CHAPTER 4

ETHICAL DECISION MAKING IN MENTAL HEALTH CONTEXTS: REPRESENTATIVE MODELS AND AN ORGANIZATIONAL FRAMEWORK

R. Rocco Cottone

No degree of preparation can fully insulate a psychologist from facing an ethical dilemma or a charge of unethical conduct. Professional savvy or ethical sensitivity, although helpful, will not suffice. Psychology practice is challenging. New situations arise that require intelligent educated action.

Even with good intentions, sometimes psychologists make choices they may later regret. Some choices may have serious repercussions. Some choices have ethical implications. Of course, some psychologists may be confronted by clients who have malicious intent, and it is difficult to protect against a manipulative client in search of a legal settlement. Prevention is a psychologist's first line of defense against ethical challenges. Once challenged, however, psychologists should address the challenge competently and ethically, ideally by means of a formal decision process.

As a best practice, the decision making of psychologists should be guided by a formal decision-making process and a positive ethic (Handelsman, Knapp, & Gottlieb, 2009), meaning that psychologists should know how to act when confronted by an ethical dilemma, not just how not to act. Ethical dilemmas, those quandaries all psychologists face in practice that place psychologists in positions requiring choices about how to act, are not only a sign of conflict (at some level) but also are the sign of a mature profession. Psychologists have arrived at a professional place and time that speaks to their membership in an established profession. Psychologists, in this regard, are intellectuals, not just trade workers and not laborers, but professionals who apply both historical and scientific knowledge to complex circumstances. The ethical practice of psychology must not be just about avoiding punishment, it also must be about establishing a means and method for high-level decision making in the best interests of clients, society, and the profession of psychology itself. Knowing how to act ethically, being willing to act, and not just knowing how to avoid being unethical, is a critical element in each psychologist's personal development and acculturation in the profession (Handelsman, Gottlieb, & Knapp, 2005).

When mental health professionals are surveyed on issues of importance related to ethical practice, decision making typically is highly ranked. Knapp and Sturm (2002) cited a study that ranked decision making second in a long list of potential needs in ethics continuing education. Practitioners must know how to apply a decision-making model in a competent and professional way. Knowing when to apply this decision-making model also is important. The *Ethical Principles of Psychologists and Code of Conduct* (the Ethics Code; American Psychological Association [APA], 2010) does not provide guidance on such matters; it also does not recommend a decision-making model, unlike its Canadian counterpart (Canadian Psychological Association [CPA], 2000). The Ethics Code, however, does define five general ethical principles to guide decision making (more on ethical principles in the section Major Intellectual Movements in Decision Making in Psychology).

Special thanks to Hsin-hsin Huang for her assistance in producing this chapter.

DOI: 10.1037/13271-004
APA Handbook of Ethics in Psychology: Vol. 1. Moral Foundations and Common Themes, S. J. Knapp (Editor-in-Chief)

As a general rule, psychologists should apply a decision-making model when they are faced with an ethical dilemma. An ethical dilemma "is a circumstance that stymies or confuses" the psychologist

> because (a) there are competing or conflicting ethical standards that apply, (b) there is a conflict between what is ethical (e.g., professional standards) and moral (e.g., religious standards), (c) the situation is such that complexities make application of ethical standards unclear, or (d) some other circumstance prevents a clear application of standards. (Cottone & Tarvydas, 2007, p. 2)

In these situations, knowledge must be applied, and judgment is involved. Knapp and VandeCreek (2006) made a similar case; they argued that decision making is necessary when judgments must be made regarding conflicting principles, laws, or institutional policies. A formal decision-making process will help the psychologist discern the best course of action when there are competing possibilities and in cases in which the application of a single standard is not clear-cut.

This chapter addresses ethical decision making in psychology. It gives a brief overview of several intellectual movements that have affected decision-making models in psychology, and it provides a categorization of models on several theoretical, philosophical, and practical criteria. It provides example models to help the reader understand the complexity of decision making and the choices professionals may make in addressing different concerns though different models. It also addresses issues related to willingness and resoluteness of the psychologist to take action to address an ethical dilemma, and it explores the question as to whether individual conscience is an adequate arbiter of decision implementation. This chapter does not provide an exhaustive review on the topic of ethical decision making, but hopefully the reader will have a broad understanding of the literature and of how decision theory relates to practice at the most basic levels. This chapter provides information to facilitate competent management of challenging clinical circumstances—those situations that will defy even the most ethically mature and experienced professional psychologist.

DEFINING ETHICAL DECISION MAKING IN PSYCHOLOGY

As used in this chapter, the term *ethical decision making* (sometimes referred to by others as *ethical problem solving* or *ethical choice making*) relates to the use of formal models or processes to address *professional ethical dilemmas within a mental health context*. Ethical choice and moral choice philosophy often address decisions, but those decisions are focused on choices that involve a moral dilemma (whether stealing to survive is justified, or whether one should kill in self-defense, as examples). Literature also addresses decision making on matters of choices that have little to do with mental health practice—like choosing to buy a certain product when alternatives are available. The literature addressed in this chapter is limited to those publications or works that specifically attend to choices mental health professionals must make when facing a professional ethical dilemma. Literature outside of the mental health realm may be relevant to professional ethical decision making, but readers must be alerted to the specific contexts within which certain models or terminology apply. Also, because ethical decision making is so important that it permeates all specialties of psychology, decision-making models are briefly mentioned in other chapters in this text, including Volume 2, Chapter 2, this handbook, on older adults, and Volume 2, Chapter 8, this handbook, on industrial–organizational psychology. In this chapter, the focus is clearly on professional ethical decision making in a mental health context, and when specific publications are referenced that veer from that focus, special notation is made.

MAJOR INTELLECTUAL MOVEMENTS IN DECISION MAKING IN PSYCHOLOGY

Three major intellectual movements are relevant to the ethical decision making in psychology. An intellectual movement, as defined here, refers to a unique philosophical framework that excludes easy application of ideals from another competitive philosophy. For example, relying on a decision maker

who rationally applies accepted standards is different than relinquishing a decision to someone based primarily on his or her character. Similarly, committee decision making and individual decision making are mutually exclusive. As applied to decision making, an intellectual movement must have a unique philosophy upon which decision making stands. Given this definition, the three major intellectual movements in the area of ethical decision making in psychology are principle ethics, virtue ethics, and relational ethics. Additionally, the theme of multicultural sensitivity represents an overarching framework within which decisions may be generated. Multicultural sensitivity does not rise to the level of a full-fledged movement, but it does provide a general theme within which decisions are framed. The next sections address the three intellectual movements and the theme of multicultural sensitivity as applied to ethical decision making in psychology.

Principle Ethics: The First Intellectual Movement in Psychology Decision Making

Some outstanding works on ethics in the health professions have influenced decision making in psychology. One of the most influential is a text entitled *Principles of Biomedical Ethics* by Beauchamp and Childress (2009) now in its sixth edition. The first edition was published in 1979. In keeping with the foundational work of R. W. Ross (1930) on principle ethics, Beauchamp and Childress defined four ethical principles to guide medical professionals in decision making. The principles were autonomy (the patient's right to make choices on his or her own), beneficence (the idea that medical professionals should primarily be concerned with the well-being of patients), nonmaleficence (the idea that medical professionals should do no harm), and justice (the idea that professionals should treat people fairly and without discrimination). They also defined an ethical rule (not as prominent as a principle) entitled "fidelity," meaning that medical professionals should be faithful to their patients. It was Kitchener, in 1984, who firmly brought psychology's attention to the biomedical ethical standards defined by Beauchamp and Childress. Kitchener (1984) in a seminal work, embraced the biomedical ethical principles, and she elevated Beauchamp and Childress's ethical rule of fidelity to an ethical principle in psychology (following the lead of Drane, 1982). (Beauchamp and Childress later defined *professional–patient relationships* as a principle, addressing concerns such as fidelity, privacy, and confidentiality.) Kitchener further heralded the works of Hare (1981) applying his two levels of moral thinking: intuition and critical evaluation. Kitchener's work is highly cited, and she succeeded in establishing the foundation for what can be called *principle ethics* in psychology. Principle ethics is the logical application of identified and highly accepted principles (overarching standards) that are crucial to any decision in psychology. Kitchener defined the ethical principles as prima facie, meaning they hold weight and should be set aside only for compelling reasons. (See Ross, 1930, seminal analysis of prima facie responsibility.) Kitchener stated,

> While the problems of applying ethical principles in decision making need to be acknowledged, this does not keep them from being useful or important. By accepting them as prima facie valid, we imply that their relevance always needs to be considered in ethical situations. (Kitchener, 1984, p. 53)

Kitchener's work (1984), specifically, and principle ethics, in general, lay the groundwork for defining one philosophical framework for understanding ethical decision making in psychology. Decision making is viewed as a process of an individual who considers ethical principles while deliberating an ethical dilemma. Principle ethics fits nicely within the context of a psychology that views the individual as a decision maker—a singular person who weighs options and makes choices.

Virtue Ethics: The Second Intellectual Movement in Psychology Decision Making

A competitor view to principle ethics is *virtue ethics*. Initially, virtue ethics (which focuses on the character of the decision maker) was viewed as a complement to principle ethics. In the 21st century, virtue ethics often is described in general textbooks on ethics as a different or as an alternative approach to

ethical judgment (Sommers-Flanagan & Sommers-Flanagan, 2007; Sperry, 2007; Welfel, 2006). Originally, Meara, Schmidt, and Day (1996) proposed that the virtue of the ethical agent (the decision maker) is crucial in decision making and worthy of study in tandem with the study of ethical principles. They proposed that personal character should be a major component in the decision process. The issue of virtue raises the discussion of making decisions from the simple means of defining right and wrong (e.g., means to avoid punishment for breaching an ethical standard or principle) to the means of an ethical ideal (virtuous professional psychologists). The proponents did not propose that virtue ethics should replace principle ethics, but they did make the case that virtue ethics complement principle ethics, and they even went so far as to call for an expansion of ethics research to encompass the character of the decision maker. They demonstrated that one cannot fully understand an ethical decision on the basis of principles alone: Some people will do the minimum only to avoid punishment or will not act ethically at all, whereas other people will embrace an ethical lifestyle regardless of ethical dictates. In either case, the decision maker is the crucial variable. This helps to explain why people bound by the same code of ethics act differently in similar circumstances.

