Integrating philosophy and psychology in teaching a graduate course in ethics.

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Abstract:

Recent surveys of doctoral and master's programs in clinical psychology suggest that there are major gaps in the frequency and quality of ethical training. After describing a model of the ethical decision-making process, we present a thorough and formal course in ethical issues that integrates the perspectives of psychology and philosophy. The course was team taught by a philosopher and a psychologist to 10 second-year master's-level students in clinical psychology. The first section of the class addressed underlying philosophical issues, including ethical frameworks and principles; the second portion focused on a series of issues that had important value dimensions, including "health and disease," virtue, and several key ethical principles; and the final section focused on applications of these basic concepts to situations typically encountered by psychologists. A follow-up survey of those students engaged in clinical practice 3 months after the completion of the course revealed that they perceived the course to have had a positive impact both attitudinally and behaviorally. Suggestions for others planning to teach such courses are offered.

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Article:

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Although the American Psychological Association (APA) requires doctoral programs in clinical psychology to provide training in ethics, recent surveys have suggested that there are gaps in ethical training. Tymchuk et al. (1979) found that between 35% and 62% of doctoral programs offered separate courses in ethics, whereas Handelsman (1986a) reported that only 29% of

master's-level programs did so (an additional 47% reported teaching ethics as a part of other courses).

Indeed, some innovative approaches to teaching graduate-level ethics courses have been reported. For example, Abeles (1980) described an approach based on value confrontations, Bloch (1980) involved moral philosophers as secondary contributors to a psychiatric ethics course, and Eberlein (1987) presented a problem-solving approach based on the Canadian Psychological Association's Code of Ethics. Eberlein's (1987) model, which resembles the course to be described in this article, challenged students to resolve ethical dilemmas by going beyond the ethical codes to underlying ethical principles and ethical theory, when necessary.

Despite such reports, there appear to be a number of graduate programs that do not teach separate, formal courses in ethics. The most common reason for not offering such courses cited in Handelsman's (1986a) survey was that such training can best be provided through other means, such as practicum supervision. Handelsman (1986b) sharply criticized the practice of ethics training only through clinical supervision by arguing that this practice has serious limitations. Possibly as a result of these limitations, practicing psychologists and students feel inadequately trained; Tymchuk et al. (1982) found that 58% of the psychologists in their survey believed that they were not sufficiently informed about ethical issues in psychology, and Tymchuk (1985) reported that 80% of a sample of psychology graduate students felt inadequately informed about such issues.

Our purposes are to present a model of the ethical decision-making process and to describe and evaluate a course that we believe addresses some of the gaps in ethical training just described. The course is designed to provide graduate students with a thorough, formal course in ethics that integrates the perspectives of psychology and philosophy. To explicitly state our position from the outset, we regard the teaching of graduate-level courses in ethics to be a critical and necessary component of graduate training in psychology. It is not sufficient merely to add a short footnote about ethics to the subject matter of various courses. Although this common practice may be helpful in showing how ethical concerns are an integral part of psychological practice, these issues are often addressed in terms of conclusions without sufficient conceptual justification for the positions taken. A separate course is necessary, we believe, because an adequate ethical analysis can occur only when there is a formulation and critical appraisal of the justifications that underlie ethical decisions.

Before we describe the course, it is important to justify why we feel that it is critically important to include a philosophical component in ethics courses for psychology graduate students. First, philosophers have studied ethics much more thoroughly than have psychologists. Ethics is generally considered the appropriate subject matter of philosophy, insofar as psychologists typically treat ethics as a tool to assist them in conducting their clinical activities, but not as a primary subject matter in itself. Second, as a result of philosophy's greater acquaintance with ethical subject matter, it is better suited to assist when there arise ethical dilemmas that cannot

easily be resolved with reference to ethical codes. For example, there are a number of situations that arise in professional practice that involve a level of specificity not found in APA's (1981) ethical code (is it a breach of confidentiality to send a nonpaying client's account to a collection agency? Is it appropriate to sell one's practice to another clinician? Are sexual relations with ex-clients appropriate?). As Kitchener (1984) and Eberlein (1987) noted, when such situations arise, one must resort to underlying principles and theories, which are within the expertise of philosophy. Third, a greater understanding of ethical theory may assist psychology as a profession in the continual process of articulating ethical guidelines or codes.

