

TOWARD A PARTICIPATORY FRAMEWORK FOR APPLIED ETHICS

Preventing Harm and Promoting Ethical Discourse in the Helping Professions: Conceptual, Research, Analytical, and Action Frameworks

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The first in a series of 4 articles, this article provides an overview of the concepts and methods developed by a team of researchers concerned with preventing harm and promoting ethical discourse in the helping professions. In this article we introduce conceptual, research, analytical, and action frameworks employed to promote the centrality of ethical discourse in mental health practice. We employ recursive processes whereby knowledge gained from case studies refines our emerging conceptual model of applied ethics. Our *participatory* conceptual framework differs markedly from the *restrictive* model typically used in applied ethics. Our research relies on lived experiences of ethics, while our analytical framework draws attention to the multiple levels and contexts in which ethical dilemmas take place. Finally, our action frame-

work is designed to collaborate with research participants and practitioners in making use of our data and interpretations. We demonstrate how the various frameworks inform each other in an integrative fashion. The article sets the stage for 2 case studies presented in subsequent articles.

Key words: mental health ethics, ethical framework, prevention of harm

We introduce in this article conceptual, research, analytical, and action frameworks designed to prevent harm and promote ethical discourse in the helping professions. The next two articles complement this theoretical presentation with case studies, while the fourth article offers an integrative critique of the preceding three articles. Our objective in these four articles is to share what we have learned so far from a multiyear, multisite research project concerned with applied ethics in mental health. The main impetus for this project came from our own experiences in the field of mental health. As workers in this area, we had the uncomfortable feeling that prevalent models of applied ethics were neither very helpful nor particularly relevant. This prompted us to study applied ethics in some depth.

Our efforts are guided by two central concerns: the prevention of harm and the promotion of ethical discourse in the helping professions. Harm in the helping professions may be expressed in either blatant or subtle forms. Blatant forms of harm can be readily identified and include sexual, emotional, and financial exploitation of clients (Corey, Corey, & Callanan, 1993; Keith-Spiegel & Koocher, 1985). In contrast, subtle forms of harm are harder to detect. They include undermining the self-determination of clients, not respecting their cultural diversity, and minimizing consumer input during the helping process (Mair, 1992; Spinelli, 1994; Sutherland, 1992; Vasquez & Eldridge, 1994). Whereas obvious forms of abuse have received considerable attention in the literature, we believe that subtle forms of harm have not been sufficiently examined (Hare-Mustin, 1991, 1994; Spinelli, 1994). Our project is concerned primarily with the latter. Specifically, we are interested in the suffering caused by unexamined practices and assumptions of clinicians (DeVaris, 1994; Doherty, 1995; Mack, 1994; Spinelli, 1994).

Our leading assumption is that harm in the context of helping relationships may be significantly reduced by promoting the centrality of ethical discourse. This may be done by proactively identifying the potential for harm in helping encounters and by suggesting ethical means for dealing with them. In our view, the current frameworks of applied ethics in mental health are not very helpful in providing clients and workers with meaningful ethical guidelines. This void increases the likelihood of causing harm. We wish to propose a new ethical framework whereby clients and workers can proactively identify injurious behaviors and deal with them in a consensual way. This would not only prevent harm but also promote healthier therapeutic relationships. Our approach deviates from traditional professional ethics and is much closer to feminist (Brown, 1994; Lerman, 1994; Lerman & Porter, 1990), discursive (Benhabib & Dallmayr, 1991; Habermas, 1990; Jennings,

1991; Kubacki, 1994), and probabilistic (Bursztajn, Gutheil, & Cummins, 1987) models of ethics.

Following a presentation of our conceptual, research, analytical, and action frameworks we will discuss the synergistic effect of integrating the four models. We will argue that each framework needs to incorporate information processed in other frameworks. Our approach combines the benefits of both deductive and inductive methods and is subject to revisions as we gather more data. What follows summarizes our emerging conceptions of applied ethics in mental health.

