasoning as the bases for ethical decision making. In this study informants responded to three ethical dilemmas: two hypothetical and one real and all the interviews were assessed for 'Care Reasoning' and 'Justice Reasoning.'

The reason for looking at this particular dichotomy was that family therapy has been criticised for lacking ethics. The particular focus of this criticism is the apparent lack of consideration for the rights of the individual in a theoretical paradigm that focuses on systems, where existing ethical models used by mental health professional organisations focus on individual rights. To test the impact of theoretical perspectives on decision making a structured interview was used with both family and individual therapists.

The three dilemmas are described below. As you read these try to pause and think about the decisions you would make as a social worker or family therapist working with the family. Before progressing also consider whether you have based your decision on either predominantly care or predominantly justice reasoning.

Dilemma 1: Real-life

"I am trying to understand how therapists make difficult choices in their professional practice. I would like you to tell me about a difficult choice you have had to make, a decision that involved a situation where you weren't sure what to do."

Dilemma 2: Individual-hypothetical

After many sessions a client informs you that he has tested positive for AIDS. When you discuss this with him, he demonstrates an understanding of the disease process and mode of transition. Although the client has been aware of this condition for several months he has continued to engage in sexual relationships, and also indicates an unwillingness to discontinue sexual activity or to discuss this information with past and present sexual partners.

Dilemma 3: Family-hypothetical

A family referred itself to your office to address communication issues. The family consisted of five persons at home: Mother, father, two daughters and a son. After several sessions, it was disclosed that father had sexually abused the oldest daughter. The father had stopped the abuse several months ago, and the family indicated that the primary reason for seeking therapy was to address issues related to the abuse. The family members had kept this a secret, and only confided in you with the request that you not appraise or involve others because they felt the problem was being resolved. To date, this family has worked hard in therapy, and all family members, including the father and daughter, seem highly motivated to continue the therapy. The father has agreed to a contract with you regarding the issues of abuse.

Family therapists (n=30) and individual therapists (n=30) were each interviewed in relation to these three dilemmas.

What were the results of the study?

Firstly there was no significant difference between individual and family therapists in relation to each of the dilemmas. There was also no significant interaction between gender and dilemma type. That is the decisions made were not influenced by the therapist being either individual or family orientated. Faced with any of these dilemmas family therapists and individual therapists were just as likely to use either care or justice reasoning..

Secondly, there was a significant difference within the dilemmas. That is, there was a significant difference across the care scores for each dilemma regardless of therapist type or gender. The therapists were making care based decisions more than 50% of the time on all dilemmas, with the personal dilemma eliciting the highest number of care based decisions.

In this study striking similarities emerged between individual and family therapists in ethical decision making suggesting that factors other than theoretical orientation were influencing their decisions. Both had adopted a model of decision making that focused on values identified with an ethic of care. There was significantly more care reasoning demonstrated on the personal dilemma than on the hypothetical dilemmas. “When the

outcome of this study is viewed with an understanding that the ethical codes of professional organizations emphasize a justice ethic, it clarifies the concerns professionals express about professional ethical codes." (Newfield et al., 2000, p.182).

The findings of this study are really quite astonishing. Firstly, that despite individual or systems orientations therapists are not more or less likely to respond to ethical dilemmas with care or justice reasoning. Secondly, given that the codes of ethics for all therapists emphasise justice reasoning, the therapists responses to ethical dilemmas are based on care reasoning in over half the decisions.

What happened to justice reasoning? The rhetoric amongst professionals would indicate that the legal frameworks within which they work determine what they are able to do. Yet the reality of working with families brings the care reasoning to the fore presumably at times, in situations which could place one or more family members at risk. Bearing these findings in mind it will now be useful to look at research focussing on duty to warn situations.

Duty to Warn Situations

Burkemper (2002) in a paper titled: "Family Therapists' Ethical Decision-Making Processes In Two Duty-To-Warn Situations" used two scenarios to try and understand the processes involved in ethical decision-making by marital and family therapists. The dilemma investigated was that of protecting client confidentiality when there was a perceived and/or actual duty to warn. The decision to protect client confidentiality or to reveal information to authorities was examined in response to two scenarios of child abuse and of HIV transmission to unsuspecting partners.