Our model of the ethical decision-making process derives from work by Beauchamp and Walters (1982) and has similarities to a discussion by Kitchener (1984). It consists of four distinct levels. The most general level of ethical reasoning consists of ethical frameworks or theories. We address two of the most commonly articulated frameworks, utilitarianism and deontology. Utilitarianism, often associated with John Stuart Mill and Jeremy Bentham, is based on the major principle that an action is ethically appropriate when it leads to the greatest possible balance of good consequences or to the least possible balance of bad consequences in the world as a whole (Beauchamp & Walters, 1982). Thus from a utilitarian perspective, one must carefully evaluate and weigh the relative value of the consequences that are expected to arise from an ethical decision and choose that action that maximizes the ratio of benefits to costs. Deontology, initially associated with Immanuel Kant, is based on the major principle (categorical imperative) that one must act to treat every person as an end and never as a means only (Beauchamp & Walters, 1982). This reflects an inherent respect for the dignity of all persons. The morality of actions is based on their intrinsic rightness, is independent of the consequences of the behaviors, and thus permits no exceptions to the major principle. For example, Kant (1785/1969) maintained that it was unethical to commit suicide because such an action violated the imperative that an individual should never be treated as a means only and that suicide was a means to relief of distress.

The case of Tarasoff v. Board of Regents of the University of California(1976) may help to clarify the meaning of the two ethical frameworks. A utilitarian judgment would involve a careful assessment of the benefits and costs of violating confidentiality and warning potential victims. Because of individual variation in the assessment of benefits and costs, differing conclusions may be reached. In fact, a majority of the justices of the California Supreme Court argued on utilitarian grounds that the potential victim should have been warned, but a minority of the justices, also using utilitarian guidelines, maintained that the greater good arose from not breaking confidentiality in such instances because the integrity of the therapeutic relationship would be enhanced and potentially violent individuals would be more likely to seek and benefit from psychotherapy. A deontological argument would suggest that one should maintain confidentiality in all cases because an individual's right to privacy is a moral absolute and should never be violated.

The next level of ethical reasoning represents specific principles derived from the frameworks. Examples of principles (Beauchamp & Walters, 1982) include autonomy (i.e., a person should

be free to perform whatever action he or she wishes, regardless of risks or foolishness, provided that it does not impinge on the autonomy of others), beneficence (i.e., one should render positive assistance to others, and abstain from harm, by helping them to further their important and legitimate interests), justice (i.e., one should give to persons what they are owed, what they deserve, or what they can legitimately claim), and paternalism (i.e., one should restrict an individual's action against his or her consent in order to prevent that individual from self-harm or to secure for that individual a good that he or she might not otherwise achieve). These flow logically from the frameworks; that is, a utilitarian perspective would suggest that one should respect an individual's autonomy, provided that it does not impinge on the autonomy of others, because this maximizes the ratio of benefits to harm. Although deontological perspectives have similar principles, they may take a somewhat different form from those derived from utilitarian perspectives. One such difference is that the purest form of deontological principles permits no exceptions.

The third level in the ethical decision-making process consists of rules. Rules are derived from principles and are general guidelines asserting what ought to be done in a range of particular cases. Ethical codes may be considered rules, insofar as they provide guidelines to assist psychologists in a range of situations.