CONCEPTUAL FRAMEWORK

There is a tension in mental health ethics between conceptions of morality driven by professional interests on one hand, and emancipatory concerns for the welfare of the public on the other. Whereas few would have questioned the noble intent of professional codes of ethics two decades ago, many now dispute the value of such codes for the public (Brown, 1994, 1997; Doherty, 1995; Jennings, 1991; Kubacki, 1994; Kultgen, 1988; Lebacqz, 1985; Reeck, 1982; Tancredi, 1995). But despite increased attention to the ethical dimensions involved in the provision of mental health services (e.g., Barker & Baldwin, 1991; Corey et al., 1993; Pope & Vasquez, 1991; Woody, 1990), the existing literature still appears to be of little help to practitioners and service recipients in their attempts to forge therapeutic alliances devoid of harm (e.g., Brown, 1989, 1997; Fairbairn & Fairbairn, 1987; Felkenes, 1980; Haas & Malouf, 1989; Holland & Kilpatrick, 1991; Lerman & Porter, 1990). As others have asserted, the helping professions have inherited an ethical framework, expressed in codified rules, that does not meet the complex moral demands of the therapeutic encounter (Bermant, Kelman, & Warwick, 1978; Bursztajn et al., 1987; Clark & Asquith, 1985; Doherty, 1995; Fairbairn & Fairbairn, 1987; Felkenes, 1980; Kultgen, 1988; Lebacqz, 1985; Loewenberg & Dolgott, 1985; Reamer, 1990; Reeck, 1982; Salladay, 1986; Steininger, Newell, & Garcia, 1984). Existing professional ethics codes tend to be reactive, rule-driven, professional-centered, and relatively distant from actual workaday practice (Brown, 1994; Holland & Kilpatrick, 1991; Lerman, 1994; Prilleltensky & Walsh-Bowers, 1993; Woody, 1990).

Some writers promote the centrality of ethics in practice (e.g., Brown, 1989; Doherty, 1995; Hare-Mustin, 1994; Holland & Kilpatrick, 1991; Reiser, Bursztajn, Applebaum, & Gutheil, 1987; Salladay, 1986; Woody, 1990). But clinical ethics have not become a central aspect of practice because they have been dominated by traditional conceptions of ethics that are distant and removed from concrete experience. Given our reservations about the narrow scope of the dominant framework of applied ethics, we have called it *restrictive*.

Our assumption is that shifting this rule-bound conception of ethics to a more process-oriented one will promote the centrality of ethics in professional practice

(Reiser et al., 1987; Salladay, 1986). Considering that mental health treatment is inherently relational, greater sensitivity to harm and risks will be fostered by understanding actual relations between persons, their needs, preferences, values, and choices. "It's crucial for counselors to be clear about their own values and how they influence their work and the directions taken by their clients" (Corey et al., 1993, p. 59). Haas and Malouf have argued that "there is a strong emotional or aesthetic component to ethical decisions" (1989, p. 7). We resonate with these authors' concern for the subjective and intersubjective dimensions of ethics. As Salladay (1986) put it,

Little bursts of real person keep popping out from behind the professional role: personality, idiosyncrasies, likes and dislikes, and many other sorts of surprises....Ethically speaking, it is impossible to separate real person from professional role.... *You keep interrupting, you keep breaking in upon professional codes of ethics, patients' bill of rights, or hospital policy manuals. It is you who live ethical decisions.* (pp. 13-14)

We have turned to the work of Jürgen Habermas on discourse ethics to develop a relational and participatory ethical framework that is sensitive to the needs and interests of the parties involved in caring relationships (Benhabib & Dallmayr, 1991; Habermas, 1990; Kubacki, 1994). In this approach, harm devolves from the power of ethically unexamined expertise. Discourse ethics provides an alternative to the problem of harm done through unchecked expertise by subjecting norms to a process of public consensus building (Jennings, 1991).

Habermas advocates an enriched public life made ethical through discourse, debate, and argumentation leading to consensus. The method of achieving such communicative action is through an ideal speech situation in which equality of access, equality of participation, and freedom from coercion are assured. Following from Habermas, our framework for preventing harm through ethical discourse depends on a shift from the view of ethics as rules by experts to a notion of ethics as public process. Within this notion is the idea that ethics must become part of daily life, rather than split off into an abstract category. As well, discourse ethics presumes that authority for ethics should be relocated from prescription to a relational process. In such a way, harm that is inflicted through unquestioned norms of expertise can be prevented (Spinelli, 1994). In our view, therapists should no longer have a monopoly on ethical decisions; clients should also contribute to the definition of applied ethics. We have termed the alternative framework *participatory*.

Our orientation is part of a general shift taking place within applied ethics. There is now an effort to "reframe traditional philosophical questions about moral knowledge into questions about moral discourse" (Jennings, 1991, p. 448). In this shift, Jennings argued,

Epistemological questions about the relationship between a rational, knowing subject and a rationally knowable, objective morality are no longer the primary focus of

theory. Instead, the aim is to understand morality as a socially embedded practice, where the crucial questions have to do with the ways in which the meanings and legitimacy of moral notions are established, reinterpreted, and reproduced or transformed over time.... Highlighting moral speech-agency and practice brings consensus and kindred concepts to the fore, as consensus is something moral agents construct, it is not something they contemplatively discover.... The implications of this theoretical reorientation for applied ethics are profound, but are beginning only now to be explored, and it is too early to say how the methodological protocols or the substantive arguments used in applied and professional ethics might be affected by this kind of "post-modern" philosophical orientation. (pp. 448-449)

We are involved in the process of articulating and constructing the emergent paradigm Jennings referred to. As researchers in this new field, we are developing conceptual frameworks that will help us make sense of this new orientation.