Relational Ethics: The Third Intellectual Movement in Psychology Decision Making

A third philosophical or theoretical movement that has affected the decision-making literature is what can be identified as relational ethics. Relational ethics, which focuses on social context, has put principle ethics in perspective, just as virtue ethics provided another way to view the decision process. One of the first publications to address contextual factors was a chapter by Hill, Glaser, and Harden (1995). In that chapter, the authors argued that consideration of contextual factors enters into value judgments, and therefore context affects decision making. They stated,

> Time in a particular setting or working from a certain theoretical base represents at least a certain amount of exposure to specific values and often a personal investment in those values. Factors such as gender, ethnicity or race, religious background, geographic location, and so forth, are even more obviously related to values. The therapist's personal experiences of oppression and the uses of power, (e.g., through race, sexual orientation, gender, size, disability, class, and age) will sensitize that individual in certain ways. Those same factors and others (such as religious background, family or living situation, or geographic location) will influence the therapist's priorities and assumptions. In order to make a feminist model for decision making, these aspects of who the therapist is cannot be separated from the decisions that she or he makes. If therapists turn to ethical decision-making models that do not address these factors, they then run the risk of making these factors invisible and thus not open to scrutiny. (1995, p. 25)

Hill et al. made a case for consideration of the social–cultural context in decision making, "particularly as it relates to issues of power" (1995, p. 36). They provided a stepwise model for decision making, which they called "a feminist model for ethical decision making." The steps are as follows: (a) recognizing a problem, (b) defining the problem, (c) developing solutions, (d) choosing a solution, (e) reviewing process, (f) implementing and evaluating the decision, and (g) continuing reflection. They argued that through the decision-making process the feminist must consider "the emotional-intuitive responses of the therapist; the sociocultural context of the therapist, client, and consultant particularly as it relates to issues of power; and the client's participation in the decision making process" (1995, p. 36). The call for a feminist ethics is a call for placing principle ethics in the context of social (and specifically social power) considerations.

Betan (1997) also made a significant contribution to the decision-making literature by introducing a hermeneutic model of ethical decision making.

Hermeneutics is a philosophical framework through which knowledge is viewed as residing in the context of human relationships. Betan stated, "Hermeneutics involves an awareness that the process of inquiry is affected by and in turn affects the person seeking knowledge" (1997, p. 352). Therefore, all historical, personal, and circumstantial factors are involved in every decision. Even ethical principles are viewed as historical and circumstantially situated—they are not standards that come from some objective source of knowledge—they are reflective of the cultural context from which they emerge and the situation in which they are applied. Betan did not provide a stepwise model for decision making. He attempted, however, to demonstrate that hermeneutics "allows the therapist to remain part of the situation, and it places authority not in abstract, externally imposed principles but rather in the connection between therapist and patient" (1997, p. 362). Social and relational considerations are prominent in this model. Still, in hermeneutics, there is an individual decision maker. The decision is not made by a committee. In other words, the model is not so extreme as to situate the mind of the individual in the social matrix. Some (one) person does weigh the social factors that are involved in a decision, and the decision is still a psychological process for the decision maker.

Cottone's (2001) model is much more extreme. Guided by social constructivism as a philosophical movement in the human services, Cottone took an extreme relational stance, claiming that decisions are not made in the head of the apparent decision maker—rather they reflect a consensualizing process that is culturally, socially, and interpersonally imbedded. He built on the works of Gergen (1985) on the constructionist movement in modern psychology, and he used the works of Maturana (1980) on the biology of cognition (as lauded by Dell, 1985) as representing a fully relational view of the human condition. Using these foundational works, Cottone developed a social constructivism model of ethical decision making, which is completely interpersonal. Decisions are taken out of the decision maker's head and placed within the social interactive context. Decision making involves negotiating, consensualizing, and arbitrating, rather than individual deliberation. (There is more on this model in the section Philosophically Grounded Models of Relational Influence.)

MULTICULTURAL SENSITIVITY: A DECISION-MAKING THEME

Multiculturalism may not constitute a fourth intellectual movement affecting ethical decision-making models in psychology, but it certainly represents a theme that has major implications for decision-making processes. Viewing ethics through the lens of multiculturalism places emphasis (even prominence) on the identification and analysis of established cultural traditions that may affect the relationship between the psychologist, the client, and other stakeholders affected by a decision. Multicultural sensitivity, for example, can be an overarching theme for decision making that applies principle ethics, virtue ethics, or relational ethics (or some combination). In this way, multicultural factors are fully acknowledged. For example, Knapp and VandeCreek (2007) framed the problem of cultural conflicts in decision making as a tension between application of universal standards (such as ethical principles) and acceptance of the plural truths that are present when addressing culturally situated behaviors (i.e., behaviors that may be counter to ethical principles). They used the example of child discipline, which may be harsher in a foreign culture than is acceptable in U.S. society. In the case described by Knapp and VandeCreek, an immigrant East Asian family in the United States used "extreme physical punishment of their children to ensure obedience and conformity" (2007, p. 660). According to Knapp and VandeCreek, defining the fine line between discipline and abuse, in this case, required a decision process that involved "respectful dialogue" and application of "soft universalism" (no hard line, black-or-white logic in defining principles of acceptable behavior). They stated,

> We suggest that psychologists engage in a respectful dialogue to help patients clarify their values and goals, and that they look for areas of agreement between the value systems. If this fails to prevent a serious threat to a fundamental ethical principle, we suggest that it is appropriate, as a last resort, to confront

> the patient's values from the perspective of soft universalism, which may mean allowing the ethical principles of beneficence or nonmaleficence to temporarily override respect for autonomy. Even so, the psychologist should only override autonomy to the minimal extent possible, consistent with the overarching goal of beneficence or nonmaleficence. (Knapp & VandeCreek, 2007, p. 663)

This suggestion implicitly defines the role of the psychologist as a transcultural negotiator responsible to facilitate solutions to problems that are both true to overarching values in psychology and respectful of cultural differences.

Hanson and Kerkhoff (2007) addressed similar concerns specific to ethical decision making in rehabilitation psychology. After providing a detailed example representing a failure to acknowledge Latino cultural factors in medical decision making, the authors stated,

> Failing to aspire to become a culturally proficient psychologist is to ignore the evolving social landscape within which psychologists practice. As the United States grapples with its founding history and contemporary views of immigration, so too is the discipline of psychology trying to find its voice in the social dialogue on diversity and the impact of multicultural approaches on education, practice, research, and advocacy. (Hanson & Kerkhoff, 2007, p. 418)

A psychologist must at least recognize the tension that arises with an automatic application of prevailing standards at the expense of cultural traditions. A decision may be different if cultural factors are understood and addressed through the decision-making process.

Garcia, Cartwright, Winston, and Borzuchowska (2003) presented a similar multicultural theme: "In examining the available ethical decision-making models published in the field, we found minimal reference to culture or how to integrate culture into ethical decision-making" (p. 269). Garcia et al. used ideas from three of the most culturally sensitive approaches known to that date (Cottone, 2001; Davis, 1997; Tarvydas, 1998) to build a formal model of ethical decision making they called the transcultural integrative model. Their model thoroughly integrates cultural factors with social and psychological factors into the decision-making process, and the model uses Tarvydas's stages as a framework. Garcia et al. made the case that the transcultural integrative model allowed cultural factors to play "an important and perhaps definitive role" (Garcia et al., 2003, p. 275) in the decision-making process. As with Knapp and VandeCreek (2007), Garcia et al. argued for prominent consideration of multicultural factors in the decision-making process.

Multicultural sensitivity, as it is described here, is more thematic than philosophical. Models developed around multicultural sensitivity typically depend on one or more of the intellectual movements to define crucial steps or processes in the decision effort. Models based on multicultural sensitivity can draw from the other intellectual movements without conflict, whereas the intellectual movements appear to be more circumscribed, theoretically distinct, and even mutually exclusive. One can appeal to principles, virtues, or relationships in defining a culturally sensitive way to address an ethical dilemma. But to move from principle ethics to relational ethics, for example, may require a Gestalt-like shift in perspective, as ethical principles are held as established truths, whereas relational ethics are always context specific and historically situated truths. Therefore, the intellectual movements in ethical decision making, when viewed from a pure or absolute point of view, are mutually exclusive, and they may not be reconciled easily.

CLASSIFYING MODELS ON PHILOSOPHICAL, THEORETICAL, OR PRACTICAL GROUNDS

The three intellectual movements (principle ethics, virtue ethics, and relational ethics) and the theme of multicultural sensitivity have influenced ethical decision making in psychology, and together they constitute a framework for classifying and analyzing existing decision-making models. These models,

however, also may be classified on other philosophical, theoretical, or practical grounds.

Beyond the intellectual movements that have affected the field, an additional philosophical, theoretical, and practical taxonomy offers another way of looking at the models and analyzing their validity. Models can be classified on the basis of philosophy, empirical formulations, or anecdotal evidence. They can be based on specific theories. They can be focused on the individual decision maker, or they can focus on a group of individuals who are influential in the final outcome. They can be a mixture of any number of such factors. Several categories will be defined, and at least one example model will be presented for each category. In every case, however, it will be obvious which intellectual movement is at its base. Individually oriented approaches will tend to be based in principle or virtue ethics, or both. Models that involve interaction will be relationally focused. So the models will tend to be offshoots of the intellectual movements with some specific and unique philosophical, theoretical, or practice-relevant ingredient added to the recipe.