The final and most particular level in the process consists of judgments, which represent decisions about specific actions of decisions. Kitchener (1984) noted that people make most ethical decisions at this level (“intuitive level”) without probing more deeply at the rule, principle, or framework level. We believe that ethical decisions typically are made at the level with which the decision maker feels most comfortable; that is, if individuals feel comfortable with an ethical rule as stated in a code, they are unlikely to probe more deeply to the level of principle or theory. At times, this may lead to questionable decisions, particularly when intuition alone is used as the basis for making ethical decisions. However, some ethical decisions are made routine in such a way that there is no need to probe more deeply because the analysis has been done for similar dilemmas in the past. Maintaining confidentiality, for example, by not revealing that an individual is receiving psychotherapy unless that person grants permission to do so should become a habit and should not require careful analysis for each client.

Description of Course

The course was team taught by a philosopher specializing in ethics, who also has a master's degree in counseling, and an academic clinical psychologist, who is also engaged in clinical practice. There were 10 students in the class; all but 1 (who was in counseling education) were in their 2nd year in the master's-level graduate program in clinical psychology at the University of Dayton.

The course met weekly for 2½ hr for 15 weeks. All sessions were attended by both instructors, who each assumed primary responsibility for approximately one half of the class material. Class

sessions consisted of a combination of didactic instruction, case presentation, discussion, and student presentation of cases.

Objectives for the students included an ability to reason intelligently about ethical issues, a working knowledge of ethical frameworks and principles, and an ability to apply this knowledge to provide guidance for action in specific cases, to recognize the distinction between ethical and legal standards, and to recognize that the quality of ethical reasoning is as important as the specific outcome or decision made in ethical dilemmas.

With these goals in mind, students were evaluated in four ways. First, to demonstrate a mastery of basic ethical knowledge, students took one in-class, short-answer midterm examination. Second, students prepared a written report of and presented to the class a detailed ethical analysis of a case that was given to them by the instructors. Third, students developed a more detailed and thorough written analysis of a case derived from their own clinical experience. Last, because of its obvious importance in this type of class, class participation and attendance were given high priority in student evaluations.

Course content was broadly divided into three sections. The specific topics addressed are listed in the left column of Table 1. The first addressed underlying conceptual issues that teach students the components and skill of conceptually analyzing ethical dilemmas. This first section addressed the first three levels in our ethical decision-making model: ethical frameworks (utilitarianism, deontology), ethical principles (autonomy, paternalism, beneficence, etc.), and ethical rules. During the rule section of the course, the ethical codes of psychologists (APA, 1981), psychiatrists (American Psychiatric Association, 1981), and counselors (American Association for Counseling and Development, 1981) were carefully reviewed. These codes are generally a set of ethical conclusions with little justification offered for the positions advocated. Our focus was to identify the ethical frameworks and principles that underlie particular propositions in the documents. The fact that more than one framework may be used within a single code may lead to difficulties in developing a consistent approach to professional practice. For example, within the APA code, there are some guidelines that are deontological and absolute (e.g., Principle 6a: “Sexual intimacies with clients are unethical”; p. 636), whereas some are utilitarian and qualified (e.g., Principle 9h: “After the data are collected, the investigator provides the participant with information about the nature of the study and attempts to remove any misconceptions that may have arisen. Where scientific or humane values justify delaying or witholding this information. …”; p. 638).

Table 1 is omitted from this formatted document.

The second section of the course addressed issues that require philosophical attention because of the major value assumptions that underlie them. Because the course focused on clinical assessment and psychotherapy, we felt that some attention needed to be directed to issues of health and disease. We use the terms health and disease, not necessarily to advocate a medical

model, but because these are the terms used in bioethics to address a cluster of value judgments related to assessing compromised functioning (Engelhardt, 1986). We believe that practicing clinical psychologists continually make judgments about which client behaviors are dysfunctional and, furthermore, which dysfunctional behaviors might benefit from psychological intervention. To focus discussion in this section, we adopt use of the term mental disorder. Because our value assumptions about what qualifies as a mental disorder color the form of therapeutic approach advocated, it is essential for practitioners to be clear about what they consider to be the normative criteria for mental disorders, why these criteria were chosen, and the clinical consequences of choosing them. Students are challenged to identify the values inherent in a number of different DSM— III— R (American Psychiatric Association, 1987) mental disorders. In the future, we are planning to discuss the controversial “new” mental disorders that are included in the appendix of the document.