Table 1 describes our conceptualization of the restrictive and participatory frameworks of applied ethics. Our characterization of the current framework of ethics is not based solely on codes of ethics, but rather on the predominant ethos of professional ethics. In other words, our critique of the restrictive approach extends beyond the language of ethical codes and encompasses the regnant mentality about ethics in the helping professions. As can be seen in Table 1, we have summarized our views concerning the dominant and alternative frameworks of applied ethics in five categories: (a) power and control, (b) decision making process, (c) scope, (d) relevance, and (e) conceptions of harm.

Power and Control

Professionals have traditionally enjoyed great respect and nearly unquestioned authority in society (Lebacqz, 1985). In many ways, they are entrusted with the task of maintaining social order and reproducing the societal status quo. This phenomenon is common to many professions. Helping professionals are not immune to the risk of acting as agents of social control, occasionally suppressing impulses for social change. There is evidence to suggest that mental health professionals use their socially sanctioned power to dominate and dictate the therapeutic agenda (Hare-Mustin & Marecek, 1997).

In the current restrictive framework, power and control are held primarily by the professional. In the dominant practice the therapeutic process is driven by the professional, with limited input from clients (Atkinson, 1993; DeVaris, 1994; Mack, 1994; Tancredi, 1995). In fact, therapists "hold extensive power that they can misuse or abuse within the therapeutic relationship" (Spinelli, 1994, p. 122). Commenting on the revised code of ethics of the American Psychological Association, Brown (1994) points out that

As a patriarchal code, this and all other dominant ethical standards privilege those holding the power—that is, the therapists—rather than trying to educate therapists in

TABLE 1
 Contrast Between Restrictive and Participatory Frameworks of Applied Ethics

<i>Dimensions</i>	<i>Restrictive Framework</i>	<i>Participatory Framework</i>
Power and control	Unequal power between professional and client Minimal input from consumer Professional driven	Equal power between professional and client Maximal input from consumer Professional and consumer driven
Decision making process	Rule driven and mechanistic	Balance between rules and attention to subjective processes
Scope	Private "property" Reactive Based exclusively on individualistic ethics Narrow definition of what constitutes an ethical issue Narrow conception of informed consent Minimally challenging of organizational culture and social structures	Public "property" Proactive Based on individual and social ethics Broader definition of what constitutes an ethical issue Broad conception of informed consent Maximally challenging of organizational culture and social structures
Relevance	Distal Minimally relevant to daily practice	Proximal Maximally relevant to daily practice
Conceptions of harm	Harm regarded as aberrant behavior of few professionals Harm identified only in its blatant forms	Harm regarded as expression of latent potential in all professionals Harm identified also in its subtle forms

how to share power and instructing aggrieved consumers on their right to power.... Patriarchal codes proscribe specific behaviors in the presumed best interest of the client, but rarely are the clients asked their opinions on what will help and what will harm. The assumption of such codes is that only the official experts are in a position to make such judgments.... This is not to say that the desires of clients are necessarily the sole valuable source, but rather that they have been almost entirely discounted as useful for therapists caught in ethical dilemmas. (p. 204)

We propose a helping relationship where priorities are mutually agreed upon, and where clients have a louder voice. The balance of power in the helping relationship has direct implications for the occurrence of harm, for unless consumers feel that their opinions are valued and respected, they are likely to undermine their own ethical sense. When clients feel devalued, "there is significant potential for abuse of power" (DeVaris, 1994, p. 592) because they think that therapists know best and because they mistrust their own judgment. To prevent abuse of power, Mack

reminds us that we need to enter the clients' world "in a manner that is attentive to and respectful of the subtle imbalances of power that are built into the structure of the relationship" (1994, p. 192).