Philosophically Grounded Models of Individual Choice

Hare (1991), in "The Philosophical Basis of Psychiatric Ethics," provided one of the most philosophically grounded models of ethical decision making. Hare argued that there are two levels of ethical decision making, the intuitive level and the critical evaluative level. At the intuitive level, an application of ethical principles is in order. Mental health professionals are taught principles as guides to professional behavior, and when confronted with a dilemma, they use their intuition to apply the principles. Hare argued that, in most cases, dilemmas will be adequately addressed by means of the intuitive application of principles. He also raised concerns about the problem of conflicts between principles. How should those conflicts be negotiated? He stated,

> That we have a duty to serve the interests of the patient, and that we have a duty to respect his rights, can both perhaps be ascertained by consulting our intuitions at the bottom level. But if we ask which duty or which intuition ought to carry the day, we need some means other than intuition, some higher kind of thinking (let us call it "critical moral thinking") to settle the question between them. (Hare, 1991, p. 35)

Hare (1991) argued that at the bottom level, the intuitive level, a decision can be absolutist, meaning that there can be a concrete application of a principle to a problem. But at the higher level of decision making (when intuition fails), absolute thinking must give way to utilitarianism. He summarized utilitarian philosophy by stating, "A utilitarian is one who thinks that when faced with a moral decision he ought to act in whichever way is best for the interests of those affected" (1991, p. 34). He used Kant's example of a madman in search of a known individual he plans to kill; when confronted, should someone reveal the potential victim's location, or lie? Hare stated,

> Most of us, as well as the duty to speak the truth, acknowledge a duty to preserve innocent people from murderers, and here the duties are in conflict. An absolutist will have to resolve the conflict by calling one of the duties absolute and assigning some weaker status to the other. ... A utilitarian, by contrast, is likely to say that neither duty is absolute; what we have to do is to decide what would be for the best in the particular case. In this case, it will presumably do most good to all concerned, considering their interests impartially, if I tell a lie. (1991, p. 36)

Effectively, Hare (1991) proposed a two-stage model of moral decision making. At the first level, one is intuitive and can apply absolutist standards of right and wrong. At the second level, one must apply utilitarian philosophy, engaging a critical evaluation of utilitarian values to the situation at hand.

Recently, research has supported Hare's (1991) contention that decision making is a two-tiered process. Kahneman (2003), in a review of the literature on judgment and choice, defined two levels of judgments. In the first level (System 1), "judgments and

preferences are called intuitive in everyday language if they come to mind quickly and effortlessly" (Kahneman, 2003, p. 716). More deliberate thought is applied at the second level (System 2), which can modify or override what occurs in System 1. The research supports a two-layered decisional process, and Hare's intuitive and critical evaluation levels mirror decision levels defined by empirical findings on the process of decision making. In this case, theory built on philosophy coincides with theory built on empirical findings.

So when a psychologist is confronted with an ethical dilemma, for example—a suicidal client—following Hare's two-stage process, he or she first must intuitively apply ethical principles (typically beneficence and nonmaleficence) and may decide to seek hospitalization for the client. But if a conflicting circumstance exists (the autonomy of a client who refuses to be admitted to a hospital), then utilitarian values come into play, and may require identifying an option that values the client's autonomy, safety, and well-being. The utilitarian will ask, "What is best for all concerned on this case?" And a decision will involve weighing hospitalization and alternative actions to find a suitable course of action so that the needs of all are summed (and a decision in the service of the greatest number is discerned). The client, in this case, may desire to go home, but a decision may be made to send the client home only under the strictest of supervision by a mutually agreed-on party or parties (involved loved ones). In this way, others may rest assured of the client's safety short of hospitalization, while respecting the client's autonomy.

Hare's (1991) model provides a good example of a philosophically grounded approach to decision making in which an individual makes a decision. In this case, an individual must assess choices on the basis of utilitarian values when intuition fails or when conflicts arise between agreed-on standards of ethical behavior. Hare's model is an excellent example of a philosophically grounded model of individual choice.

Quantitative Models of Individual Choice

Gutheil, Bursztajn, Brodsky, and Alexander (1991) provided a unique perspective of decision making. Their model was presented in a text on decision making as applied to psychiatry. They designed a model using probability theory as a basis for formulating a decision. They described two quantitative paradigms in science—the mechanistic and the probabilistic paradigms. Historically, quantitative analysis was reflective of defining absolute truths in nature through mechanistic approaches to research. Gutheil et al. (1991), however, defined a shift from mechanistic analysis to analysis of probability, which involves not only the search for truth, but acknowledgment of variables that may influence outcomes, including the variable of the observer (experimenter). They made the case for decision analysis, a means to apply statistical probabilities to a decision tree to define the likelihood of an outcome. They stated,

> Decision analysis can also be used to build logic and rationality into our intuitive decision making—to educate our intuition about probabilities and about the paths of contingency by which our actions, in combination with chance or "outside" events, lead to outcomes. (Gutheil et al., 1991, p. 41)

A decision is structured around a decision tree. They described how a decision "sets in motion a chain of controllable and uncontrollable, predictable and unpredictable, events" (Gutheil et al., 1991, p. 43). Each outcome is connected with what came before and with the choices that follow—effectively building a decision tree or visual representation of the path of the decision. They stated, "A decision tree can be drawn to capture this sequence of chosen actions and chance events" (Gutheil et al., 1991, p. 43), so that actions, uncontrollable events, and outcomes (intended and unintended) can be outlined in terms of contingencies. Probabilities on each branch of the decision tree can be estimated.

According to Gutheil et al. (1991), estimating probability is complicated, but one way "is to calculate the relative frequency with which the event in question occurs over a large number of trials in similar circumstances" (p. 46). This is problematic when trying to estimate the outcome of unique events, in which case the authors acknowledge that

subjective judgment must be used. They stated, "Psychologists have found that subjective probability estimates can be reasonably accurate when the people making them are knowledgeable about what they are estimating as well as experienced in probability estimation" (Gutheil et al., 1991, pp. 46–47). The intention is to quantify, to whatever degree possible, the likelihood of decision outcomes by anticipating and enumerating probable choices along the way.

Gutheil et al. (1991) made a compelling argument that even in cases in which measurement is not precise, decision analysis makes decision making "conscious, methodical, and critical," thereby rendering the decision analysis process beneficial (p. 48). They finalized their arguments by comparing decision analysis to conscious gambling, with the latter being less formal and systematic. Although conscious gambling may be more haphazard than decision analysis, it still provides an opportunity for decision makers to hone their decision-making skills in a stepwise fashion. In the end, they took a position that quantification is valuable in decision making whenever some individual makes a choice.

Decision analysis cannot happen outside a principle ethics context. For example, if a psychiatrist is faced with a suicidal patient, decision analysis will show that there is nearly a 100% probability that the patient will survive over night if he or she is hospitalized in a safe room. In this case, decision analysis provides a quantitative means of defining an outcome, but the value of the outcome does not derive from the decision analysis; rather the value of the outcome derives from the ethical principles of beneficence (client well-being) and nonmaleficence (do not harm). So decision analysis based on probability still is guided by a principle ethics and is carried out by an individual decision maker.

Practice-Derived Models of Individual Choice

Almost every major textbook on ethics in psychology practice provides a model for decision making. Some of the earliest texts (e.g., Corey, Corey, & Callanan, 2007, now in its 7th edition) provided a stepwise approach that was logical and supported by anecdotal evidence of its usefulness. Typically, these models describe an initial step of problem identification. Problem identification is followed by another step of information gathering. Consultation with codes, laws, or experts may be a separate step or part of the information-gathering effort. Options are identified; options are weighed. Finally, an option is chosen for action, and the decision is finalized.

Table 4.1 provides a comparison of several textbook models of ethical decision making. The table does not produce a line-by-line comparison, but it does provide a visual picture of some of the common textbook models of decision making, and how their steps compare. Also, the table illustrates the overlap across the models (as with many models described in this chapter). For example, the Corey et al. (2007) model shares common steps or stages with other models listed on and off the table. Typically, this overlap occurs in steps defining the problem, fact finding, defining alternative courses of action, and making a choice.

In all of the models in Table 4.1, an individual makes a decision after following the steps of the decision process. It is not clear how the decision is finally made. One must conclude that the decision maker applies logical principles to determine the final outcome, and few of the models acknowledge the process of weighting the cognitive, intuitive, or emotional aspects involved in a decision. Few address interpersonal involvement in the process, except as related to expert consultation. Some models do encourage an analysis of probability before a decision is made (e.g., Keith-Spiegel & Koocher, 1985).

Overall, these models are more mixed than those that are more purely theoretically derived. One can find principle ethics, a focus on the character of the decision maker, and even acknowledgment of the influence of interpersonal consultation on the final decision. So practice-based models tend to draw on a number of sources and apply concepts across the intellectual movements, even in ways that are contradictory or mutually exclusive at times.

Consider the example from the prior section—the suicidal patient. Applying the well-known Corey et al. (2007) model (described in Table 4.1), the problem is first identified. Other issues then are identified, and in this case, the safety of the client is

TABLE 4.1

Comparison of Textbook Models of Ethical Decision Making

Corey, Corey, and Callanan (2007)	Forester-Miller and Davis (1996)	Hass and Malouf (2005)	Keith-Spiegel and Koocher (1985)	Sperry (2007)	Welfel (2006)
1. Identify the problem	1. Identify the problem	1. Identify the ethical problem	1. Describe the parameters	1. Enhance ethical sensitivity and anticipation	1. Develop ethical sensitivity
2. Identify potential issues involved		2. Identify legitimate stakeholders	2. Define the potential issues	2. Identify the problem	2. Identify relevant facts and stakeholders
3. Review relevant ethical guidelines	2. Apply the American Counseling Association *Code of Ethics*	3. Identify relevant standards	3. Consult legal and ethical guidelines	3. Identify participants affected by the decision	3. Define central issues in dilemma and available options
4. Know applicable laws and regulations	3. Determine nature of dilemma	4. Review the relevance of the existing standard	4. Evaluate the rights, responsibilities, and welfare of involved parties	4. Identify courses of action and benefits–risks for participants	4. Examine relevant ethical standards, laws, and regulations
5. Obtain consultation; consider possible and probable courses of action	4. Generate potential courses of action	5. Evaluate the ethical dimensions of the issue and specify a primary ethical dimension if possible	5. Generate alternate decisions	5. Evaluate benefits–risks context considerations	5. Search out ethics scholarship
6. Consider possible and probable courses of action	5. Consider potential consequences; determine course of action	6. Consult and review codes of ethics; review literature; consider ethical principles	6. Enumerate the consequences of each decision	6. Consult with peers and experts	6. Apply ethical principles to situation
7. Enumerate consequences of various decisions.		7. Generate a list of possible actions	7. Estimate probability for outcomes of each decision		7. Consult with supervisor and respected colleagues
8. Decide on best course of action		8. Do cost–benefit analysis and choose based on optimum resolution for greatest number	8. Make the decision	7. Decide the most feasible option and document the decision process	8. Deliberate and decide
	6. Evaluate selected course of action	9. Evaluate the new course of action for effect on people and unforeseen ethical problems			
	7. Implement course of action	10. Judge whether course of action can be implemented		8. Implement, evaluate, and document the decision	9. Inform supervisor and take action
		11. Implement the chosen course of action			10. Reflect on the experience