> **Dilemma 1: Child Abuse**
>
> In a therapy session your client informs you that s/he has been disciplining her/his child with the buckle end of the belt that leaves welts on the child. The client will not contract to end her/his use of this form of discipline. The client will not authorise you to share this information with anyone.
>
> **Dilemma 2: HIV**
>
> In a therapy session, your client informs you that s/he is HIV positive and is engaging in unprotected sex with her/his uninformed mate. The client will not authorise you to share this information with anyone.

The bases of ethical decision making includes lower- and higher-level components. The lower-level decision components include personal/therapeutic response, professional ethics, and legal considerations/laws of the State. The higher-level decision components include nonmaleficence (avoiding harm), autonomy (individuals' right to decision making), beneficence (doing good),

fidelity (client's right to confidentiality), and justice (being fair to my client). Respondents (n=177) were asked to rank order these components to indicate which were most and which least important in their decision making in relation to these two dilemmas. All respondents were members of the American Association of Marital and Family Therapists.

Statistical results indicated that in the child abuse scenario, professional ethics and legal considerations/laws of the State were considered most important. In the HIV scenario, professional ethics were considered most important.

Across both scenarios, the preferred higher-level decision base was nonmaleficence, that is avoiding harm. There were differences between the child abuse and HIV scenarios in the perceived significance of the remaining higher-level decision base items (see Table 1).

Table 1: Order of importance of the principles in relation to scenarios of Child Abuse and HIV.

Child Abuse		**HIV**	
Avoiding Harm		Avoiding Harm	
Doing Good - Beneficience		Confidentiality	
Being Fair – Justice		Being Fair – Justice	
Confidentiality		Autonomy	
Autonomy		Doing Good - Beneficience	

The idea of this research was to identify potential hierarchy of preferences in ethical decision making. "Ethical decision making is often viewed as an abstract enterprise. This research should, however, provoke a sense of identifying and putting into words the possible components in ethical decision making." (Burkemper, 2002, p.208). The author hoped that the idea of breaking ethical decision making into discrete elements could be utilised in teaching, supervision and self-analysis of practice decisions. This certainly seems a valuable enterprise since at times lives may rest upon our ability to deal with ethical dilemmas appropriately. These concepts can be used in all situations where there could be competing claims from individuals within a family system.

Unlike the previous study legal considerations and laws of the state were considered most important. However this may depend on the clarity of the scenarios and we know that in real life even situations of child abuse are often not clear and that there will be scope forinterpretation of the timing and appropriateness of legal interventions.

Having grasped these core concepts in relation to competing claims of individuals it will be interesting to consider a situation where the basis of the ethical dilemma is between which concepts to place greatest value on in relation to one family members well-being.

Ethical dilemmas in Caring for an Elderly Family Member - Beneficience versus Autonomy

The issues of beneficience (doing good) versus autonomy (individuals' right to decision making) may arise in a number of care situations. These issues are clearly identified and researched in an article on family care of older persons. There is a tendency to think of family therapy as mainly relating to families with children, but family therapy in social work practice is highly relevant to families at all stages of the life cycle.

Families have always been and continue to be the main caregivers for frail and elderly relatives. Barber & Lyness (2001) in their article: "Ethical Issues in Family Care of Older People with Dementia: Implications for Family Therapists" highlight some of the ethical dilemmas families face in caring for an elderly loved one, particularly focussing on those caring for elderly parents suffering from a dementing illness.

Families face a number of ethical dilemmas relating to the dependent care including: determining the extent of filial responsibility, family equity, competing commitments, care recipients autonomy and safety/decision making, knowing what the care recipient wants and financing the cost of care. From the perspective of the caregiver, what the care receiver wants may not always be in her or his best interests, at least from the perspective of the caregiver. Dilemma 1 is an example of this.

> **Dilemma 1: Who decides?**
>
> A person wants to continue to drive even though their mental capacity makes this activity dangerous to both themselves and others.

This is difficult for the caregiver who has to weigh up whether to let the care receiver continue to drive (respecting their autonomy) or whether to take away the keys viewing their safety as more important. "Often family members let benefience overrule the principle of autonomy while feeling guilty about taking away some of the family members independence." (p.7) Barber and Lyness (2001) see an important role for systemic therapists in working with families facing these dilemmas helping the family to deal with its internal needs and the decisions relating to the wider system including health care providers.