Decision Making Processes

Decision making processes concerning ethics tend to be driven by rules stipulated by professional bodies, without much input from the public. The practitioner is supposed to apply rules in a somewhat mechanistic fashion, detached from his or her own subjectivity (Bursztajn et al., 1987), an idea that belies the complexities of ethical decision making (Tancredi, 1995). "Conservatives' rigid rule-following and liberals' excessive individualism and reliance on abstract reasoning...do not offer reliable guides for moral discourse in psychotherapy" (Doherty, 1995, p. 39). Ethics are viewed not so much as a live process that invites input from consumers and the public alike, but rather as codified rules that are the "property" of professional regulatory bodies (Kultgen, 1988; Lerman, 1994). Clients are neither invited to define the ethical parameters of the therapeutic relationship, nor are they proactively warned about potential harm that may result from the helping process (Brown, 1994). As Keith-Spiegel and Koocher (1985) have pointed out, "inquiries to ethics committees or calls for consultation on ethical matters often arrive after the fact and the resolution primarily involves reactive or remedial, rather than preventative steps" (p. xiv). "Ethical codes, by their very nature, tend to be reactive, emerging from what has occurred rather than anticipating what may occur" (Corey et al., 1993, p. 4).

Scope

We find the scope of ethics in the traditional framework rather narrow. The moral dimension is based almost exclusively on individualistic ethics. This orientation looks primarily at the microethics of the therapeutic relationship to the neglect of social ethical issues involving organizational, cultural, and social contexts (Doherty, 1995; Salladay, 1986). The intricate relationship between ethical behavior and organizational constraints is described in Kolenda's edited book, *Organizations and Ethical Individualism* (1988). While we may disagree with some of the contributors' focus on ethical individualism, the book clearly shows the organizational impositions experienced by workers in their attempts to do the "right thing." In her recent presidential address to the Canadian Psychological Association, Jean Pettifor (1996) asserted that "the concept of personal individual ethics needs to be extended to the social and cultural environment, because the environment influences the ethical behavior of psychologists and the quality of life of all citizens" (p. 1).

Doherty (1995) captures well the narrow scope of mental health ethics. According to him,

Most case consultation and supervision settings provide little opportunity to explore our moral beliefs and our commitments to community and political well-being. Mainly, we discuss "cases," as if each case were not also a moral passion play being co-created by the client, the therapist, and the community. (p. 18)

Doherty goes on to claim that "when we discuss 'ethical issues,' we are usually speaking about following rules of conduct and avoiding ethical or legal trouble" (p. 18). There is definitely more to ethics than rules of conduct. The fact that mental health workers have chosen to define ethics in terms of the microtherapeutic encounter says more about their professional socialization than about the proper scope of ethics. Failing to oppose or change oppressive conditions that ruin the mental health of our clients is a moral choice, one that supports the societal status quo (Prilleltensky, 1994). Challenging or supporting exploitive social structures affecting clients' welfare is as much of an ethical act as it is to keep confidentiality or obtain informed consent. In all cases, our behavior has an impact on the welfare of clients and the public. We envision a broader conception of ethics where civil obligations toward a just and caring society are central to the ethical mandate and not marginalized as "political" preferences (Brown, 1997; Doherty, 1995; Mack, 1994; Salladay, 1986).

Current conceptualizations of applied ethics appear abstracted from organizational and social structures. Principles and rules are divorced from the social structure of work. It is therefore not surprising that codes of ethics are minimally challenging of organizational cultures, however oppressive of clients and workers they may be. We do not ascribe conspiratorial intent to clinicians. We do not think they are necessarily reluctant to challenge organizational arrangements they benefit from. In fact, clinicians often do challenge adverse working conditions, but their struggles are not framed as *ethical*, but as *technical* in nature. This is an important distinction that should not elude us. For technical remedies are advanced within the confines of existing power arrangements, whereas ethical challenges have the potential to transform illegitimate power structures, not just to reform them.

An illustrative example of how writers in applied ethics deal with organizational and social issues is provided by Appelbaum (1987). According to some writers, Appelbaum says, workers "should not only recognize their own values, but be prepared to take responsibility for shaping some part of the health care system in accord with these values. This goal, of course, is itself the expression of a moral position: that one should feel obliged to alter perceived injustice" (p. 44). But Appelbaum goes on to say that "not every clinician or program will embrace such an ideal; a justifiable alternative may be to see the obligations of professionals extending only to those with whom they are in immediate contact, their own patients or clients, rather than asking them to promote systemic changes. The goal of teaching mental health ethics need not be to breed a generation of reformers" (pp. 44-45). While Appelbaum acknowledges that some perceive the need to change unjust structures as part of an ethical mandate, he adopts a weaker position with respect to social change. These two positions are quite typical in the literature. In

line with our call to expand the scope of applied ethics, we ally ourselves with the position that advocates social and organizational change. To do otherwise is to ignore powerful social forces that intrude in the therapeutic relationship.