Note. Adapted from "Ethical Decision Making Models: A Review of the Literature," by R. R. Cottone and R. E. Claus, 2000, *Journal of Counseling and Development, 78*, p. 279. Copyright 2000 by the American Counseling Association. Reprinted with permission. No further reproduction authorized without written permission from the American Counseling Association.

prominent. Ethical principles direct the psychologist to consider the best interest of the client and to prevent harm, which would mean the psychologist should act in some way to prevent suicide. Relevant laws and other standards must be considered. Corey et al. (2007) then encourage the mental health professional to seek consultation to consider possible and probable courses of action. In this case, a psychologist can be directed by colleagues or supervisors to consider the safety of the client first. The consequences or repercussions of possible choices must be defined. If the client hurts him or herself, then the psychologist faces serious repercussions, especially if the psychologist had an opportunity to act in a way to prevent harm. Finally, the psychologist is directed to decide on the best course of action. As can be gleaned from the scenario, individual and social factors come into play, but the decision, in the end, is defined by the individual psychologist who must in some way consider and weigh the pros and cons of the situation and negotiate through consultations on the matter. The model is stepwise, logical, and practical; however, it does not offer guidance on the value associated with following simple standards versus addressing other issues or concerns raised by consultants. For example, how does a psychologist react when a consultant recommends a course of action that is counter to the psychologist's initial impressions or ethical choice? Viewing the model positively, it is easy to apply. From a negative point of view, it provides little guidance on the weight to be given to consultant opinion, especially when the opinion is contrary to the decision maker's position. This same criticism is valid for any model that mixes individual decision making with a step involving consultation. In the end, the decision risks are the decision makers to bear, and little explanation is given as to what happens (or what is to happen). This is contrasted by the Gutheil et al. (1991) model, which provided a means for final decision determination through decision analysis and probability; in that case, the decision maker must individually compute the probabilities and follow the statistically most likely positive result. It also contrasts to Hare's (1991) position, in which the utilitarian must sum what is best for all involved. The Gutheil et al. (1991) model and the Hare (1991) model, therefore, provide useful examples of how individual decision making is to be conceptualized—it is theoretically grounded and explains the process; other models of individual choice appear to leave the decision maker without a means of weighing options—the decision appears to just happen, perhaps out of individual conscience (which will be explored in the section Is Autonomous Decision Making Problematic?).

Philosophically Grounded Models of Relational Influence

The social constructivism movement in psychology may represent the emergence of a body of knowledge that constitutes a full-fledged paradigm of counseling and psychotherapy (Cottone, 2007). Its implications are pervasive for the psychology and the mental health enterprise both theoretically and practically. The practical aspect of the social constructivism movement is clearly exemplified in the "social constructivism model of ethical decision making" (Cottone, 2001, 2004; Cottone & Tarvydas, 2007), which provides a purely philosophically directed model of decision making. The constructivism model is a decision-making model with a clear focus on relationships—there is no individual decision maker—decision making occurs outside of one's head (so to speak) and in the social matrix. Building on the works of a cognitive biologist (Maturana, 1978, 1980, 1988; Maturana & Varela, 1980) and expanding the ideas of Gergen's (1985) constructionism movement in modern psychology, I defined an extreme relational framework for decision making. As Gergen (1991) stated, "When individuals declare right and wrong in a given situation they are only acting as local representatives for larger relationships in which they are enmeshed. Their relationships speak through them" (pp. 168–169). Likewise, I defined decision making as a process of addressing conflicts between people as relationships speak through them—"conflicts of consensualities"—where a consensuality is a socially constructed truth. Consensualities generally are considered absolute truths within the confines of the relationship system within which the truth is distinguished and defined; but consensualities may appear as relative to outsiders who view other alternatives as equally valid. As an example, the

acceptability of drugs within the drug culture may be viewed as a truth to those in the culture, but to outsiders, drug use may be viewed as unacceptable. Professional ethical conflicts derive from conflicting consensualities, where at least two people disagree on the nature, harm, or intent of an act of a mental health professional.

The social constructivism model involves three interpersonal processes: consensualizing (the process of acting with others according to some socially agreed on definition), negotiating (discussing and debating through disagreements while making distinctions and attempting to reconcile differences), and arbitrating (the process whereby negotiators in a stalemate seek the judgment of a consensually acceptable individual to resolve a conflict). All three processes are social; no individual (internal) decision making is involved. The decision is processed in the interaction with stakeholders and others who potentially can contribute to an outcome. The model is represented graphically in Figure 4.1. Individuals involved in the decision-making process obtain information from involved parties, assess the nature of relationships (are they conflicting or adversarial?), and consult valued colleagues and expert opinion (including ethical and legal standards). The decision makers then attempt to reach a consensus about what should happen or what occurred. If a difference of opinion exists, then continued negotiating and ultimately arbitrating are necessary. The model also allows for a period of interactive reflection, during which time stakeholders define whether they can modify their stance and reenter negotiation to avoid arbitration.

In the case of a suicidal patient, the psychologist following the social constructivism model would first address the issue of suicide with the patient. Assuming that the client is not incapacitated, and using knowledge of suicidal factors, the psychologist would evaluate and address the risk factors with the client. The client would either agree that the factors were or not. The psychologist might ask the patient who the patient believes would be most negatively affected by the patient's suicide. The psychologist might also explore the patient's thoughts on who might be viewed as benefiting from the suicide. The intent of questioning is to clearly define all of the relationships of significance from the perspective of the patient. The psychologist also might explain the process of hospitalization and explore the implications of hospitalizations for the client's current and future relationships. In cases in which the opinions of others are valued by the client, especially from a multicultural perspective, consultation would occur (as legally permitted) with other stakeholders in the decision about how to address the suicidal intent. Then, using his or her training and past supervision as a guide, the psychologist would consult other professionals about the circumstance. He or she might consult a supervisor, a hospital emergency physician, or a colleague for such matters. Discussion of options or even negotiation with stakeholders and involved professionals may occur while developing an agreement on the best course of action. Their counsel would be valuable in determining whether some action should be taken. The psychologist in this social context will agree or disagree with the emerging or historical (learned in prior circumstances) consensualities, which are viewed as socially defined truths. The psychologist might facilitate hospitalization of the client, or perhaps he or she would act otherwise to ensure safety consistent with ethical imperatives, social factors, cultural standards, legal standards, and best practice in the field. What appears to be a decision of an individual actually is an action consistent with an operative consensus (currently or historically situated) that looks like an individual choice. If there is impasse, then arbitration likely will occur in the courts (e.g., involuntary hospitalization), where a judge or jury will decide the operative truth. The legal system is viewed as the final arbiter (as both clients and counselors operate within the constraints of a sociolegal consensus). On matters that are not adversarial, the social constructivism model encourages agreements between parties on problem arbitration in advance. For example, a psychologist-in-training and a supervisor ideally would agree that unresolved ethical or clinical disagreements would be presented to a consulting psychologist (or ethicist) and that both parties would defer to the judgment of the consultant. Whereas arbitration may be defined legally by the contract of services between a psychologist and a