When ethical principles are in conflict as in the example above Barber and Lyness suggest using the principles of universalizability and balancing. "When utilising the criterion of universalizability, therapists ask themselves: 'would I want this decision applied to me, my family or all other families in similar situations?' According to the

criterion of balancing, ‘an ethical decision is one that produces the least amount of avoidable harm to all individuals involved.’” (Barber & Lyness, 2001, p.7).

Dilemma 2: Own home or residential care?

Whether to sacrifice the care recipients autonomy in favour of restrictions (e.g. institutional care) which are in the recipients best interests but may be prejudicial to the care recipients well being as well (i.e. how will they react to the change).

In this situation it is difficult to balance the needs of the care receiver (for autonomy) and the needs of the caregiver (to support the care receivers safety). What is more important? Their safety or autonomy and who should make this decision. If the safety of third parties is involved it is easier to take the decision to limit an individuals autonomy. If it is only their own safety which is at risk the ethical dilemmas are experienced most acutely. There is a clear role for working with the family here. All too often decisions are made by family members on behalf of each other without a family meeting to explore the issues together. Generally it is the professionals who fear what will happen if the family are brought together but the reality is tha this offers a chance to share together in what are extremely painful decisions at this stage of the life cycle.

A further ethical principle which can come into play in decisions relating to elderly family members is justice. That is the notion of fairly distributing caregiving responsibilities among family members and of the need to preserve the well-being of the caregiver. Hasselkus (1991) interviewed 60 caregivers and found that most placed the needs of the care recipient above their own, although this did not occur without feelings of resentment and guilt. For family therapists and/or social workers it is important to explore the families view of justice as they reveal the caregivers implicit ethical code.

There is no clear ethical code to guide the ethical decisions of caregivers and their families. Therapists must be able to work with the individual differences between families. For example, families may differ in the value they place on the person with advanced dementia. Faced with a family members disintegration they may need help in deciding what the goals of their care should be. The family therapist or social worker can help keep a focus on the family system as in dealing with a patient with dementia many medical clinicians become problem oriented. Family therapists may be in a unique position to help families make ethically sound decisions as they struggle with caregiving since they are able to access the ethical issues for the family system rather than focussing on the needs of one member.

There can be other dilemmas in relation to health for the family and the section below raises issues which are pertinent to all those working with families.

Ethical Dilemmas in Relation to Health Care

The physical health of family members is another arena where there can be competing claims. (One potential scenario, choice of treatment for a child with depression will be

considered in the next section.) Parents have a role in deciding medical treatments for their children given the inexact state of knowledge about best treatments in most conditions. With some ongoing conditions there can be conflict caused by the condition, for example, the control of diabetes in pregnancy. The health of the mother during pregnancy directly impacts on the outcome for the baby. “There has been a change from a hierarchical model of delivering care in which health professionals take on full responsibility to one in which responsibility is shared and there is a partnership between the person with diabetes and the health care professional….. Whether these models are applicable to pregnancy has received little attention.” (Josse et al., 2003, p.290). If the diabetes is poorly controlled who should take responsibility?

In health care the Common Law principles relating to capacity, best interest and duty of care form the ethical bases for decision making. Central to these principles is the idea that every adult has the right to decide whether or not to accept or refuse medical treatment. The reasons for refusal are irrelevant as long as the person has the capacity to make the decision.

The social worker and other professionals working with such dilemmas will not find any easy answers. Social work at the present time is particularly interested in models of partnership and empowerment and the situation of diabetes control in pregnancy, throws into sharp relief the ethical dilemmas which can be raised when working in partnership. This would be particularly acute when the partnership is of a pseudo nature as the social worker has legal responsibilities in some situations which would take precedence.

The ideas from evidence based practice can give some help in treatment and inervention decisions but they are far from perfect and need viewing with caution as is suggested by Ryan (2002).

Ethical Safeguards For Research Subjects

Research is meant to provide a balanced and unbiased view of the topic researched. Is this possible? What factors might influence both who participates in research and the content of its inquiry?

In order to undertake research funding is needed. If the funders have a vested interest in the outcome then the research or dissemination of findings could be influenced by this. The paper by Ryan (2002): “Safeguards For Research Subjects: Who’s Watching Whom?” identifies some of the ethical dilemmas in the research process when working with vulnerable populations.