The constricted scope of rule-following is also manifested in informed consent. Consent tends to be narrowly defined in terms of confidentiality, alternatives to therapy, and technical aspects of therapeutic interventions (Cobrin, 1995; Pilgrim, 1992). A broader definition of consent would account for the power differences between therapist and client and would take into account the process employed to reach consent. At present, consent typically means signing a form at the beginning of therapy or having a conversation about limits to confidentiality. We propose renewed consent every time there is the potential for deviating from the original contract between client and professional. This is consistent with process models for obtaining consent in clinical practice (Appelbaum, Lidz, & Meisel, 1987) and with contractualist approaches in research ethics (Lawson, 1995).

Given the dynamic nature of therapy, new issues periodically emerge that may require different approaches than the ones explained to clients at the outset of therapy. Clients need to be apprised of changes in strategies. They should not sign a blank check permitting therapists to utilize whatever techniques they wish without renewed consent. The same applies to the direction of therapy. A couple seeking help for marital problems has to be warned that as a result of therapy they may seek a divorce. Partners should be warned about this potential outcome as soon as the possibility arises. At this point, clients may wish to reconsider the course of therapy.

Relevance

We question the immediate relevance of current ethical frameworks for clinicians and clients alike. We doubt clinicians see codes of ethics as central to their repertoire of helping tools. From the clients' perspective, we doubt they are even aware of how codes of ethics could or should inform the therapeutic process (Sarason, 1985).

We concur with Haas and Malouf (1989) that "much of what has been written concerning professional ethics has been so general and theoretical that it is difficult for the practitioner to apply" (p. vi). "In whatever ethical language" we discuss therapeutic dilemmas, Bursztajn and colleagues (1987) argue, "the discussion comes to be about abstract, isolated entities rather than about therapists and patients in relationships" (p. 31). Consequently, clinicians find current resources for applied ethics to be distal and rarely applicable to their conflicts. This lack of relevance derives from rigid rules brought to ethics by social and medical scientists, and from the abstract analyses brought to ethics by philosophers. Bursztajn and colleagues (1987) put it well when they claimed that

Clinicians who turn to ethics seeking to be "scientific" about their choices tend to reduce the possibility of dialogue and of change. Ethicists, such as "rights theorists," who speak of fictitious people who have only "the right to choose or to will" or the

“right to protection of interests” forget that real people may have conflicting wishes and rights. (p. 32)

The search for the “quick fix” or “natural law” that will dispel our ethical uncertainty is fraught with irreducible contextual cues that defy prefabricated solutions. We need to balance our pursuit for adequate theories with methodologies that are sensitive to the proximal and contextual features of ethical dilemmas. Such an approach should prove more useful and relevant than current ones to clinicians and philosophers alike.

Conceptions of Harm

The final dimension of the conceptual framework deals with conceptions of harm implicitly promoted by models of applied ethics. The dominant thinking is that harm is the result of aberrant behavior on the part of few clinicians and that it exists only in its most blatant forms (Hare-Mustin, 1992; Spinelli, 1994). In other words, attention is directed toward gross violations of clients’ rights and little concern is shown for more subtle forms of harm, such as the perpetuation of power inequalities and the denial of clients’ participation in decision making processes (Lerman & Porter, 1990; Pilgrim, 1992; Sarason, 1985; Spinelli, 1994; Sutherland, 1992).

According to Spinelli (1994), there are multiple sources of subtle harm. These include “a variety of *assumptions* held by psychotherapists and counselors regarding their role and function, their employment of specialist skills and their (sometimes unquestioning) reliance upon, and belief in, the ‘truths’ of their theories” (p. 14). While these assumptions and practices are occasionally challenged for their therapeutic effectiveness, their morality is seldom questioned. Spinelli documents in his book the ill-effects of imposing on clients prefabricated, theory-led solutions; of elevating counselors to the level of experts; and of mystifying the healing process as one clients could not undertake without professional healers.

By relocating the source of harm from the individual therapist to the professional norms, we can explore structural features of the therapeutic encounter that may cause harm or abuse. If clinicians and ethicists continue to individualize and define harm as a pathology on the part of helpers they will obviate cultural determinants that provide fertile soil for the emergence of abusive treatments. Our framework calls for an in-depth study of the culture of professionalism, a culture that encourages clinicians’ authority and clients’ submissiveness.

In contrast to the restrictive framework, the participatory model strives to empower clients to be active members in all facets of the helping relationship. By creating safety spaces between workers and clients, clinicians will help consumers to be meaningfully involved in the ethical discourse of therapy and counseling (Kubacki, 1994). Such process will facilitate the centrality of ethics in therapeutic practice. As can be seen from the features of the proposed framework, its main

thrust is to promote the centrality of ethical discourse in daily practice. The introduction of the proposed approach into moral professional reasoning is likely to reduce harm wittingly or unwittingly inflicted by workers (Holmes & Lindley, 1989).