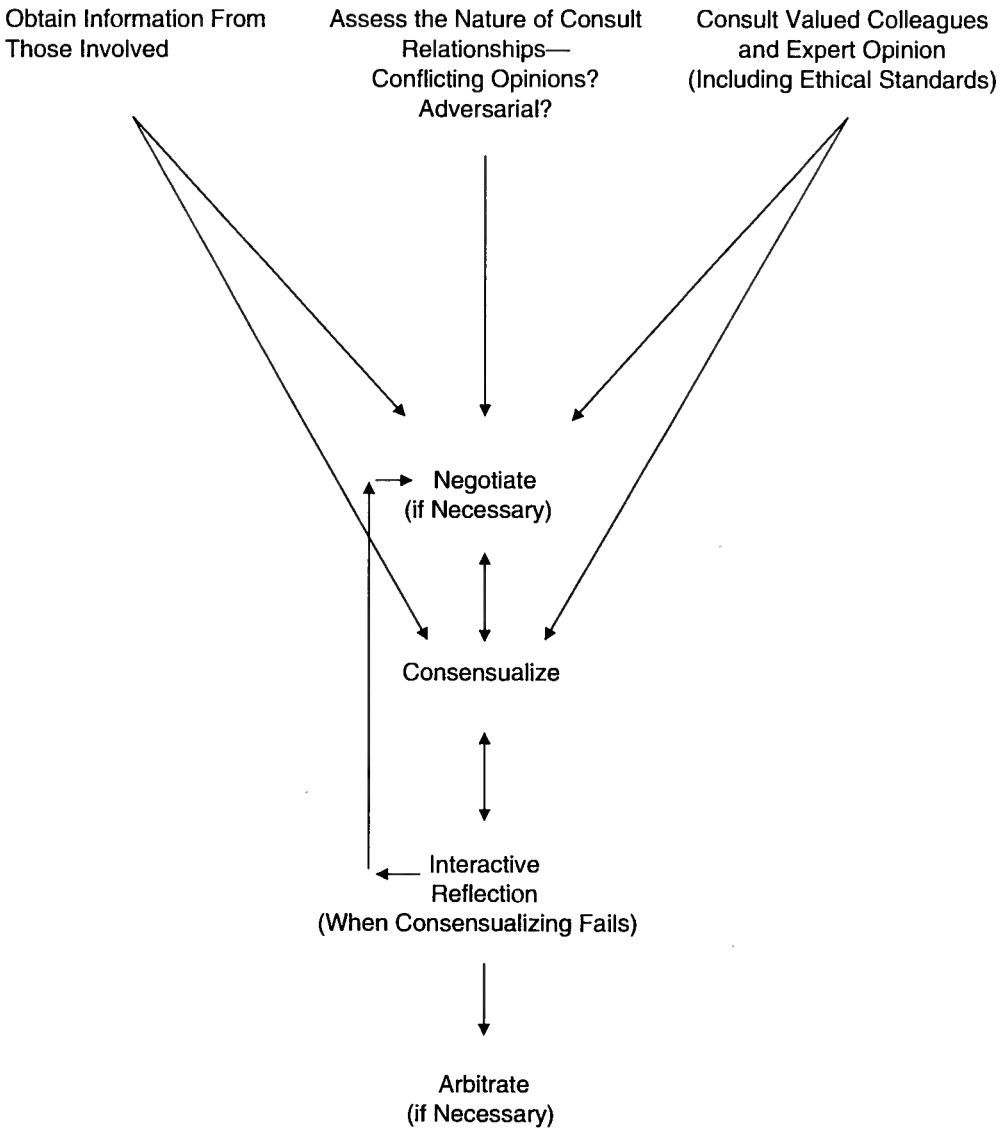

FIGURE 4.1. The interactive process of socially constructing an outcome to an ethical dilemma. From "A Social Constructivism Model of Ethical Decision Making in Counseling," by R. R. Cottone, 2001, *Journal of Counseling and Development, 79,* p. 43. Copyright 2001 by the American Counseling Association. Reprinted with permission. No further reproduction authorized without written permission from the American Counseling Association.

client, professional relationships may establish alternative means of arbitration (short of legal recourse) in their daily practices. The legal system is viewed as a consensual system in which judges apply case law and juries socially construct a decision within rules of law.

The social constructivism model of ethical decision making is an example of a purely relational decision-making process that is derived solely from theory or philosophy—the social constructivism movement in mental health services. Decisions are removed from the individual decision maker's head and instead are defined within the social interaction that ensues around a dilemma. The decision is in the social matrix. The psychologist, according to this model, acts in accord with an operative consensus and not as an isolated individual decision maker.

Mixed Models of Individual and Relational Influence

Probably the most comprehensive model that formally addresses both psychological and social processes in decision making is the Tarvydas integrative model of ethical decision making (Cottone & Tarvydas, 2007; Tarvydas & Cottone, 1991). Tarvydas's model incorporates the best of theory from a number of original sources. She draws on the works of Hare (1981), Rest (1984), Kitchener (1984), and Beauchamp and Childress (2009) representing principle ethics. She included the concept of virtue ethics (Meara et al., 1996). She also carefully built a contextual component in her model, so that relational influences are addressed. And she added a reflective component, consistent with recommendations of Hill et al. (1995) and Welfel (1998), so that selecting the best ethical course of action is not the final step in the decision process. Tarvydas's model is a comprehensive model of decision making. The model is understandably complex, but, at the same time, it uses the best of theory to the point of its development.

The Tarvydas model is a four-stage model: Stage 1, interpreting the situation through awareness and fact finding; Stage 2, formulating an ethical decision; Stage 3, selecting an action by weighing nonmoral values, personal blind spots, or prejudices; and Stage 4, planning and executing the selected course of action.

Considering the suicidal patient and applying the Tarvydas model, one can see the model's ability to address multiple layers of theory and context. The first two stages are much like any logical decision-making process in which an individual makes a choice. One is sensitive and aware of the dilemma, defines involved parties (stakeholders), goes through a process of fact finding (all in Stage 1). In Stage 2, one reviews the data; applies relevant codes, laws, and institutional policies; and generates possible courses of action, considering the consequences of each. Consultation with supervisors or other knowledgeable professionals occurs in Stage 2, and then the best course of action is selected. In the case of the suicidal client, the best course of action may be to act to prevent suicide by facilitating hospitalization. However, the Tarvydas model does not stop there. There are two more stages. In Stage 3, there is reconsideration of the choice around context and nonmoral or other values are considered that might in some way blind the psychologist from the right choice. Maybe hospitalization is just an easy way to unload one's responsibility to a hospital staff physician (a psychology blind spot). Perhaps hospitalization may engage the client in a medical model of treatment when the problems leading to suicidal threat were more relational than psychological. Perhaps hospitalization may lead to stigmatization that in the end will brand the client negatively and cause problems within the social network within which the client operates. It might be harder for the psychologist to come up with another option, but in this case, it might be justified. Stage 3, then, might lead to a decision to seek some other means of safety, short of hospitalization. That may be the preferred course of action. The final stage (Stage 4) of the Tarvydas model requires definition of the exact steps to be taken to implement the decision, possible barriers to execution of the decision, and possible counter measures if something prevents the preferred option. Finally, the decision is carried out and evaluated.

At specific stages in the Tarvydas model, a number of components reflect the contributions of theorists at the foundation of her model. Her model skillfully addresses context, involves a degree of collaboration, and encourages reflection before a final determination. It engages principle ethics, but it also recognizes that the decision maker's intuition and character may be crucial factors in the decision. Relationship factors are weighed heavily, and her model is truly integrative. Although it is vulnerable to criticism on the basis of its merging what may be viewed as mutually exclusive philosophies (relational versus individual), her model will stand as an historical marker of the status of the field at the time of its development.

A BRIEF SUMMARY OF MODELS APPLIED TO SPECIFIC ETHICAL DILEMMAS OR POPULATIONS

The complexity of professional mental health practice is reflected in the number of publications that

present guidelines or models that apply to specialized ethical dilemmas. These publications are found not only in psychology journals, but also in social work, marriage and family therapy, behavioral science, and counseling journals. A number of publications address specific challenges when serving clients who have faced such issues as (a) domestic violence or battered women (e.g., Edwards, Merrill, Desai, & McNamara, 2008; Koenig, Rinfrette, & Lutz, 2006), (b) end-of-life care (e.g., Werth, 2002), (c) geriatric neuropsychology (e.g., Martin & Bush, 2008), and (d) HIV and AIDS. There also have been models or guidelines developed for serving clients within specific contexts, such as (a) religious communities (e.g., Hill & Mamalakis, 2001), (b) managed care (e.g., Belar, 2000; Tjelveit, 2000; Younggren, 2000), (c) child clinical psychology (e.g., Mannheim et al., 2002), (d) outpatient care (Truscott, Evans, & Mansell, 1995), and (e) play therapy (Seymour & Rubin, 2006). And there are recommendations for psychologists who counsel specific populations of clients, such as Asian Americans (e.g., Littleford, 2007) or those vulnerable to exploitive dual relationships (Gottlieb, 1993). These are just a few of any number of publications that address specific ethical challenges in mental health practice.

Most publications addressing ethically challenging specialized circumstances direct mental health professionals on matters that are specific to the issue at hand; few actually provide a formal model of decision making. Some examples of publications that formalize a decision process are Erickson (1990); Chenneville (2000); Costa and Altekruse (1994); Garfat and Ricks (1995); Gottlieb (1993); Knapp, Gottlieb, Berman, and Handelsman (2007); Truscott et al. (1995); and Seymour and Rubin (2006). Two publications address HIV and provide stepwise decisional processes. Chenneville (2000) specifically addressed confidentiality and the duty to protect, and provides three steps in a decision-making model: (a) determine whether disclosure is warranted, (b) refer to professional ethical guidelines, and (c) refer to state guidelines. Erickson (1990) provided a set of guidelines for working with "irresponsible AIDS" clients, those who are involved in behavior that could potentially lead to spread of HIV. She provided three levels of action that will lead to a logical decision. The first level involves engaging the client in services to help in recognizing the unacceptable behavior and addressing the denial process. The second level involves physician contact and advice to encourage appropriate behavior. The third level involves contact with agencies to inform authorities of the behavior of the resistant client. Costa and Altekruse (1994) provide a list of duty-to-warn guidelines to direct mental health professionals addressing clients who have made a threat. The guidelines include preventative measures and specific steps to be taken once a threat has been made. If one follows both the preventative measures and the steps following a threat, the act of warning an endangered party is a justifiable outcome. Garfat and Ricks (1995) described a self-driven model of decision making when working in child and youth care. The decision is self-driven and involves "critical and reflective analysis" (1995, p. 395). Like many more general individual-focused models, the decision somehow happens in the logical part of the self, as data are weighed in some way and a defensible outcome emerges. The intention is to engage an "aware and responsible self" in ethical practice, as opposed to practice moderated or "driven by external variables" (Garfat & Ricks, 1995, p. 397). Another example is the P3 model presented by Seymour and Rubin (2006) as related to ethical play therapy. The P3 model incorporates "principles, principals, and process (P3)" (p. 101). The principles referred to in the article are those that were addressed by Kitchener (1984), with the addition of veracity or truthfulness. The principals are essentially the decisional stakeholders, and include the client, counselor, collaterals, and community ("the four Cs"); these individuals' voices are heard in the process (the third P), which is an inclusive collaborative process of recursive interaction. Knapp et al. (2007) provided a structured format for addressing conflicts between laws and ethical standards. Steps in the decision-making process follow questions that must be asked, such as "What does the law require?" or "What are your ethical obligations?" After answering a set of questions, the psychologist must discern whether either the law or ethical standard must be breached, that is, that the

conflict cannot be resolved. In these cases, the authors recommended a set of steps to take if a decision is made not to obey the law. They also provide a guideline for minimizing harm resulting from offending ethical values. Truscott et al. (1995) provided four decisional cells (two levels of therapeutic alliance versus two levels of violence risk) to address dangerous clients in outpatient settings. Assessments are made to place clients in the scheme of four decisional cells. Finally, Gottlieb (1993) provided a three-dimensional model of decision making to avoid exploitive dual relationships. The three dimensions are power, duration of the relationship, and clarity of termination. A stepwise analysis is then carried out, much as with a decision tree, so that the psychologist has an answer to concerns on any one dimension. In all of these publications, the authors provide the reader with specific guidelines or steps to take when confronted with the respective ethical dilemma.

WILL THE APPLICATION OF A DECISION-MAKING MODEL ENSURE AN ETHICAL ACTION?