A related issue that we addressed was one that caused considerable puzzlement on the part of students. This was the matter of identifying the “virtues” of clients. Aristotle (1985) described virtues as consciously chosen habits that give direction to the ethical choices that we make and the behaviors in which we engage. Although one can fruitfully explore the virtues of professional psychologists, we now focus on virtues of clients. With respect to clients, the investigation of virtue occurs on two levels. The first has to do with characteristics affecting the therapeutic relationship itself (willingness to change, receptivity to suggestion, etc.). The second level is concerned with the virtues that are operative in conducting the ordinary activities of life. In this sense, the exercise of virtues may admit a multitude of expressions that vary in their degree of adaptiveness, according to some value judgments of what constitutes healthy behavior. When the judgment is that the habit is maladaptive, psychologists must determine whether this behavior is the result of a mental disorder requiring intensive psychiatric or psychological intervention, or merely a characterological deficit (e.g., inability to save, poor time management skills, lack of assertiveness) that could benefit from the assistances of a variety of professionals (e.g., lawyers, clergy, or other types of counselors), in addition to psychologists themselves. The latter consideration is akin to some of the issues in managing “problems in living,” as examined by Szasz (1987).

In the final portion of the second section of the course, a number of particularly important ethical principles were explored in more depth than when they were introduced in the first section. These included autonomy, beneficence, and justice. For example, we presented readings that suggested that paternalistic interventions may be used in cases in which one's autonomy is severely compromised. This notion is critically evaluated, particularly with reference to mental disorders, for which it is difficult to identify the boundaries of “severely compromised autonomy.” Having a clear concept of autonomy will permit psychologists not only to identify those disorders that may produce severely compromised autonomy, but also to provide some direction to the choice of interventions that may reduce or increase restrictions on client autonomy. Last, because one of the key features of autonomous persons is the exercise of

responsible behavior, the notion of responsibility and limitations upon it induced by mental disorders required focused attention.

The third and final section of the course addressed practical applications of the philosophical issues addressed in the first two sections. We focused on those applications that psychologists are likely to confront directly in the course of their professional experience. These included confidentiality; assessment; rights of clients to expect or refuse treatment; social responsibilities of psychologists, including the duty to warn potential victims of aggression by clients; research; involuntary commitment; clinical supervision; laws governing psychologists, with emphasis on the differences between ethics and law; and the ethical implications of various psychotherapeutic techniques, including hypnosis, psychoanalysis, cognitive therapies, and strategic interventions.

Readings were taken from a textbook on ethics in psychology (Carroll, Schneider, & Wesley, 1985), an anthology of articles addressing psychiatric ethics (Edwards, 1982), and a series of readings taken from the philosophical and psychological literatures and compiled by the instructors.

Evaluation of Course

In terms of student ratings, the class recorded a mean of 3.2 on a scale of 0 (poor) to 4 (excellent). This compares favorably with other graduate courses and is slightly above average for graduate classes offered for the first time (M = 2.8–3.0). Positive feedback focused on the good working relationship between the two instructors, the value of having instructors open themselves up for ethical scrutiny by considering difficult clinical cases that they have, the amount of discussion generated, and the greater ethical insight provided by the course. Negative feedback concerned assignments (not having case analysis assignments explained in sufficient detail) and the occasional tendency for discussion to be unfocused and tangential.