RESEARCH FRAMEWORK

Our work in applied ethics combines deductive and inductive approaches. In order to develop, enliven, and enhance the trustworthiness of our conceptual framework we need to give it meaning by incorporating phenomenological accounts of experiences of people involved in ethical dilemmas. Otherwise, our theoretical framework would be removed from practice as much as the present one we criticize. This dynamic and dual process of theory construction and grounded input ensures that the proposed framework could become, in fact, an applicable and meaningful tool. In order to obtain grounded input we developed a research program. The next two articles represent our initial efforts to inform the conceptual framework with grounded input. The information obtained from the case studies is used to inform the frameworks presented here, which are evolving. In other words, the emerging frameworks inform the research, but are not static or rigid. We aspire to reach an integration between our theoretical notions and our grounded input from the various investigations, but at this stage we are not in a position to reach such an integration because our research efforts are not complete.

Research Objectives

Our research program fulfills descriptive and prescriptive functions. Description is necessary to check the trustworthiness of our portrayal of the restrictive framework. By compiling accounts of lived ethics we can ascertain whether the current model of applied ethics is experienced by clinicians and clients as restrictive. Workers' and clients' descriptions will improve our conceptual understanding of applied ethics. At the same time, our ethnographic research serves a prescriptive function by studying workers' and clients' conceptions of ideal ethics. Our interviews with service providers and service recipients help us evaluate the merit of the participatory framework. As this framework constitutes our emerging prescription for practice, it is imperative to obtain input from workers and clients.

In essence, our research program seeks (a) to elucidate the experience of lived clinical ethics, and (b) to obtain grounded input for the creation of a better and more practical ethical framework. With those descriptive and prescriptive goals in mind we launched a multisite, 3-year action–research project. We strive to create research partnerships with each of the agencies we collaborate with in order to make the research relevant and useful.

Research Sites and Participants

To describe the lived experience of ethics in mental health practice we are gathering data from five different research settings: (a) a general social work family service agency (10 participants), (b) a multidisciplinary child guidance center (17 participants), (c) a hospital social work department (7 participants), (d) a feminist collective of women working in mainstream social services (6 participants), and (e) a sample of service recipients (20 participants). We use a variety of sites in order to increase the diversity of our sample. Our service providers deliver individual, marital, family, and group therapy as well as consultation to schools. They work with children, youth, and adults from various homogenous and multicultural communities. Across the sites our workers include junior and senior clinicians coming primarily from the disciplines of social work and psychology. The case studies that follow in the next two articles pertain to the family service agency and to the hospital social work department. Results from the other sites are being analyzed now.

The second objective of our research is to generate a practical framework. To this end we work with a planning committee in each of the three service research sites and with the feminist collective to tailor the research to their particular circumstances. In collaboration we consider how the framework can be best implemented in the various settings.

Research Method

The two main methods employed are in-depth interviews and participation in discussions concerning ethics. We conduct interviews with all participants, with the exception of the feminist collective where one of our members actively participates in deliberations related to ethics. Research questions are designed (a) to understand the experience of clinical ethics in practice, and (b) to help formulate a practical model of ethics. The general research questions are common to all the research participants. Particular questions tailored to the unique circumstances of each setting develop through discussions with the respective constituents before the formal interviewing process begins.

In general, the interview inquires about four general domains of applied ethics:

1. *Ethical discourse*: This section asks participants about what constitutes an ethical issue or dilemma, what are the dimensions of ethical conflicts, how do they experience them, and what principles do they use in resolving dilemmas.

2. *Ethical action*: Here we explore the contrast between the actual and ideal ways in which conflicts are resolved by participants or their colleagues. Workers' conceptions of ideal ethics are elicited.

3. *Resources and processes*: Participants are asked to identify persons, structures, processes, or resources that either facilitate or inhibit satisfactory resolution of ethical dilemmas.

4. *Recommendations*: We ask participants to offer recommendations for creating better decision making processes concerning ethics. Suggestions are sought at the personal, organizational, and professional levels.

Although the case studies that follow use slightly different language, the areas covered parallel the four domains stated above. The first author of each case study had primary responsibility for shaping the research and contributed his or her own wording to the interview guides and to the interpretation. Although the case studies do not use the same language used here, the research falls within the general conceptual and research frameworks.