With ethics education of psychologists and with the attention on ethical issues and ethical decision making in the literature, one would think that using an ethical decision-making model automatically would lead to an ethical decision, and a defensible decision as well. This may be true in many cases, but not in all cases.

It certainly is likely that professional psychologists will follow decision-making processes with action, especially in cases where (a) the well-being of clients is in danger, or (b) there is serious professional or legal repercussion for not addressing a dilemma. But research has shown that some intuitive (ethical) judgments may be overridden or even blocked under certain circumstances (Kahneman, 2003). And what about blind spots, those dilemmas prone to bias or that may be confused by personal feelings (Cottone & Tarvydas, 2007)? In those cases, it becomes a question of ethical willingness and resoluteness (cf. Bernard & Jara, 1986; Bernard, Murphy, & Little, 1987; Betan & Stanton, 1999). Typically, publications that address ethical willingness document empirically that students of psychology or professional practitioners are unwilling in certain cases to take ethical action. Scenarios presented in such research typically involve a decision to report a peer who was behaving unethically. In as many of 50% of responses, participants admit that they would "do less than what they realized they should do" (Bernard et al., 1987, p. 490). In effect, the psychologists (or trainees) who responded to these surveys were blinded by personal factors. Betan and Stanton (1999) stated,

> Ethical decision making and willingness are not simply a matter of implementing principles. We suggest that psychologists are making inadequate decisions about ethical dilemmas in part because they are not well attuned to the influential role of emotions, values, and contextual concerns in ethical discourse. Consequently, anxiety or other concerns can impede the ability to implement the ethical course of action. By contrast, those who are more aware of personal emotions and values may be better able and willing to intervene ethically. Awareness of competing factors can enable one to override barriers, as well as to integrate emotional sensitivity with rational analysis of a dilemma, in order to act ethically and protect the welfare of the affected parties. (p. 299)

So knowledge, in and of itself, is not enough. Motivational factors enter the equation, and emotion and personal values play a role. In effect, research is supporting the virtue ethics and relational ethics movements, as studies are showing that the decision maker is responsible to address personal blind spots (often relationship-based) to ensure that nothing prevents the just application of ethical standards. It speaks to the character of the decision maker and the influence of relational allegiances.

Detert, Trevino, and Sweitzer (2008) were able to show that some individuals are capable of *moral disengagement* (a term originally defined by Bandura, 1999), which means those individuals are able "to deactivate moral self-regulatory processes" and in cases in which they make unethical decisions, they

are able to do so "without apparent guilt or self-censure" (Detert et al., 2008, p. 374). Personal factors are associated with moral disengagement, and the authors found that moral disengagement predicts unethical decision making. So there appears to be a subset of professional psychologists who are capable of unethical action on the basis of personal factors or some weakness of character—an issue that must be taken into account when admitting and training individuals in professional psychology. The profession must not be blind itself. It must assume that there will be professional psychologists, who, for whatever reason, will choose to be unethical, or will not choose to be ethical, no matter how much training on ethical matters they receive.

IS AUTONOMOUS DECISION MAKING PROBLEMATIC?

When decisions are left to an individual autonomous decision maker without specific guidance as to what is suppose to happen in the decision maker's head, then the decision appears to rely on subjective factors of individual conscience. In such cases, there is always the concern that the psychologist will lack a conscience. Nonrelational approaches to decision making have traditionally relied on the willingness and resoluteness (Betan & Stanton, 1999) of the mental health professional to do the right thing. This is an assumption of questionable validity because it appears that, in certain circumstances, psychologists can have blind spots that will prevent or inhibit fulfillment of ethical responsibility (as discussed in "Will the Application of a Decision-Making Model Ensure an Ethical Action?"). Typically, the ethical dilemma associated with vulnerability involves allégiances where acting ethically is at the potential expense of an established relationship.

Two good reasons exists to have and to use a formal ethical decision-making model. First, the obvious reason is that a model will guide a practitioner through an ethical dilemma. In effect, models are guides that help to ensure ethical practice when professionals are faced with a quandary. A second reason for having a formal decision-making model relates to adjudication. If a psychologist's ethics are challenged, and the psychologist must defend his or her choices and consequent actions, documentation of the use of a formal decision-making process will likely serve the psychologist well. Defense of a decision will always be easier when a formal and recognized process has been utilized. If one is able to defend one's decisions beyond intuition, then it is less likely one can be found negligent or guilty of malpractice. The problem for adjudicators is the possibility that the psychologist charged with unethical conduct claims to have operated on individual conscience without evidence of consultation, thereby relegating the decision process nonobjective or immune to corroboration.

At face value, it seems likely that a psychologist would choose to act on an ethical dilemma if others have been consulted during the process (Betan & Stanton, 1999). If there has been acceptable and ethical consultation with colleagues or ethics experts on a case, it is likely that sharing the dilemma will help to ensure follow-through on a decision. No guarantee of ethical action in such a situation exists, and there is always the slight possibility of conspiracy (where the psychologist and consultants together decide to act unethically), but the likelihood of decisive ethical action would seem enhanced by collaboration. Research is lacking in this regard. Will a psychologist more likely follow through with a report of a colleague's questionable practice if a decision-making model requires consultation with other colleagues as a formal part of the process (versus a model that does not require interaction)? This is an area that warrants further study and may be significant to the training on and development and implementation of future models of ethical decision making.

Psychologists have traditionally viewed autonomy as a valuable ethical imperative (an ethical principle); but in the area of ethical decision making of professional psychologists, autonomous decision making may allow for secrecy, inaction, or noncompliance with ethical directives.

THE ETHICAL DECISION MAKER'S DECISION-MAKING DILEMMA

Beyond the issue of autonomy, the profession of psychology must also be alert to another issue that

may compromise easy application of standards. Professional psychology has arrived at a place at which a psychologist, confronted with an ethical dilemma, must not only address the dilemma, but also make a decision as to which ethical decision making model to apply.

For Canadian psychologists, the CPA's *Canadian Code of Ethics for Psychologists* (CPA, 2000) provides a recommended decision-making model. The CPA model is clearly a model of individual choice—providing logical steps for applying the CPA ethical standards. It is not attuned to the influence of relational or multicultural factors (group influence is given lip service) or to the relative weight applied to professional consultation (which is addressed only as a postscript to the model). Although there are weaknesses in the model, at least Canadian psychologists know what is expected of them when applying standards from their code of ethics. Members of the APA comparatively have much more flexibility in applying decision-making models to an ethical dilemma, for better or for worse.

It is ironic that the profession of psychology, which prides itself on its scientific foundation, has little in the way of scientific data to offer the practitioner attempting to discern which decision-making model to use. Only a few studies have empirically assessed ethical decision-making models (e.g., Dinger, 1997; Garcia, McGuire-Kuletz, Froehlich & Dave, 2008; Garcia, Winston, Borzuchowska & McGuire-Kuletz, 2004). The number of published studies is surprisingly small; this may be true, in part, because ethical decision-making processes have derived their meaning from the study of ethics, which is a branch of philosophy. It is easy to see that the nature of decision-making models is aligned with the study of moral philosophy and the literature of moral choice. Theories of philosophy underpin some of the best known models (e.g., utilitarianism). The application of logic (another branch of philosophy) also pervades existing decision-making models. There is, therefore, more of a philosophical than empirical basis for decision-making model development. Decision-making models, only recently and by means of virtue ethics and the relational movements, are breaking from the classic philosophical mode. The newer models offer distinctions that may serve researchers well, as they begin to define real and measurable differences in the processes involved in decision making. For example, Cottone's (2001) social constructivism model provides an opportunity to measure observable interpersonal processes in the decision process, in contrast to the isolated weighing of options (based on some criterion) of the typical model of individual choice. In effect, the decision-making knowledge base has expanded to the degree that empirical studies may prove fruitful.

A question that logically flows from this analysis is, "Does it really matter what model is chosen?" It is fair to ask, "Aren't most decision-making models going to lead to the same conclusions?" The answer is that it does matter because decisions may be quite different depending on the model. For instance, a model that operates on the extreme of one of the intellectual movements of psychology decision making (principle, virtue, relational) or that takes a purist philosophical position (utilitarianism, social constructivism) likely will produce outcomes that are different and perhaps unique to the model. Those models that are less extreme or that combine elements of differing philosophies or movements may produce less distinguishable outcomes. Take, for example, the case of an adult client being counseled about adjustment to disability issues who reveals he is participating in sexual online communications with individuals identified as underage children. Assume also that this person is operating in a state or province where electronic communications of sexual content with individuals identified as under age is not a crime—that the communications must be followed by action to engage the children in personal contact for there to be criminal activity. The law in this case is clear—the client's actions are not illegal, and the client communicates no intent to make personal contact with any identified child contacted electronically. A psychologist might, regardless of the law, find the client's actions offensive and abhorrent. The psychologist might use a utilitarian model of decision making and conclude that the greatest number are served (the children) if the client stops such action and a firm request is made to the client in that regard. The client adamantly refuses to stop his electronic contact with children

on sexual matters, states firmly that his purpose for seeking counseling has nothing to do with his electronic contact with children, and asserts he is not doing anything illegal and that it is his choice to continue. The psychologist then may refuse to counsel the client unless the client ceases such communication. The psychologist's intent, by taking a strong stand, would be to stop the client's activity. But since the client continues to communicate no willingness to stop or intention of stopping, the psychologist may decide to withdraw services on moral grounds. This decision would be defensible on the basis of the actions of the client, the values of the psychologist, and the decision-making model employed. Because decision making is an individual choice based on personally defined standards, both the counselor and the client are justified in their choices. Choice, in this case, is based on the individual conscience of the decision maker.