This clinical report, from an adult mental health perspective, identifies the need for a public forum for discussion and debate when research subjects are recruited from vulnerable populations and/or groups with impaired decision making-ability. “In all of these debates, mental health advocacy groups represent a valued and valuable player. Are their concerns regarding research in the mental health field warranted? Yes. Should research using psychiatrically ill patients therefore be banned? No.” (Ryan, 2002, p.9).

The paper goes on to consider the dilemmas and competing needs of the researchers, the patients and their advocates. Ryan says that most researchers recognise the need for feedback from mental health advocacy groups, even if they do not welcome it. On the other hand there are times when mental health groups act like vigilantes rather than concerned advocates of ill patients. At other times a paternalistic attitude creeps in under the presumption that a person with a psychiatric illness cannot make an informed decision. This paternalism can originate from an overly concerned family member, an advocacy group, or the clinician, and may not represent a patients wish to participate in a research study or clinical trial.

The ethical issues raised in this paper are important to discuss in both therapy and research and are relevant to all vulnerable populations. This point is highlighted also by a study considering childhood depression. “There is no definitive course of treatment for children with depression. Each treatment option, therefore, has ethical implications for both providers and families. Providers must balance the principles of beneficience and nonmaleficience for the patient. Parents must be allowed autonomy in selecting the best treatment course for their child.” (Nelson, 2003). One approach to this decision making would be to base the decision on evidence-based research. However, as we have seen research also has ethical concerns (Ryan, 2002; Kerridge et al., 1998). Further treatment studies are needed in childhood depression. This involves both the parents giving consent and the children giving assent. Ethical assent with children needs to be appropriate to their developmental stage and preferably proposed by a neutral clinician to help minimize pressure to participate whilst at the same time recognising the potential importance for treatment advances.

Discussion

This chapter has described a number of studies that have focussed on ethical considerations in family therapy practice including ethical concerns for families participating in research. These issues are crucial to respecting the rights of the individual family members whilst working with the family system. It is very helpful for therapists to keep these ideas as key to their negotiations and interventions with families since there is constant possibility for competing claims amongst family members. What is best for one family member may not be best for other members. Here, in a way, is the great value of working with the whole family system since these dilemmas have to be resolved and may be part of the reason that the family has come to therapy. When just one family member is worked with these crucial ethical dilemmas may not even be identified and cannot be resolved without the cooperation and working together of the whole family.

These ethical dilemmas can arise at any stage in the life cycle though are particularly easy to identify when working with families with concerns about the welfare and care of elder members or with young children. We are also influenced by ideas and procedures current at the time (Rivett & Street, 2003). Ethically sound decisions will in effect be time and context bound.

For the professional working with the family the balance of care and justice reasoning should be held as important principles along with legal frameworks. The question of duty to warn and of the components of ethical practice, including confidentiality, beneficience and autonomy should be visited with each family to ensure ethical and anti-oppressive practice.

References

American Association for Marriage and Family Therapy. (1991). AAMFT Code of Ethics, Washington DC: Author.

Barber, C.E. & Lyness, K.P. (2001) Ethical Issues in Family Care of Older People with Dementia: Implications for Family Therapists. Home Health Care Services Quarterly, 20(3), 1-26.

Burkemper, E.M. (2002) Family Therapists' Ethical Decision-Making Processes In Two Duty-To-Warn Situations. Journal of Marital & Family Therapy, 28(2), 203-212.

Hasselkus, B. R. (1991) Ethical Dilemmas in Family Caregiving for the Elderly: Implications for occupational therapy. The American Journal of Occupational Therapy, 45, 206-212.

Josse, J., James, J. & Roland, J. (2003) Diabetes Control in Pregnancy: Who takes responsibility for what? Pract Diab Int, 20, 8, 290-293.

Kerridge, L., Lowe, M. & Henry, D. (1998) Ethica and Evidence Based Medicine." British Medical Journal, 316, 1151-1153.

Nelson, E. (2003) Ethical Concerns Associated with Childhood Depression. Bioethics Forum, 18(3/4), 55-62.

Newfield, S.A., Newfield, N.A., Sperry, J.A. & Smith, T.E. (2000) Ethical Decision Making Among Family Therapists and Individual Therapists. Family Process, 39(2), 177-88.

Rivett, M. & Street, E. (2003) Family Therapy in Focus. Sage Publications, London.

Ryan, C. (2002) Safeguards For Research Subjects: Who's Watching Whom? Behavioral Healthcare Tomorrow, June, 9-11.