ANALYTICAL FRAMEWORK

In order to interpret the data from the various sites in a coherent fashion, we designed the following analytical framework. Based on our conceptual framework and preliminary data we constructed an analytical tool to interpret the findings. The analytical framework presented in Figure 1 serves several purposes. First, it organizes the results in a coherent fashion. Second, it facilitates comparisons across sites. Third, it facilitates the transfer of grounded input into our conceptual framework. Fourth, it draws attention to the multiple contexts and levels where ethical dilemmas are experienced. And fifth, it aids in the formulation of practical recommendations. The framework presented in Figure 1 is not meant to be static. On the contrary, it is a flexible tool that may change as we collect more data and refine our notions about applied ethics.

The framework organizes data deriving from the main four research questions (ethical discourse, ethical action, resources and processes, recommendations) according to personal, interpersonal, organizational, and social contexts. Preliminary findings indicate that ethical issues arise at all of these levels. We divide the *ethical discourse* section into issues and dilemmas, and principles. Under issues and dilemmas we place people's examples of ethical problems. Under principles we put people's guiding ethical values. In the *ethical action* section we find it useful to distinguish between what actually happened in examples brought up by interviewees and what they see as an ideal outcome. We distinguish between facilitative and inhibitory *resources and processes* to identify what works for participants when they face ethical issues. The final column of Figure 1 refers to *recommendations*. Here we categorize respondents' suggestions regarding ethical practices at the personal, organizational, and professional levels.

<i>Contexts</i>	<i>Ethical Discourse</i>		<i>Ethical Action</i>		<i>Resources and Processes</i>		<i>Recommendations</i>
	Issues and Dilemmas	Principles	Actual	Ideal	Facilitative	Inhibitory	
Personal and Interpersonal							Personal, Organizational, or Professional Level
Worker							
Client							
Peers							
Management							
Others							
<i>Organizational and Social Contexts</i>							
Agency							
Interagency							
Professional Bodies							
Socioeconomic Climate							
Other							

FIGURE 1 Analytical framework for interpretation of ethical discourse, action, processes, and recommendations.

As we shall see in the case studies, the contexts of lived ethical experiences are varied and interconnected. The contexts range from the intrapersonal to the sociopolitical. The lived experience of ethics at one level can be transformed by changes in other contexts. Thus, for example, social and economic conditions pressuring clinicians to use short-term therapy present the worker with personal (how to confront regulations that seem unethical and nontherapeutic) as well as interpersonal (how to negotiate short-term therapy with clients) dilemmas. Examples of interconnections among levels of analysis abound. We could think of how supervisors may create a safe or threatening environment for the disclosure of ethical dilemmas, thereby facilitating or inhibiting the exploration of moral issues. In this case, the context of peer consultation or supervision has an impact on the personal level. Personal issues of power and control shape the climate of ethical discussions among workers as well as between clinicians and clients. In essence, then, we espouse an ecological model of applied ethics whereby experiences at one level modify ethical thinking and action at another level.

The analytical framework reflects the research questions which, in turn, inform our conceptual framework. Thus, there is a bidirectional relationship between inductive and deductive methods of inquiry. The conceptual framework presented already incorporates elements derived from preliminary data, data that were gathered to corroborate our initial conceptual model. But while the demand for more sophisticated ethical theories is great, so is the need for action. Our project aims not only to understand lived ethics but also to effect positive changes in practice. With this objective in mind, we set out to create an action framework.

ACTION FRAMEWORK

Our project has an action component designed to promote more participatory practices in applied ethics. We have worked in each agency with an advisory committee to help us shape the research so that participants will benefit from it. Our plan with each of the agencies is to decide on research questions that answer investigators' interests as well as organizational needs. Following the data-gathering process there is a consultation period to discuss the interpretation of findings. The next step is to create with agencies workshops or professional development events to employ the results in a productive fashion. Although this is not always feasible because of agency dynamics and politics, we strive to build into our research relationship an action component to translate the findings into practical guidelines. In the two case studies that follow, this aim proved to be elusive. The fact that we have not been able to promote action in these agencies is in itself important data that will be discussed in the following articles. Despite our initial difficulties implementing the action phase with two organizations, we have been successful in implementing an action plan with a third agency.

Action, we have learned, occurs not only as the result of carefully designed plans. The very research process constitutes action. We have learned that by framing ethics in a particular way and by interviewing workers on ethical issues, action is generated at several levels. The organization and its workers begin to see applied ethics in a different light. Their new perceptions, in turn, have an impact on the way they conceptualize ethics. The mere asking of ethical questions sometimes causes people to question agency rules and norms. Consequently, even though we are encountering some difficulties implementing recommendations emerging from our findings, the research process itself has generated some changes in how people think and talk about applied ethics. We have learned that this type of research, in our case at least, means more than inquiry; it also means intervention.