By way of contrast, a psychologist using a more relational model of decision making, such as Betan's hermeneutic model, might act differently in a similar circumstance. Even though the client's actions are not illegal, the psychologist may find the behavior immoral, offensive, or abhorrent. But considering the relational ramifications of the psychologist's actions, the psychologist might consider the consequences if the therapeutic relationship is terminated on moral grounds—will society be benefited by an untreated Internet abuser, even though the purpose of counseling is unrelated or tangential to the moral issue? The psychologist might ask, "Could the influence of the psychologist–client therapeutic relationship potentially result in a remedy over time so that the psychologist's values are not compromised and the client's behaviors may be affected?" In this case, relationship factors would prevail, and a decision to continue with the client for a specified time (even though a number of children might continue to be contacted in the interim) to attempt to remedy the behavior or to replace it with harmless behavior would be the preferred course of action. An underlying philosophy directs such action, because the psychologist is operating from an assumption that the client's choice is not based on character or individual conscience; rather, it is the result of the relational context within which the client operates, which would include the therapeutic context. So the psychologist's actions would be quite different. In the first case, using a point-in-time utilitarian model of individual choice, refusing to continue counseling on moral grounds is defensible because the psychologist first acted firmly to stop the unacceptable and morally reprehensible behavior. In the second case, the relationally oriented decision maker might continue counseling justifiably (at least for a short while) in hopes of influencing the client therapeutically at the risk of impingement of strongly held personal values. Decision-making models do make a difference in defining outcomes, especially if competing models are grounded in unique and distinct philosophies and applied in a purist fashion. Either model or outcome may be viewed as right or wrong. Both are laudable, and both are vulnerable to criticism. What is important, however, is the fact that the psychologist used a model, was thoughtful in application of the model, and followed the model to a defensible outcome; this is evidence of an educated professional competently applying theory to practice.

It is recommended that professional psychologists consider their own theoretical and philosophical biases as they consider which model to use. For those with a philosophical bent, for example, the choice of a model grounded in philosophy may serve them well, such as Hare's (1991) or Kitchener's (1984) models. For those with interest in relational theory, Betan's (1997) or Cottone's (2001) model may be of interest. The culturally sensitive models (e.g., Garcia et al., 2003; Knapp & VandeCreek, 2007) likely will appeal to those who value the identification and study of multicultural traditions as factors in decision making. For those who want to incorporate the best of known theory, an integrative model will be attractive (e.g., Cottone & Tarvydas, 2007, model). And for those just interested in the application of logic to solve a problem, the use of stepwise models with anecdotal support is logical, whether it is a comprehensive model (as presented in textbooks) or a model for a specialized ethical circumstance. Regardless of which approach is chosen, the profession has advanced to the degree that a psychologist who makes a crucial ethical decision without the use of a model will appear naïve, uneducated, or potentially incompetent. When faced

with defending a decision, if a psychologist can show (especially in a way that can be corroborated) that a formal decision-making approach was taken, it is likely that the decision will be viewed as thoughtful, grounded, and reasonable.

ADVANCED ANALYSIS OF PREMISES

The identification of major intellectual movements in decision making in psychology has a benefit in addition to delineation of a classification framework—the cross-evaluation of the tenets underlying each movement. For example, virtue ethics provides a framework for analyzing both principle ethics and relational ethics because, in the end, a professional psychologist will act (or fail to act) when confronted with an ethical dilemma. Virtue ethics provides a unique perspective—one that focuses on the traits of the decision maker rather than the nature of the dilemma. Virtue ethics also requires an analysis of social factors that may affect the willingness and resoluteness of a psychologist to act, which places a decision within a relational context, much like the hermeneutic model of Betan (1997). Likewise, principle ethics will challenge the relational theorist to concretize the interpersonal processes that lead to an action. Just as individual decision making may be criticized because, in many cases, the decision making disappears into the decision maker's head, the process of consensualizing may, at its worst, appear to be a simple majority vote of stakeholders. Decision making is a complex process, and the identification of the three intellectual movements and the theme of multicultural sensitivity helps to place models in historical, philosophical, and theoretical contexts, providing a new framework for core analysis and critique of existing models.

A good example of how identification of the intellectual movements in psychology ethical decision making leads to advanced analysis would be a relational critique of principle ethics. As a relational theorist, my critique here is both convenient and defensive, as I clearly and comfortably operate from a relational bias. Principle ethics fits nicely within the mold of a psychology of an individual deliberator. It identifies the psychologist as a decision agent, one that (to the extreme) can analyze a decision, and on his or her own, discern a course of action. A purist relational theorist would argue that such a scenario (the independent decision maker) is not theoretically possible and must be undergirded by social factors. Such a criticism has credence when one critically analyzes, for example, the process of applying ethical principles to a dilemma. For example, Beauchamp and Childress (2009) relied heavily on the work of Ross (1998), as Ross challenged utilitarian decision-making processes in favor of intuitive induction (Beauchamp & Childress, 2009, p. 362). But an examination of Ross's position reveals that his arguments are grounded on something close to a consensual ethic. Ross (1998) stated,

> The existing body of moral convictions of the best people is the cumulative product of the moral reflection of many generations, which has developed an extremely delicate power of appreciation of moral distinctions; and this the theorist cannot afford to treat with anything other than the greatest respect. The verdicts of the moral consciousness of the best people are the foundation on which he must build; though he must first compare them with one another and eliminate any contradictions they may contain. (p. 285)

So just thinking about a dilemma, as Ross would recommend, does not happen outside a socially established framework, which is exactly what a social constructivist would argue.

Identification of the intellectual movements in psychology decision making allows for a high level cross-evaluation of precepts and assumptions and provides an enriched understanding of models. It becomes obvious, no matter where a psychologist begins the decision process, decision making is complex and may be viewed from a number of perspectives. Those perspectives may be mutually exclusive. They may intersect. Or one perspective may supersede or reframe the others. The debate is open.

CONCLUSION

A number of ethics decision-making models apply to the practice of psychology. There is also enough

variability among models to begin to classify them according to several movements in the field (principle ethics, virtue ethics, and relational ethics and the theme of multicultural sensitivity) and to analyze them on theoretical, philosophical, and practical grounds.

When it comes to training psychologists or acculturating them (Handelsman et al., 2005), it is becoming important not only to address ethical issues, values, and dilemmas, but also to address formal models for decision making and the willingness and resoluteness of the psychologist to make a decision. As ethical decision-making models become more prevalent and sophisticated, it also will be important for psychologists to study and to assess them. This may be especially important on the issue of consultation and the importance of sharing ethical dilemmas with others as a means to ensure that the decision-making process may be corroborated. Psychology has advanced to a degree at which competitive models of decision making exist, presenting a quandary (in addition to an ethical dilemma itself) as professionals may be faced with an additional decision as to which model to apply. The dearth of empirical studies on ethical decision-making models and processes in psychology is alarming, and hopefully this chapter will be a catalyst for the application, study, and research of ethical decision making in psychology, especially related to cross-evaluation of models from the perspective of different intellectual movements in the field.

References

American Psychological Association. (2010). *Ethical principles of psychologists and code of conduct (2002, Amended June 1, 2010)*. Retrieved from http://www.apa.org/ethics/code/index.aspx

Bandura, A. (1999). Moral disengagement in the preparation of inhumanities. *Personality and Social Psychology Review, 3,* 193–209. doi:10.1207/s15327957pspr0303_3

Beauchamp, T. L., & Childress, J. F. (2009). *Principles of biomedical ethics* (6th ed.). New York, NY: Oxford University Press.

Belar, C. D. (2000). Ethical issues in managed care: Perspectives in evolution. *The Counseling Psychologist, 28,* 237–241. doi:10.1177/0011000000282002

Bernard, J. L., & Jara, C. S. (1986). The failure of clinical psychology graduate students to apply understood ethical principles. *Professional Psychology: Research and Practice, 17,* 313–315. doi:10.1037/0735-7028.17.4.313

Bernard, J. L., Murphy, M., & Little, M. (1987). The failure of clinical psychologists to apply understood ethical principles. *Professional Psychology: Research and Practice, 18,* 489–491. doi:10.1037/0735-7028.18.5.489

Betan, E. J. (1997). Toward a hermeneutic model of ethical decision-making in clinical practice. *Ethics and Behavior, 7,* 347–365. doi:10.1207/s15327019eb0704_6

Betan, E. J., & Stanton, A. L. (1999). Fostering ethical willingness: Integrating emotional and contextual awareness with rational analysis. *Professional Psychology: Research and Practice, 30,* 295–301. doi:10.1037/0735-7028.30.3.295

Canadian Psychological Association. (2000). *Canadian code of ethics for psychologists* (3rd ed.). Ottawa, Ontario, Canada: Author.

Chenneville, T. (2000). HIV, confidentiality, and duty to protect: A decision-making model. *Professional Psychology: Research and Practice, 31,* 661–670. doi:10.1037/0735-7028.31.6.661

Corey, G., Corey, M. S., & Callanan, P. (2007). *Issues and ethics in the helping professions* (7th ed.). Pacific Grove, CA: Brooks/Cole.

Costa, L., & Altekruse, M. (1994). Duty-to-warn guidelines for mental health counselors. *Journal of Counseling and Development, 72,* 346–350.

Cottone, R. R. (2001). A social constructivism model of ethical decision-making in counseling. *Journal of Counseling and Development, 79,* 39–45.

Cottone, R. R. (2004). Displacing the psychology of the individual in ethical decision making: The social constructivism model. *Canadian Journal of Counselling, 38,* 5–13.

Cottone, R. R. (2007). Paradigms of counseling and psychotherapy, revisited: Is social constructivism a paradigm? *Journal of Mental Health Counseling, 29,* 189–203.

Cottone, R. R., & Claus, R. E. (2000). Ethical decision making models: A review of the literature. *Journal of Counseling and Development, 78,* 275–283.

Cottone, R. R., & Tarvydas, V. M. (2007). *Counseling ethics and decision making* (3rd ed.). Upper Saddle River, NJ: Pearson/Merrill Prentice Hall.

Davis, A. H. (1997). The ethics of caring: A collaborative approach to resolving ethical dilemmas. *Journal of Applied Rehabilitation Counseling, 28,* 36–41.

Dell, P. F. (1985). Understanding Bateson and Maturana: Toward a biological foundation for the social sciences. *Journal of Marital and Family Therapy, 11,* 1–20. doi:10.1111/j.1752-0606.1985.tb00587.x

Detert, J. R., Trevino, L. K., & Sweitzer, V. L. (2008). Moral disengagement in ethical decision making: A study of antecedents and outcomes. *Journal of Applied Psychology, 93,* 374–391. doi:10.1037/0021-9010.93.2.374

Dinger, T. J. (1997, April). *Do ethical decision-making models really work? An empirical study.* Paper presented at the American Counseling Association world conference, Orlando, FL.