To assess the medium-term effects of the course on the clinical functioning of the students, we sent those 8 students who were engaged in clinical settings a follow-up questionnaire 3 months after the completion of the seminar. We sampled only those students in clinical settings because one of the objectives was to determine how much of an impact the course had had on actual clinical behavior. On the questionaire, students rated on a scale of 1 (not at all) to 5 (a great deal) how much each topic within the course and the course as a whole affected them in each of four areas: (a) understanding, reflecting the extent to which their conceptual horizons had been broadened and their ethical reasoning ability improved; (b) professional attitudes, indicating to what degree their perceptions of professional roles, responsibilities, and duties had been changed; (c) attitudes toward clients, including their perceptions of clients' needs, rights, strengths, weaknesses, responsibilities, and autonomy; and (d) applications, reflecting the degree to which their behavior in clinical situations had changed. Students were asked not to record their names on their questionnaires in order to ensure anonymity.

The results of the follow-up survey are presented in Table 1. As the table reveals, the course as a whole was perceived as having considerable impact. With respect to specific course topics, the issues of health and disease, autonomy and paternalism, laws governing psychologists, confidentiality, and ethical implications of specific psychotherapeutic techniques were considered to have particular impact. Those topics considered least helpful were sections on research, virtues and roles of clinicians and clients, and social responsibilities of clinicians. As expected, the course was perceived as affecting cognitive dimensions more than practical domains. Of course, the relatively short time period (3 months) for the follow-up is insufficient to judge the long-term impact of the course on behavioral dimensions. The finding that the course was perceived as having more of an impact cognitively than behaviorally suggests that training should occur on multiple levels, including course work and clinical supervision in practicum settings.

Critical Issues to Consider in Teaching Ethics Courses

Others who choose to teach such a course should consider the following issues in developing their plans: (a) We believe that it is critical to have a major philosophical component contributing to the course and preferably a philosopher specializing in ethics to work with a practicing psychologist; each member of the team should have more than a casual acquaintance with the other's discipline. (b) Students greatly valued case presentations, both their own and the instructors', and we expect to build more such presentations into future offerings of the course. In such presentations, appropriate restraint must be exercised so that students do not overly concentrate on the clinical details of the case at the expense of its ethical dimension. (c) Psychology graduate students at the master's level had particular difficulty with conceptually analyzing the ethical dimensions of clinical cases. We believe that psychologists' training typically does not emphasize in-depth scrutiny of all of the features of individual cases. Instead, ethical or legal imperatives are identified with little, if any, analysis of justifications that support them. Accordingly, instructors may have to demonstrate the process of conceptual analysis by critically examining specific clinical cases with reference to ethical frameworks and principles. (d) It is very important that the process of ethical reasoning be emphasized as much as the product or outcome of this reasoning. Given the pluralistic nature of our society (Engelhardt, 1986), and our adoption of the commonly used utilitarian framework, we believe that differing values among psychologists may lead to the existence of more than one ethically justifiable course of action in many situations. The thoroughness of the ethical decision-making process is particularly important in such instances. (e) Toward this end, and recognizing the considerable modeling influence that instructors have, we feel it desirable that instructors from time to time take risks and allow the ethical dimensions of their practices to be reviewed. (f) There is a tendency for discussion to drift toward legal rather than ethical standards and toward the clinical effectiveness of various practices rather than the ethical dimensions underlying these techniques. Although such discussion is fruitful, we recommend exercising the restraint noted in Item b and focusing on the relevant ethical issues. (g) There is always a need to reconsider both the selection

of issues to be discussed and how they are addressed. We are confident at this time that the issues that we selected for consideration are appropriate. However, some changes are anticipated for future offerings of the course: We are using sections from a different psychology textbook on ethics (Keith-Spiegel & Koocher, 1985) that nicely complements other readings; we recognize that the significance of the notion of virtue needs to be presented in a clearer and more cogent fashion; and we are also considering the addition of a section on views of human nature because the clinician's stance on this dimension has a direct bearing on how he or she will assess the appropriate ethical dimensions of a case.

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