The action framework has the potential to generate practical changes and to inform theory at the same time. Ideally, we would follow up changes in agencies stemming from the research. We could then examine the effects of new practices and feed this information into our conceptual model. At this time it is uncertain whether we will be able to do such follow-up.

Regardless of our ability to implement changes suggested by ourselves and participants, we feel that an action component is a crucial part of studying applied ethics. Trying to change practices teaches us about people's resistances and institutional capacities for renewal. But participants' resistance to change need not reflect intransigence on their part. It can also reflect lack of sensitivity on our part. Ideas that may seem appealing in theory can be either impractical or inappropriate under particular circumstances. The practical meaning of the participatory framework presented in Table 1 is not always clear. What precisely does it mean to have ethical guidelines formulated by professionals and consumers? How is it done? How can agencies cope with ethical guidelines that challenge hierarchical structures? What does it mean to enlarge the scope of ethics to include social injustice? In all likelihood there is a gap between the theoretical merit of our notions and their practical feasibility. Quite possibly, the slow pace of change we have encountered so far reflects the reluctance of agencies to embrace threatening notions, and our own lack of awareness of how threatening some of our notions can be. Indeed, there are many lessons to be learned from this project.

Had we remained at a theoretical level, we would have never tested the feasibility of our propositions. It is only by trying to apply our concepts that we can test their relevance and significance. The interconnection among theory, research, analysis, and action become more readily apparent in the next section.

INTEGRATION OF FRAMEWORKS

The various frameworks presented in this article inform each other and operate in concert. Based on our work so far we can show how they are interconnected.

Although the restrictive and participatory frameworks presented in Table 1 were initially conceptualized with the worker–client relationship in mind, we are finding that the model applies equally well to relationships involving (a) supervisors and supervisees, (b) peers, (c) workers and their place of employment, and (d) workers and the public at large. For instance, it appears that some supervisors employ a restrictive frame of reference when dealing with supervisees, an issue perceived by workers as ethical in nature. For instance, workers have limited opportunities to participate in decision making processes concerning their performance evaluations. When the restrictive model is employed, practitioners are excluded from participating in ethical decisions affecting them. We are not sure clinicians see the paradox of suffering from a mentality they invoke themselves in working with clients.

This situation illustrates the multilayered positions of power that workers occupy in mental health settings. Whereas they are in control of therapeutic sessions with clients, during supervision or other dealings with management they are in a subordinate position that minimizes their voice. It would seem important to raise the consciousness of therapists concerning the oppressive dimensions of a framework used against them, a framework that they, in turn, use with clients.

Perhaps one of the main findings we have come across so far is that therapists working in organizations tend to define ethics very broadly. When we ask open-ended questions concerning the nature of ethical conflicts in their work, the vast majority of participants describe conflicts that go beyond the worker–client relationship. As can be seen in Figure 1, there are multiple contexts to ethics. Our participants readily identified ethical issues pertaining to personal, interpersonal, organizational, and social contexts. It is becoming apparent to us that ethical thought and action taking place in any one of these spheres have considerable impact on the others. Ethical problems emerging from organizational dynamics have an effect on the way workers deal with clients. For example, when limited resources dictate that workers shall engage mostly in short-term therapy, clinicians feel caught between the need to be productive on one hand, and the needs of clients who require long-term therapy on the other. Whatever course of action the clinician adopts, it will have a direct impact on his or her clients. Another example concerns the distribution of workload within an agency. Unfair assignment of responsibilities in an organization creates resentment on those clinicians who end up doing most of the work, a feeling that undermines their morale and sometimes their ability to perform at their best. Mental health workers have shown to us that applied ethics cannot be academic exercises disengaged from the realities of the workplace. It is becoming clear to us that ethics involve much more than the application of rules. The whole person is involved in acting ethically. Feelings, perceptions, attitudes, relationships, oppressions, and injustices are inextricably intertwined with ethical decision making.

The concepts, research, and analyses elaborated so far should help us promote applicable frameworks and tools. But promoting participatory ethics is a very difficult task. It is, in fact, a humbling experience. We have learned that the

application of theoretical frameworks, however valuable, is fraught with obstacles, not the least of which is our own presumption that our concepts are always practical and empowering. Like many writers before us, we believe that ethical notions need to be tested for their applicability and relevance. Now we are discovering for ourselves how difficult this process really is.

We have given in this article an overview of the frameworks we are employing in our project. In the next two articles the frameworks come to life with data obtained from two mental health agencies, a family service organization, and a social work department of a middle-size hospital.

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