Drane, J. F. (1982). Ethics and psychotherapy: A philosophical perspective. In M. Rosenbaum (Ed.), *Ethics and values in psychotherapy* (pp. 15–50). New York, NY: Free Press.

Edwards, K. M., Merrill, J. C., Desai, A. D., & McNamara, J. R. (2008). Ethical dilemmas in the treatment of battered women in individual psychotherapy: Analysis of the beneficence versus autonomy polemic. *Journal of Psychological Trauma, 7,* 1–20. doi:10.1080/19322880802125878

Erickson, S. H. (1990). Counseling the irresponsible AIDS client: Guidelines for decision making. *Journal of Counseling and Development, 68,* 454–455.

Forester-Miller, H., & Davis, T. E. (1996). *A practitioner's guide to ethical decision making.* Alexandria, VA: American Counseling Association.

Garcia, J., Cartwright, B., Winston, S. M., & Borzuchowska, B. (2003). A transcultural integrative ethical decision-making model in counseling. *Journal of Counseling and Development, 81,* 268–277.

Garcia, J., McGuire-Kuletz, M., Froehlich, R., & Dave, P. (2008). Testing a transcultural model of ethical decision making with rehabilitation counselors. *Journal of Rehabilitation, 74,* 21–26.

Garcia, J. G., Winston, S. M., Borzuchowska, B., & McGuire-Kuletz, M. (2004). Evaluating the integrative model of ethical decision-making. *Rehabilitation Education, 18,* 147–164.

Garfat, T., & Ricks, F. (1995). Self-driven ethical decision-making: A model for child and youth care. *Child and Youth Care Forum, 24,* 393–404. doi:10.1007/BF02128530

Gergen, K. J. (1985). The social constructionist movement in modern psychology. *American Psychologist, 40,* 266–275. doi:10.1037/0003-066X.40.3.266

Gergen, K. J. (1991). *The saturated self.* New York, NY: Basic Books.

Gottlieb, M. C. (1993). Avoiding exploitive dual relationships: A decision-making model. *Psychotherapy: Theory, Research, and Practice, 30,* 41–48. doi:10.1037/0033-3204.30.1.41

Gutheil, T. G., Bursztajn, H. J., Brodsky, A., & Alexander, V. (1991). *Decision-making in psychiatry and the law.* Baltimore, MD: Williams & Wilkins.

Handelsman, M. M., Knapp, S., & Gottlieb, M. C. (2009). Positive ethics: Themes and variations. In C. R. Snyder & S. J. Lopez (Eds.), *Oxford handbook of positive psychology* (2nd ed., pp. 105–113). New York, NY: Oxford University Press.

Handelsman, M. M., Gottlieb, M. C., & Knapp, S. (2005). Training ethical psychologists: An acculturation model. *Professional Psychology: Research and Practice, 36,* 59–65. doi:10.1037/0735-7028.36.1.59

Hanson, S. L., & Kerkhoff, T. R. (2007). Ethical decision making in rehabilitation: Consideration of Latino cultural factors. *Rehabilitation Psychology, 52,* 409–420. doi:10.1037/0090-5550.52.4.409

Hare, R. (1981). The philosophical basis of psychiatric ethics. In S. Block & P. Chodoff (Eds.), *Psychiatric ethics* (pp. 31–45). Oxford, England: Oxford University Press.

Hare, R. (1991). The philosophical basis of psychiatric ethics. In S. Block & P. Chodoff (Eds.), *Psychiatric ethics* (2nd ed., pp. 33–46). Oxford, England: Oxford University Press.

Hass, L. J., & Malouf, J. L. (2005). *Keeping up the good work: A practitioner's guide to mental health ethics* (4th ed.). Sarasota, FL: Professional Resource Press.

Hill, M., Glaser, K., & Harden, J. (1995). A feminist model for ethical decision-making. In E. J. Rave & C. C. Larsen (Eds.), *Ethical decision-making in therapy: Feminist perspectives* (pp. 18–37). New York, NY: Guilford Press.

Hill, M. R., & Mamalakis, P. M. (2001). Family therapists and religious communities: Negotiating dual relationships. *Family Relations, 50,* 199–208. doi:10.1111/j.1741-3729.2001.00199.x

Kahneman, D. (2003). A perspective on judgment and choice: Mapping bounded rationality. *American Psychologist, 58,* 697–720. doi:10.1037/0003-066X.58.9.697

Keith-Spiegel, P., & Koocher, G. P. (1985). *Ethics in psychology.* New York, NY: Random House.

Kitchener, K. S. (1984). Intuition, critical evaluation and ethical principles: The foundation for ethical decisions in counseling psychology. *The Counseling Psychologist, 12,* 43–55. doi:10.1177/0011000084123005

Knapp, S., Gottlieb, M., Berman, J., & Handelsman, M. M. (2007). When laws and ethics collide: What should psychologists do? *Professional Psychology: Research and Practice, 38,* 54–59. doi:10.1037/0735-7028.38.1.54

Knapp, S., & Sturm, C. (2002). Ethics education after licensing: Ideas for increasing diversity in content and process. *Ethics and Behavior, 12,* 157–166. doi:10.1207/S15327019EB1202_3.

Knapp, S., & VandeCreek, L. (2006). *Practical ethics for psychologists: A positive approach.* Washington, DC: American Psychological Association. doi:10.1037/11331-000

Knapp, S., & VandeCreek, L. (2007). When values of different cultures conflict: Ethical decision making in a multicultural context. *Professional Psychology: Research and Practice, 38,* 660–666. doi:10.1037/0735-7028.38.6.660

Koenig, T. L., Rinfrette, E. S., & Lutz, W. A. (2006). Female caregivers' reflections on ethical decision-making: The intersection of domestic violence and elder care. *Clinical Social Work Journal, 34,* 361–372. doi:10.1007/s10615-005-0023-3

Littleford, L. N. (2007). How psychotherapists address hypothetical multiple relationships dilemmas with Asian American clients: A national survey. *Ethics and Behavior, 17,* 137–162.

Mannheim, C. I., Sancilio, M., Phipps-Yonas, S., Brunnquell, D., Somers, P., Farseth, G., & Ninonuevo, F. (2002). Ethical ambiguities in the practice of child clinical psychology. *Professional Psychology: Research and Practice, 33,* 24–29. doi:10.1037/0735-7028.33.1.24

Martin, T. A., & Bush, S. S. (2008). Ethical considerations in geriatric neuropsychology. *NeuroRehabilitation, 23,* 447–454.

Maturana, H. R. (1978). Biology of language: The epistemology of reality. In G. A. Miller & E. Lenneberg (Eds.), *Psychology and biology of language and thought* (pp. 27–63). New York, NY: Academic Press.

Maturana, H. R. (1980). Biology of cognition. In H. R. Maturana & F. J. Varela (Eds.), *Autopoiesis and cognition: The realization of the living* (pp. 5–58). Boston, MA: D. Reidel. (Original work published 1970)

Maturana, H. R. (1988). Reality: The search for objectivity or the quest for a compelling argument. *The Irish Journal of Psychology, 9,* 25–82.

Maturana, H. R., & Varela, F. J. (Eds.). (1980). *Autopoiesis and cognition: The realization of the living.* Boston, MA: D. Reidel.

Meara, N. M., Schmidt, L. D., & Day, J. D. (1996). Principles and virtues: A foundation for ethical decisions, policies and character. *The Counseling Psychologist, 24,* 4–77. doi:10.1177/0011000096241002.

Rest, J. R. (1984). Research on moral development: Implications for training psychologists. *The Counseling Psychologist, 12*(3–4), 19–29. doi:10.1177/0011000084123003

Ross, W. D. (1930). *The right and the good.* Oxford, England: Oxford University Press.

Ross, W. D. (1998). What makes right acts right? In J. Rachels (Ed.), *Ethical theory* (pp. 265–285). New York, NY: Oxford University Press.

Seymour, J. W., & Rubin, L. (2006). Principles, principals, and process (P3): A model for play therapy ethics problem solving. *International Journal of Play Therapy, 15,* 101–123. doi:10.1037/h0088917

Sommers-Flanagan, R., & Sommers-Flanagan, J. (2007). *Becoming an ethical helping professional: Cultural and philosophical foundations.* Hoboken, NJ: Wiley.

Sperry, L. (2007). *The ethical and professional practice of counseling and psychotherapy.* Boston, MA: Pearson/Allyn & Bacon.

Tarvydas, V. M. (1998). Ethical decision-making processes. In R. R. Cottone & V. M. Tarvydas (Eds.), *Ethical and professional issues in counseling* (pp. 144–158). Upper Saddle River, NJ: Prentice Hall.

Tarvydas, V. M., & Cottone, R. R. (1991). Ethical responses to legislative, organizational and economic dynamics: A four level model of ethical practice. *Journal of Applied Rehabilitation Counseling, 22*(4), 11–18.

Tjeltveit, A. C. (2000). There is more to ethics than codes of professional ethics: Social ethics, theoretical ethics, and managed care. *The Counseling Psychologist, 28,* 242–252. doi:10.1177/0011000000282003

Truscott, D., Evans, J., & Mansell, S. (1995). Oupatient psychotherapy with dangerous clients: A model for clinical decision making. *Professional Psychology: Research and Practice, 26,* 484–490. doi:10.1037/0735-7028.26.5.484

Welfel, E. R. (1998). *Ethics in counseling and psychotherapy: Standards, research, and emerging issues.* Pacific Grove, CA: Brooks/Cole.

Welfel, E. R. (2006). *Ethics in counseling and psychotherapy: Standards, research, and emerging issues* (3rd ed.). Belmont, CA: Thompson Brooks/Cole.

Werth, J. L., Jr. (2002). Legal and ethical considerations for mental health professionals related to end-of-life care and decision making. *American Behavioral Scientist, 46,* 373–388. doi:10.1177/000276402237770

Younggren, J. N. (2000). Is managed care really just another, unethical Model T? *The Counseling Psychologist, 28,* 253–262. doi:10.1177/0011000000282004